

# Casebook Complaints & Compliments for UL Hospital Group 2022



## Foreword by the Director of Quality and Patient Safety, UL Hospitals Group.

At UL Hospitals Group (ULHG), we believe that patient feedback is extremely important in assisting us to understand our patients and their relative's experiences of our services. The complaints & compliments process ensures that all patients have a clear pathway to record their experience – whether it be positive or negative and the process provides reassurance to our patients of our commitment to learn from their experience.

The priority for us at ULHG is to ensure that every staff member recognises that they have a role to play in the patient experience including the management of complaints. One of the challenges for the hospital group is to further promote and encourage the practice of addressing the complaint at the point of source. It is important that patients have an opportunity to express their concerns in the most appropriate ward/ department/ service area and that the matter is resolved at the first point of contact. Significant investment has been made in the Patient Advocacy Liaison Service (PALS) for ULHG which has been providing direct support to many of our complainants and to the Directorates who are managing the complaints. The PALS team is working closely with the various departments to impart the team's training and experience.

To support the complaints & compliments management process and in conjunction with the Ombudman's Office one of ULHG's priorities has been to publish a complaints/ compliments casebook to share the learning and experiences of our patients and their relatives. This casebook is the result of a comprehensive review of patient complaints and compliments received with particular focus on the first half of 2022.

I would like to acknowledge the contribution of all the staff who work tirelessly in managing complaints on a day to day basis, throughout the various disciplines across our hospital group. I would like to thank the patients and their relatives for taking the time to engage with us and providing us with this invaluable feedback.

Paula Cussen Murphy
Director of Quality and Patient Safety



**Category:** Dignity and Respect (Delivery of care) and Improving Health (Catering)

**Status:** Compliment

## **Background to compliment**

A patient who had spent some time as an inpatient wrote to compliment the staff and the service which they had received.

## Nature of positive feedback

The patient wrote that the service was absolutely outstanding. The staff on this ward should be used as a textbook example of how to carry out duties, while showing compassion, care, integrity and deep understanding and interest. The patient had been blown away with how they were made to feel in a bad situation. The food was also top class and as good as any hotel food that they have had. Well done to all.

## **Outcome and learning**

The compliment was shared with the ward staff and the Catering Department. The hospital promotes a process of ensuring that all positive feedback is shared with staff within and across services as this motivates staff to continue the good work that they do and demonstrates the impact that such care has on patients.

Category: Safe and Effective Care

**Status:** Compliment

## **Background to compliment**

A compliment email was received from a patient acknowledging the care and attention that was received over a prolonged period of time. A special acknowledgment was made to the consultant and his team in the Interventional Radiology Department.

## Nature of positive feedback

The patient stated that their treatment required their attendance at the Interventional Radiology Department on a regular basis. The patient advised they were treated with great care and attention and the dedication shown has helped them through a most difficult and challenging time. The patient advised that the efforts of the team allowed them to live their life while awaiting specialist care abroad. The patient wished to express heartfelt thanks to the consultant, the Consultant's team and all those involved in the care provided in the hospital.

## **Outcome and learning**

This compliment was forwarded to the Radiology Team to highlight how their holistic approach to patient care contributed to a person's life even when dealing with a challenging health issue. Such an approach has relevance to all healthcare staff delivering health services.

Category: Safe and Effective Care

**Status:** Compliment

## **Background to compliment**

A patient was admitted to the High Dependency Unit (HDU) within the hospital. The patient's spouse had passed away in the hospital some years ago and the family, at that time, had a very negative experience and had submitted a complaint that was managed through the complaints process.

The patient's daughter contacted the Hospital's Patient Advocacy Liaison Service (PALS) to request support with access to clinical updates and support around linking with the clinical team. She also wanted to see if the recommendations following the complaint regarding their parent's care, which were provided at a family meeting were implemented.

The PALS Manager supported the family throughout their time in the hospital and over the course of the week the family meet with 3 PALS Managers who provided the liaison support with all teams. The hospital explained to the staff the previous concerns and experience that the family had so they may understand the heightened levels of anxiety that the family had around their parent in HDU.

