HSE Your Service Your Say

HSE Anonymised Feedback Learning Casebook Q4 2019

Welcome to the fourth and final edition for 2019 of the **HSE Anonymised Feedback Learning Casebook**. This casebook sets outs a selection of complaints, four from Hospital Groups, six from Community Healthcare Organisations and one from the National Ambulance Service, which were investigated and/or reviewed along with their outcomes.

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

The cases included in this edition, although each unique, present themes and issues that needs to be examined in the context of quality and service improvement.

In this final edition for 2019 the underlying theme of communication and the provision of information features heavily as it did in previous casebooks. The issue of access is again highlighted, primarily in relation to the wait times for appointments and waiting times at clinics.

Accountability in relation to the proper application of the HSE's complaints management process was also raised particularly for the assessment phase of the process which resulted in complaints progressing through all stages of the process due to complaint issues not having been correctly identified.

Clinical issues were also examined in the areas of health and safety, continuity of care, and medication.

These cases have brought about some important practice changes but have raised issues that require further attention and improvement.

The casebook will be widely circulated to staff within the HSE and shared with Complaints Managers who will consider how the findings and recommendations can be applied to their service area and used as a quality initiative.

We hope that this casebook and subsequent casebooks will continue to develop and will offer a valuable insight into the issues that give rise to complaints and will assist in guiding decision making to improve services and the service user experience.

Hospital Group

Category: Communication and Information
Status: Upheld

Background to Complaint

Parents had a difficult Multi-Disciplinary Team (MDT) meeting to discuss the possibility of life-saving treatment for their child to be provided at this hospital. Whilst this MDT meeting was the culmination of a number of previous consultations to discuss treatment, it was a particularly difficult meeting for all concerned due to the fact that the parents were strongly advocating for a course of treatment that the consultant had previously advised would not be clinically warranted for the patient. During the consultation the parents felt that the Consultant's body language and tone of voice was aggressive, inappropriate and insensitive to the parents' wishes for their child. The parents felt shocked and saddened by what they described as the Consultant's outburst and stated that they were extremely hurt by the words and actions the Consultant portrayed.

Investigation

The Complaints Officer contacted the Consultant to discuss the parents' concerns. The Consultant felt that the parent's understandably heightened emotional state was inhibiting their ability to accept the difficult message being conveyed. Consequently, the Consultant felt that in order for the parents to understand what was being said, and the seriousness of it, it was appropriate to become more firm with them as the discussions progressed. The Consultant's primary concern was that it was not clinically appropriate or in the patient's best interest, to provide the treatment being requested by the parents and furthermore to provide it would have been irresponsible.

Outcome and Learning

The key learning is that staff needs to be reminded about the best modes and methods for communicating difficult messages and that the particular sensitivities of each case are taken into account during each communication. The family's experience has since been used, in an anonymous way, to teach relevant staff members the appropriate communication skills for use in difficult consultations. All consultant staff have also been invited to enrol on the National Communications Programme for Consultation Skills. A sincere apology was expressed to the parents for their experience during the MDT.

Hospital Group

Category: Accountability and Communication and Information
Status: Upheld

Background to Complaint

The patient and guardian (complainant) attended the Emergency Department (ED) for treatment following review by an out-of-hours GP the previous night. The complainant did not have a letter of referral to present so Registration staff requested the statutory payment of the ED charge of €100. The complainant felt that the charge should be waived as the patient had attended the out-of-hours GP service where full payment was made. The patient was subsequently admitted to a ward from the ED. Following discharge, the complainant attended the Accounts Department with the GP referral letter requesting reimbursement of the statutory ED charge which could not be facilitated at that time. The complainant was unhappy that the fee was not waived in the first place and also that the option to pay the charge at a later time was not given. The complainant also stated they were unhappy with the manner in which that the ED Registration staff member communicated with them and was also unhappy that the option was not given to have the GP referral letter sent to the ED by fax.

Investigation

The complaint was investigated by the Complaints Officer and the Healthcare Records Manager.
The hospital responded to the queries raised in relation to the statutory ED charge advising that it is a statutory charge which is requested upon registration at all Emergency Departments and it is not the practise to issue invoices for later payment.