## Nature of positive feedback

The patient sadly passed away and the family phoned a week later to thank the PALS team for their role in advocating for their parent and family in ensuring that they were supported through the final days.

## **Outcome and learning**

Listening to this family's previous experience and ensuring that the communication deficits which occurred in the past were addressed, all contributed to this family feeling well supported during this admission. As the staff were made aware of the family's previous experience and their sensitivities around same, staff were cognisant of the family's needs and included the family in clinical decisions and provided regular updates.

The hospital is actively demonstrating empathy and learning having listened to and clearly committed to building back trust lost.

An additional learning point for the hospital in this complaint was to appoint a liaison staff member for families who have had challenging experiences within the hospital in the past. To support them during further admissions to mitigate any anxieties and fears that they might have.

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

**Status:** Compliment

## **Background to compliment**

A young patient was diagnosed with a chronic condition neither they nor their family was familiar with. The patient regularly attended a hospital unit for treatment over a number of years, but had recently been transferred to a specialist consultant and was now no longer under the care of the original unit.

## Nature of positive feedback

The patient wrote to the unit to thank them most sincerely for the high standard of care and attention which they had received and to say that they felt this care had greatly contributed to their improvement. The patient highlighted the professionalism of the staff and their dedication to helping them over the years.

The patient and the patient's family stated that they have fond memories of their time in the clinic and with the staff. The patient felt that anyone attending their unit is indebted to them for the care they provide. The patient was greatly appreciative of the care received and wished the staff well.

## **Outcome and learning**

The compliment was forwarded to the staff in the unit. The staff in in the unit knew the patient well and were delighted to know that they made such a difference to the quality of their life and that their time in the unit was positive experience.

This compliment further reinforces the power of the personal touch in clinical care. The human element of care cannot be underestimated and can have a powerful and lasting impact on a person and can be a positive force in their care and recovery.

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

**Status:** Compliment

## **Background to compliment**

A patient went into unexpected labour at 33 weeks' gestation and underwent an emergency caesarean section. The patient was in a state of shock and found the suddenness of the experience traumatic, particularly as her partner or any family member could not be with her.

## Nature of positive feedback

The patient wrote to the hospital to compliment the ward nurses who took excellent care of her. The patient highlighted their little touches of kindness that 'brought me back from the brink' on many occasions. The patient stated that the most important aspect of the care she received, for her, was the compassion and understanding that the nurses displayed. The patient thanked the nurses sincerely for the kindness and love shown to her.

# **Outcome and Learning**

This compliment was shared with the nursing staff who were delighted to know that their care made such a difference and that their care had such a positive impact on the patient's recovery.

**Category:** Safe and Effective care (Treatment and Care)

**Status:** Compliment

## **Background to compliment**

A patient completed the Your Service Your Say online feedback form following their attendance and experience at the hospital's Medical Assessment Unit.

## Nature of positive feedback

The patient wrote to the hospital to relate their experience as the staff, from start to finish, were so friendly, supportive and competent. The nurses carried out the relevant tests and completed the necessary documentation so expertly, all while ensuring that the Service User was comfortable and not in any pain.

The patient was also regularly asked if they needed anything to eat or drink during their assessment. The examining doctor was very supportive and thorough. This approach was so appreciated especially as the patient was aware how must stress the hospital was under. The patient also noted that strict adherence to infection prevention control measures was clearly evident. The patient felt so well looked after and wanted to thank the very competent, friendly and supportive staff.

## **Outcome and learning**

This compliment was passed onto the staff of the MAU who were happy that their care and attention had such a positive impact on the patient.



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

**Status:** Compliment

#### **Background to compliment**

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

## Nature of positive feedback

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

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

## **Outcome and Learning**

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

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

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

Category: Communication and Information (Communication Skills), Dignity and Respect (Behaviour)

**Status:** Compliment

#### **Background to compliment**

A patient attended the Emergency Department (ED) of a hospital where they waited over 5 hours to see a doctor. It was an extremely busy night in the ED with lots of activity in the department.