The hospital sincerely apologised for the communication experience in the ED and for the option to send a fax of the GP referral letter not being given. The complaint was discussed with the ED registration staff member by their manager and furthermore, a meeting was arranged with all ED registration staff to identify areas of improvement e.g. consistent approach to informing the public of the statutory ED charge.

Outcome and Learning

The complainant requested a review on the basis that they were unhappy that an invoice was incorrectly raised for the ED charge. A Review Officer was assigned who sought additional information.

Accountability: As an incidental finding, a processing error on the Patient Accounts System was identified by the Review Officer. While the application of a charge was correct, the statutory ED charge should have been automatically replaced by the lesser Inpatient Charge (€80) on admission. The Patients Accounts Department were asked to review the system to see why this failure occurred and to prevent it from occurring again. The reimbursement of the difference between the ED charge and the Inpatient Charge was processed and returned to the complainant.

Communication & Information: Signage has since been displayed within the ED Registration area to advise the public of the statutory ED Charge. A consistent approach to requesting the statutory payment was developed and all Registration Staff have been advised of the process for advising the public of the charge and payment options.

Hospital Group

Category: Safe and Effective Care; Communication and Information
Status: Upheld

Background to Complaint
The patient was admitted by ambulance to ED with a history of on-going severe pain. Whilst using a bed pan, the patient lost balance and fell off the bed onto the ground. The bed rails were down at the time. The patient lodged a complaint with the hospital based on the standard of care received, delay in receiving pain relief following the fall, the communication and information received from nursing and medical staff. The patient stated that after the fall nursing staff shouted, used inappropriate language and made the patient to feel like a nuisance to them.

Investigation
The complaint was reviewed and an apology was issued to the patient for the level of service received during attendance to the hospital. The nursing staff involved in the patient's care denied using inappropriate language or shouting during their interactions but apologised if the communication was deemed unprofessional.

The hospital reported that there was a difference between the recollections of the nursing staff and the patient's account of events. The nursing staff recalled the patient easing down onto the ground rather than falling from the bed and stated that this was the reason neither a medical review nor an incident report form was required.

The hospital acknowledged the delay in providing pain relief to the patient and apologised for the open bottle of medication left at the bedside as this is unacceptable practise. On-going education in relation to medication safety and also safety with regard to bed rails was reinforced within the hospital. The hospital unreservedly apologised for the experience the patient had in the ED.

Outcome and Learning
The patient requested a review as they remained unhappy with the care received and the lack of communication from the hospital. A Review Officer was assigned and it was suggested that a meeting be arranged to address the outstanding concerns. The patient agreed to this meeting and the outcomes were as follows:

Safe and Effective Care: As an area of improvement, a newly appointed ED Clinical Facilitator was given the responsibility of delivering an awareness programme within the department for timely and effective pain relief for patients to address this concern going forward.

It was acknowledged by the hospital that the bed rails were positioned down at the time that the patient was using the bed pan. Education in relation to safety and use of bed rails was reinforced within the hospital. This programme is ongoing.

Safe and Effective Care / Health and Safety: There were inconsistencies between the patient and staff recollections of the fall. This meant that an incident report form had not been completed at the time and it was agreed that this would be undertaken on the patient's behalf. A copy of the completed form was then provided to the patient.

Communication: The necessity for clear, professional and empathetic communication with a patient was also recognised and continues to be re-iterated to staff and supported through a continual learning programme delivered in the hospital.

Hospital Group

Category: Communication and Information
Status: Partially Upheld

Background to Complaint
Patient stated surgery was cancelled on two occasions.
Patient advised they were in pain which was causing them to feel very down and depressed.

Investigation
The complaint was investigated by the Complaints Officer and Consultant Orthopaedic Surgeon. On investigation it was noted that the patient's surgery was cancelled as a result of the planned nurses strike nationally which led to the cancellation of all scheduled surgery. The patient was contacted by the admissions nurse and was re-scheduled for surgery. The manager in theatre advised that once the date of surgery is agreed with the admissions nurse and the patient, it is normal practice to order the required equipment. Unfortunately the company who provide the equipment advised that it would not be available for the scheduled surgery date. This resulted in the second cancellation.
The patient was rescheduled and surgery went ahead successfully.