## Nature of positive feedback

The patient contacted the hospital to advise how a 'very nice' porter escorted them from triage to the treatment cubicle where they had to wait to be seen by the doctor. The patient stated how the porter was so nice and reassuring and took time out to sit and talk. This put the patient at ease and alleviated some of the stress of the situation. The patient was then seen by 'a lovely' doctor and nurse. They introduced themselves and the patient was delighted to get their names. They talked the patient through everything that they were going to do. The patient stated in their compliment to the hospital that these three staff members made the time in the ED a much better experience and for that, thanked them all sincerely.

## **Outcome and Learning**

This compliment highlights the importance of taking time to talk to service users especially if they seem distressed. Taking even a small amount of time to reassure them makes their experience so much better. The compliment also highlights the importance of staff introducing themselves and keeping the Service User fully informed of all elements of their care. The care and attention shown by these staff members to this patient, in a challenging environment contributed to a very positive experience.

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

**Status:** Compliment

#### **Background to compliment**

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

## Nature of positive feedback

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

#### **Outcome and Learning**

The patient's spouse phoned the PALS team to let them know how happy they were that their voice had been heard. The patient's spouse expressed their satisfaction and appreciation for the help and assistance they had received and relayed that they could really notice a difference in the patient's mood and felt that they were being well cared for. The patient's spouse also commented that they had also observed the delivery of care and described it as 'amazing'. The patient's spouse complimented the PALS service and was delighted with the follow up and support. The importance and value of communicating effectively with patients and their families was highlighted to all staff involved. Communication is one of the most important skills and alleviates a lot of concerns and worries for patients and their families. Once patients and their families are aware of the procedures and the time line, they feel reassured with the care that they are getting. Using the Assist Model is very important as it has a step by step approach to effective communication. Having the service user centre and first in our approach keeps us grounded and on the right path.

Category: Communication and Information (Communication Skills), Dignity and Respect (Behaviour)

**Status:** Compliment

#### **Background to compliment**

The spouse of an older patient contacted the hospital to advise them of an upcoming outpatient appointment for their spouse. The spouse advised that the patient has a number of medical conditions which makes wearing a mask for longer than about 10 minutes very uncomfortable. Any longer and the patient gets breathless and panicky. Prior to the appointment the spouse rang the receptionist of the clinic to discuss how best to manage the patient as they were at risk of panicking and leaving, thereby wasting the appointment and not getting the necessary review.

## Nature of positive feedback

The receptionist advised the spouse that they would look into this and call them back. The spouse stated that they received the call-back, as promised, from a very nice receptionist who advised that she had discussed the patient's case with one of the nurses and they had a plan to progress the patient as speedily as possible through the clinic. When the patient arrived at the clinic, the staff were expecting them. They took great care and they ushered the patient to a quiet place to sit and ensured that the patient was seen promptly, thereby reducing the time spent in the clinic.

The spouse advised that this receptionist went out of her way to assist and really listened and heard the concerns raised. The spouse said that this was an example of values in action as purported by the hospital and deserving of acknowledgement. The spouse wished to thank the receptionist for her kindness and for taking the patient's situation into account. The patient was also delighted with the care and attention received and wished to sincerely thank the receptionist and all the staff involved.

#### **Outcome and learning**

This compliment highlights the importance of listening to patients and their families and understanding their individual care needs. The receptionist took the time to listen, discussed the case with a nurse and put in place a solution to enable the patient to attend the appointment while minimising any stress and resulted in a positive experience at the clinic.



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

**Status:** Complaint Upheld

#### **Background to complaint**

During one of the peaks of COVID -19, a person wrote in a complaint relating to both their parent and spouse. The complainant stated that a member of the security team in the Emergency Department (ED) asked their spouse to leave the ED which meant leaving their 93-year-old parent on their own.