Outcome and Learning
The hospital apologised at all stages of their communication with the patient and explained the reasons for the cancellations and acknowledged the upset it caused. A follow on response letter to the patient's complaint was issued by the Complaints Officer. The complaint was partially upheld. The patient was satisfied with the explanation and the surgery went well.

Community Healthcare Organisation

Category: Communication and Information
Status: Partially Upheld

Background to Complaint
A complex complaint was received in relation to an elderly residential unit.
The complaint was made by the daughter of a short stay resident. There were a number of elements to the complaint relating to the level of care that the resident received, concerning:

~ Activity
~ Falls management
~ Mobility
~ Wound management
~ Assistance whilst feeding and food quality
~ Communication with the family

Investigation
The complaint was investigated by a Complaints Officer under Stage 2 of the Your Service Your Say policy. Only one issue was upheld. This concerned the element around communication and the management of expectations.

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 Clinical Nurse Manager, the Physiotherapist and Occupational Therapist. Discussions were also held with the complainant.

Outcome and Learning
Following completion of the investigation, recommendations were made and are currently in the process of being implemented.

1. The Director of Nursing, nursing/care staff and the Rehab MDT to devise a guideline to clarify for families the type of care delivered in the Rehabilitation Unit, the expectations for both the patient/family and for the Rehab Unit e.g. if patient assessed as high risk for falls then families need to be advised of decisions required to mitigate the risks, e.g. bed rails/ring bell for assistance/patient not go to the bathroom unsupervised etc., offer assistance on discharge from Rehab Unit and detail costs associated with the Rehab Unit. A checklist to be signed and dated by staff when completed will also be included in the guidance.

2. Families to be notified of any significant changes to the patient and this to be documented signed and dated, for example, reduction in mobility requiring two person transfer/hoist transfer, reason for introduction of antibiotics, reason for BP monitor, skin integrity, poor diet/intake of food, low participation/engagement with therapy services etc.

3. Consultant to be requested to schedule MDT meetings with family following weekly ward round on Rehab Unit.

The General Manager for older person services has devised an action plan regarding the implementation of the recommendations made. Some of the recommendations were site specific and these have been discussed and implemented. The other recommendations which may lead to service improvements in other units are currently being examined.

Community Healthcare Organisation

Category: Communication and Information; Accountability
Status: Not Upheld

Background to Complaint
The complaint related to a Service User's dissatisfaction with access to an alternative consultancy resource within Mental Health Services. The Service User also wanted to have any proposed treatment double checked by an alternative consultant. The Service User also expressed upset at the way they were communicated with by their Consultant.

Investigation
The complaint investigation did not uphold any aspect of the complaint and a closure letter was issued to that effect.

However, the service user was dissatisfied with this outcome and sought an internal review.

The internal review upheld the findings of the complaint investigation but identified that the outcome on the communication issue had not been fully explained.

The review report included more complete information around the communication aspect of the complaint. The differing accounts around the communication exchanges between the Service User and the Consultant could not be verified one way or the other by the Complaints Officer and therefore a determination could not be made. This in no way, however, implies that the Service User's version of events is not accepted but just that it is impossible to reach a conclusion on the issue. Therefore such issues cannot be upheld.

The Service User sought an external review through the Office of the Ombudsman in relation to clarification of terminology in the original complaint letter; in particular reference to a 'geographically based sector system' as it related to the allocation of consultancy resources.

The Office of the Ombudsman sought clarification on behalf of the Service User in respect of this reference.

The subsequent review on foot of the request from the Ombudsman explained that the 'geographically based sector system' referred to the allocation of resources within a designated area. This meant any change in the allocation of a resource, such as a consultant, would normally only take place if the service user changed address to another geographical area where there was a different resource team for that service.

The original internal review letter and report which had issued to the Service User referred to resources but did not specifically explain the context around allocations within geographical areas and related access requirements as above.

Outcome and Learning
This case highlighted the importance of the need to properly identify all issues at the outset of a complaint and fully address them in the closing correspondence. It is also important that where an internal review is requested that the specific issues for review are identified and agreed at the outset and fully addressed.