## Investigation

The directorate complaints officer met with the security manager and discussed this complaint in detail. The incident was then investigated further. Once the investigation was completed, the directorate complaints officer wrote to the complainant apologising for their experience. The complainant was informed that the complaint had been fully investigated. The complainant was advised that a meeting had taken place with the security officer involved and while the security officer involved was following procedure, it was highlighted to him by the security manager that it was inappropriate or indeed unsafe to leave this older patient on their own in a busy ED. The directorate complaints officer outlined that the security officer involved offered their sincere apologies to the person's parent for the way they were made feel alone and vulnerable on the night in question.

The hospital also relayed an apology from the Security Manager of UL Hospital for the worry and upset it caused the family.

The complainant was thanked for bringing the complaint to our attention as it highlights the additional training requirements for all security staff in across ULHG.

## **Outcome and Learning**

- The security manager was made aware of the actions of the security officer involved.
- The security manager brought this complaint to the attention of the security officer involved.
- The Security Manager used this example for further roll out customer service training for all of the security officers within the department.

A follow up email was received from the complainant thanking the hospital for the response and for the apology from the Security Officer and Security Manager. The complainant was glad to hear that the Security Officer was following the recommended COVID guidelines, however, highlighted that a bit more compassion could have been shown under the circumstance.

Another piece of learning is to be cognisant at all times of our Values in Action and, in particular the values: "Am I putting myself in other people's shoes" and "Am I aware that my actions can impact on how patients feel". This learning will be used by our Security Officer in his customer service training going forward.

Category: Communication and Information (Information), Safe and Effective Care (Continuity of

Care), Discharge), Accountability (Patient Feedback)

**Status**: Complaint Upheld

## Background to complaint

An elderly patient was admitted for elective surgery. The patient lives with their spouse and had no other support at home. The patient asked on two occasions if additional time in the hospital post-surgery could be provided. However, the patient was discharged home within 24 hours with a drain in situ and was referred to a community support service. The patient complained that there was an assumption of knowledge around the post-surgery recovery and that their concerns were not taken into consideration.

The patient stated they were given a prescription for medication and not given any written or verbal information about their prescription or what to expect. The patient became disorientated and confused with this medication at home. The patient was upset at how their written complaint was responded to. The patient felt there should have been greater sensitivity to the complaint and someone should have phoned to discuss this in more detail upon receipt of same. Instead the patient received a lengthy written response. The patient requested a review of the response and contacted PALS for support. They were considering looking for a review and submitting their complaint to the Ombudsman.

#### Investigation

Upon receipt of the call from the patient, the PALS Manager took a detailed description of the patient's experience and interaction with the hospital to date. The issues were themed and assigned to the appropriate areas. The Complaints Officer who had responded to the initial complaint was contacted and advised of the patient dissatisfaction at the response.

A face to face meeting with the patient, the treating consultant, the clinical nurse manager and the PALS Manager took place, where all issues relating to the response were aired and addressed. The patient was very thankful to have the opportunity to speak to the team and tell them about her experience.

A week later the patient decided not to proceed to the review stage or go to the Ombudsman.

## **Outcome and Learning**

The primary issues relating to this complaint were how the patient was communicated with pre and post-surgery and the 'assumption of knowledge' that they would appreciate what to expect on discharge home. While the patient underestimated the personal toil that recovery would take on them, the hospital presumed they would manage despite living with an elderly spouse with no immediate family.

The opportunity to refer to the PALS Manager at an earlier stage would have enabled a quicker resolution to the complaint and mitigated the stress of the patient by demonstrating a level of empathy, compassion and acknowledgment of their experience as well as supporting them through the complaints process.

Communicating effectively with patients allows them to raise any issues or concerns they have in advance of being discharged.

**Category**: Safe and Effective Care (Confidentiality)

Status: Complaint Upheld

#### **Background to Complaint**

The complaint related to General Data Protection Regulations (GDPR) compliance and how personal data was being stored. The request was for the provision of photographic ID as proof of identity when attending the Radiology Department to collect a disc with radiology images on behalf of a relative.

## Investigation

It was found that the complainant presented to the Radiology Department to collect a disc with images for a relative. The complainant was asked to provide photographic ID as proof of identity of next of kin and advised that a copy of the proof of identity is recorded on the patient's record. The complainant expressed an objection to this procedure. It was advised that that it was the policy of the department to request proof of identity, copy the identification provided and record this information against the patients' record as proof as to who collect the CD. The complainant provided photographic ID as requested. The complainant questioned GDPR and if there was a breach of same.

## **Outcome and learning**

Under the Right to Erasure Articles 17 & 19 of the GDPR, the complainant has a "right to be forgotten". Following review, it was considered sufficient to document that photographic ID had been supplied rather than further processing and storing the complainants photographic ID.

The complainants' photo ID was removed from the relatives' record and a note recording the name of the person collecting the disc and confirmation that photographic ID was provided was maintained instead. A letter confirming the removal of the photo ID was issued to the complainant.

The local policy has been reviewed and updated. All staff in the Radiology Department have been informed of the procedure.

**Category**: Safe and Effective Care (Communication Skills/Information)

**Status:** Complaint Resolved Informally

## **Background to complaint**

A patient's spouse sent in a complaint to the national Your Service Your Say Office and then contacted the hospital directly.

The patient had been readmitted through the Emergency Department (ED) where they had a poor experience and they alleged that the staff were rude and did not understand the presenting problem.

In the complaint submitted, the spouse advised that the patient was complaining that they:

- 1. Had no discharge letter on previous discharge.
- 2. Were not given discharge information or advice on discharge.
- 3. Were still awaiting the CT of abdomen report.
- 4. Had received no medical update.
- 5. Were concerned that the antibiotics didn't relieve symptoms first time.
- 6. Were anxious regarding the perceived delay in treatment.
- 7. Are self-employed with two young children and this was the fourth week unwell.
- 8. Had no idea of how the system of getting information worked.

## Investigation

The PALS Manager attempted to informally resolve the issues raised. The PALS Manager contacted the patient's spouse and using the "ASSIST" model, provided the reassurance that they would link directly with the patient.

The PALS Manager linked in first with the ward and spoke to the nurse manager there. The nurse manager had advised the patient to contact PALS as they wanted the complaint to be escalated.

The PALS Manager went to see the patient and acknowledged the concerns raised. The PALS Manager apologised for their experience and answered as many questions as possible but advised that further contact with colleagues would be needed to obtain all the information requested.

The PALS Manager then contacted the relevant clinical team and asked if they could issue the CT result and review the patient and discuss a plan of care with the patient to ease concerns.

The PALS Manager explained the process to the patient who was happy with the response.

## **Outcome and learning**

Both the patient and their spouse found the management of their complaint very beneficial and were happy with the outcome.

The importance of communicating effectively with patients and their families was highlighted to all staff involved. Effective communication is one of the most important skills and alleviates a lot of concerns and worries for patients and their families.

Once the patient and their spouse were advised of the procedures and the time lines, they both felt reassured with the care that was being provided. Using the assist model is a very important communication tool that enables clear two-way communication and information flow and promotes patient centeredness.

**Category**: Safe and Effective Care (Accountability, Communication/Information)

**Status:** Complaint Upheld

## Background to complaint

A patient with a background of an aggressive form of cancer was being treated in hospital. A complaint was received from the patient's spouse and was acknowledged by the complaints officer. The hospital was subsequently advised that the patient had sadly passed away.

Following this communication, the Complaints Officer made contact with the patient's spouse to establish the main issues within the complaint:

The main elements are detailed below:

- 1. Questions about the treatment provided.
- 2. It was felt that communication from the treating doctor was poor due to poor language/eye contact.
- 3. Questions about the proposed timeframe for treatment at the time and the lack of a plan subsequent to further diagnosis being made.
- 4. General lack of interaction, communication and planning when the patient's condition changed.

The family were very distressed and upset as the patient died during a time when Covid restrictions were in place and they felt they were not supported and not being heard, despite numerous contacts by email.

#### **Investigation**

A pre meeting arranged by the complaints officer with the consultant to discuss the main issues within the complaint and to ensure that all information regarding the patient's journey through the services would be available at the family meeting.

During the meeting, the family relayed their experience. The consultant and medical team listened.

The approach of the consultant and the medical team to the meeting provided for an open and calm environment and which was respectful to the family's emotions. This allowed the time needed for the family to ask questions and raise concerns but also created an atmosphere which was supportive, enabling the family to hear the answers being provided.

Detailed explanations for clinical decisions were carefully provided by the consultant and the medical team using language that was clear and easy to understand. Further opportunities to ask questions was given at various points and explanations, where needed, were provided.

The use of the "Chuck & Check" technique throughout the meeting allowed the family the time to absorb the information given. The family thanked the consultant and the team for their time and for the opportunity to have their experience heard and this provided an element of closure.

A wholesome apology was also given by the consultant for communication issues that the family encountered with an NCHD (Non-Consultant Hospital Doctor). The Consultant explained that since coming to Ireland and to this teaching Hospital, the doctor has been undergoing communication

skills training (both verbal and non-verbal) to overcome any cultural differences and better improve engagement with patients and families. This was accepted by the family. A commitment was made by the consultant to go through the experience the family described about language and cultural barriers they encountered with his team and the wider medical teams in the hospital.

The family also expressed their frustration regarding the delay in responding to their complaint. An apology was given by the complaints officer for this delay. The complaints officer explained some of the issues encountered and these impacted on the timeframe. The apology and explanation was accepted by the family.

#### **Outcome and learning**

The family thanked (via PALS) the consultant and the medical team for the time given to the meeting. The hospital took significant learning from this complaint on the importance of clear, effective and regular communication during a patient's care and, thereafter with their family when requested and as appropriate.

An additional learning note is to ensure adherence to the Your Service Your Say process, which is set out under policy and guidance, for effectively managing complaints and which promotes contact/meeting with patient's and/or families to discuss issues and answer questions as this can result in a more satisfactory outcome for all involved.

**Category**: Safe and Effective Care (Communication/Information)

**Status:** Complaint Resolved Informally

## **Background to complaint**

The hospital received a telephone call from a spouse of a patient who outlined the difficulty they were experiencing in getting through to the ward. They stated that they had one visit in five weeks and that the patient's team had not provided a recent update to the family. They explained that the family were very upset with not being able to get through to the ward, not being permitted to visit and the lack of information provided. They highlighted that the patient was very unwell and not able to retain the information given by the team. The family felt, from their phone calls with the patient, that the patient's appetite and mood were deteriorating and that a family visit in person was needed. The family wanted to know what was the plan of care and requested a visit and if a meeting could be arranged with the consultant.

## Investigation

The PALS Manager met with the patient to provide support and ascertain how they wished to proceed.

The PALS Manager then contacted the Consultant, voiced the concerns of the family and advised of their request for a family meeting. The PALS Manager also contacted the ward and discussed the family's concerns and the importance of providing regular updates as well as the importance of compassionate visits due to the deteriorating condition of the patient.

#### **Outcome and Learning**

Using the Your Service Your Say framework to assess concerns raised provides an opportunity to handle and resolve complaints informally. This can avoid escalation to a formal complaint investigation as well as providing a better outcome for those involved.

In this case, a family meeting was arranged with the consultant and the family. A plan was put in place in the ward to facilitate compassionate visiting and they linked in with the family to establish a schedule for same. The family were very happy to have visiting arrangements in place.

The importance of providing regular updates to Next of Kin(NOK) /family from nursing and clinical teams to be established as per the Time Out document.

Visiting is to be considered on a case by case basis, patients that are very unwell should always be facilitated with visits from their family. This had been highlighted to all members of the Multi-Disciplinary team.

**Category**: Safe and Effective Care (Communication/Information)

**Status:** Complaint Upheld

## **Background to complaint**

The parent of a paediatric patient complained about the distress to her child following attempts to draw vials of blood for testing. The complainant explained that for 40 minutes the child's hand was squeezed and no numbing cream was used. When the patient went home, the patient was sick and still upset after the withdrawal of blood and their hand was bruised and swollen to the sight and touch.

## Investigation

The complaint was fully investigated by the Complaints Officer. It was explained to the complainant that it was necessary to take 6 vials of blood from the patient to enable sufficient testing in the receiving Hospital. While the aim was to avoid any undue stress or injury to the patient, it was clear that the process caused upset to both the patient and their parent.

## **Outcome and Learning**

A full apology was issued to the family for any distress caused. Following review of the complaint, the process for taking paediatric bloods has been reviewed and changes implemented. These changes include having a dedicated phlebotomist taking the blood and also assistance to administer the numbing cream.



**Category:** Communication and Information

Status: Complaint Partially Upheld

## **Background to complaint**

A patient who attended the Day Ward for a procedure made a complaint in relation to the following: -

- The lack of management and security in relation to Covid-19 at the Admissions Office.
- No social distancing at the Admissions Office.
- A number of people appeared to have the same appointment time.
- Advised to wait in car until phone call received from the Admissions Office to enter the hospital and no call was received.
- No Security on the door and front door was not locked.
- Mask wearing was not being enforced.

## Investigation

The complaints officer investigated the complaint and established the following:

- On the morning in question, a number of patients entered the hospital prior to receiving a phone call from the Admissions Office and some arrived ahead of scheduled time causing increased activity outside Admissions Office.
- It is clearly outlined on information sheet sent to patient with appointment letter that patient should remain in car on the morning of surgery until Admissions Office rings at admission time.
- The patient did receive a phone call from the Admissions Office at his appointment time and was asked to remain in his car to allow for social distancing.
- Security personnel are on duty at both the front and back doors. It is not possible to lock front door as urgent access is required at all times.
- The wearing of masks is mandatory for all staff and anyone entering the hospital. Signage is in place.
- It was noted that additional safety measures in relation to Covid-19 were also in place such as hand gels, Temperature Monitoring Machine etc.

## **Outcome and Learning**

The complaints officer wrote to complainant following investigation and outlined the above findings. The patient thanked the complaints officer for taking the time to feedback and allowing the complaint to share what they had experienced.

Following a review of the Admission Office processes, additional spacing has been put in place between patient appointment times and an additional clerical resource has been put in place in the Admissions Office each morning to assist with patient flow.

**Category:** Communication and Information (information)

**Status:** Complaint Upheld

#### **Background to complaint**

A relative of a patient with an OPD (Outpatients Department) appointment wrote to the hospital to complain about the lack of car parking spaces available and a queue of cars for each of the public car parks when she arrived to bring her parent to their OPD appointment. She advised that if he had been alone he would have been very late for his appointment and would not have had any idea where to park. The complainant felt that this issue needed to be addressed urgently. They stated that the majority of patients attending OPD are elderly and already stressed and anxious about their appointments when attending the site and that parking adds to this stress.

#### **Investigation**

Upon receipt of this complaint, the complaints officer made contact with the car parks manager and highlighted this lady's concerns. He explained that unfortunately some days the car park can be particularly busy with high attendances at OPD clinics. He confirmed that every morning first thing all of the car parks are patrolled and the available spaces are identified and the car park counters are updated to reflect the number of spaces available.

Throughout the day one car park attendant patrols the site in a van, regularly going into the three public car parks ensuring spaces are matching the counter and that there are no vehicles double parked or parked incorrectly. When the car parks are full the car park staff are constantly taking calls from all of the entry points he explained that as soon as somebody exits, the next person can pull a ticket from the machine and enter the car park.

During extremely busy hours, car park staff stand at the pedestrian crossing by the car parks directing vehicles to the carparks which have spaces available.

## **Outcome and learning**

The complainant was made aware of the ongoing issues experienced every day in relation to car parking and the efforts that are made on a daily basis by the car park staff to try to ensure that all patients/service users gain easy access to car spaces.

The learning from this complaint was the understanding of the frustration and anxiety experienced by patients and their families when they are unable to get a car space while rushing for an appointment. Car park staff have increased their patrolling of the site particularly on days when the clinic numbers are high, they were also made aware of the importance of them being visible and communicating with the drivers who are waiting for a car space.

The complainant was very impressed with the efforts made by the car park staff and felt this should be highlighted further.

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

Status: Complaint Partially Upheld

## **Background to complaint**

A patient wrote to complain about their distress following a surgical procedure. The patient stated that when they woke after surgery, they were being held down by staff and it felt like they were being strangled. The patient also advised that the following day when they looked at their neck in the mirror they noted bruising. The patient advised that when they raised this with staff at the time there appeared to be a communication deficit. A statement was taken from the patient on the ward, they were examined and then discharged without an explanation.

## Investigation

The complaints officer fully investigated the complaint. They contacted all staff involved in the patient's care. The complaints officer established that the patient had undergone anaesthetic delirium following their procedure. The patient did not remember or recollect the period whereby in order to keep their airways clear from obstruction a 'thrust procedure' was performed. The nursing staff were trying to support the patient and protect them from falling from the bed. The patient had begun to recollect what they experienced whilst on the ward and coming around from the anaesthetic, following the delirium.

## **Outcome and Learning**

When the patient brought this to the attention of staff on the ward they should have ensured that a member of the anaesthetic team was afforded an opportunity to meet the patient and explain what had happened.

The complaints officer set up a virtual meeting with the patient and the Anaesthetics Team to go through the phases of care in chronological order to address the issues raised in the complaint. The patient was very happy with this approach. The following learning resulted for the Hospital:

- All multidisciplinary team members will continue to engage and attend the National Communications Programme which will support and drive optimum engagement and communications with the multidisciplinary team internally and also with the patient.
- The hospital will continue to promote patient engagement in all aspects of their care and aftercare.
- A Quality Improvement (QI) initiative surrounding a patient information leaflet is to be
  developed to include content on 'emergence delirium', which can develop as a result of
  anaesthesia, during transition from unconsciousness to complete wakefulness. Such
  information will assist service users to understand and process this experience, should it
  occur.

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

Status: Complaint Upheld

## **Background to complaint**

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

## Investigation

The Complaints Manager brought the complaint directly to the attention of the treating Doctor and asked the Doctor if they could make a call to the parent to discuss their complaint. The Doctor apologised to the patient's parent for not getting in touch sooner and took the time to answer all of the parent's questions relating to the care of the patient.

# **Outcome and Learning**

The parent of the patient was very pleased and very thankful that the Doctor had taken the time to address concerns and that the Doctor had taken the time to call the parent. The parent of child also followed up with a call to the Complaints Officer to thank them for their assistance. This complaint highlights the importance of making sure that all parents are kept fully informed of their child's medical condition and care plan. Parents need to be given the time to meet with and discuss their child's care with the medical teams treating them.

Category: Communication and Information (Delay and Failure to Communicate)

**Status:** Complaint Upheld

#### **Background to complaint**

The hospital was contacted by the parent of a patient who was extremely concerned that the patient had no follow up on test results. The parent thought that here was no treatment plan in place for the patient or if there was one, it had not been communicated or discussed with them. The parent was concerned that the lack of follow up would have an adverse effect on the patient and that their condition may worsen as a result.

## Investigation

The Complaints Officer contacted the secretary of the treating Consultant. The treating Consultant offered to retrieve the patient's healthcare records and review them along with the complaint with the Paediatric Consultant. The patient had a further appointment and was seen by the Consultant and Registrar in the Paediatric Day Ward. The parent of the patient had an opportunity to discuss their concerns with the Consultant and a plan was put in place for the care of the patient. This included a new prescription being sent to the patient's GP which was communicated to the parent. The Complaints Officer organised for the Consultant's secretary to call the patient's GP to confirm that they had received this prescription. The GP advised that they would fax the prescription to the Pharmacy and the Complaints Officer followed up with the parent to confirm this arrangement. The Complaints Officer contacted the complainant to confirm the closure of the complaint to their satisfaction. The parent responded to the Complaints Officer directly and expressed their gratitude for following up and ensuring that their concerns for the patient had been listened to and addressed.

## **Outcome and Learning**

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