The need for clear communication was also highlighted specifically in relation to ensuring that service specific terminology or jargon is also accurately explained.

Community Healthcare Organisation

Category: Access / Communication and Information
Status: Upheld

Background to Complaint
There is a category of complaints which relates to requests from Service Users as to when they will receive a service which they have been referred to. Following such queries the Service Users are given, in good faith, a projected date for receipt of the service. However, when the projected date passes without an appointment having been received, the Service User submits a complaint about the non-receipt of that service.

Investigation
Following investigation it was identified that particular services were experiencing ongoing resource issues, such as staffing, and that a commitment to providing the service on a specified date was not feasible and unfairly and unrealistically raised Service Users' expectations.

Outcome and Learning
Following completion of these investigations, it has been recommended that Service Users on enquiring about service provision for these services be advised of the issues affecting the service and consequently, advised that unfortunately, definitive dates for receipt of the service cannot be given. Assurance should be given that the service will be in contact when service provision is available and an apology made for the delay and upset caused.

Community Healthcare Organisation

Category: Access / Communication and Information
Status: Upheld

Background to Complaint
A complaint was submitted by a Service User of mental health services raising the issue of long waiting times at clinics and that this was causing them further anxiety and stress.

Investigation
The Complaints Officer checked with Medical Secretaries to see if allocated appointment times were given on appointment letters and they were.

Outcome and Learning
Electronic Notice Boards to be sourced to inform clients of possible delays at clinics when attending for appointment in the area's mental health services.

Community Healthcare Organisation

Category: Access / Communication and Information
Status: Upheld

Background to Complaint
An anonymous complaint was submitted which raised the issue of attending clinic appointments within the mental health services that are scheduled for a specific time but where the person attending the clinic is not called to their appointment until hours after their scheduled time. The anonymous complaint highlighted that such long waiting times were experienced previously. Although this was an anonymous complaint the service wanted this issue examined.

Investigation
The Complaints Officer assigned to the complaint spoke with the staff at the clinic in relation to the timeliness of appointments scheduled. The Complaints Officer was advised by the service that it endeavours to adhere to the scheduled appointment times. However, the service acknowledged that some appointments can run over due to the nature of the appointments, e.g. crisis presentation, etc. and can be difficult to anticipate.

Outcome and Learning
As this complaint was made anonymously, the Complaints Officer was not able to contact the Service User involved to offer an apology or an explanation. The Complaints Officer recommended that staff inform clients when they arrive for their appointment if appointment times are running behind schedule. The Complaints Officer further recommended that a T.V. screen be sourced for the waiting room to inform clients if and how long clinics are running over time.

Community Healthcare Organisation

Category: Access / Communication and Information
Status: Not Upheld

Background to Complaint
The key issue of the complaint was the lack of a Speech & Language Therapy Service in respect of a child who was diagnosed with Autism (Asperger's Syndrome) and being subject to long waiting times.

Investigation
A parent of the Service User submitted a formal complaint to the HSE. It was examined by the Complaints Officer under Stage 2 of the Your Service Your Say process. The Complaints Officer examined files and made enquiries with the Speech & Language Therapy Managers and the Project Administrator of Autism Spectrum Disorder (ASD) services.

However, the complainant was unhappy with the response in regard to waiting lists and communication and so the complaint was referred to a Review Officer under Stage 3 of the Your Service Your Say process.

Outcome and Learning
The service is currently being reconfigured to the new Progressing Disability Services model where referrals will be prioritised according to need. The change to the new service model is an essential element in optimising the resources available but implementation had not been completed in the service at the time of referral. It will improve service delivery by ensuring that those with the greatest need are prioritised.

This was explained to the parent of the service user and an apology issued for the lengthy waiting time experienced.

It is important that services communicate to parents and carers the issues that are currently affecting the provision of their service. Whilst it is not always possible to offer a definitive time for an appointment it is important that the service gives as accurate a timeline as possible about when they are likely to receive a service and update the service user if any further issues arise.

The investigation and recommendations has resulted in important learning for the service which will subsequently lead to better communication and service improvement.

National Ambulance Service

Category: Access / Communication and Information/ Safe and Effective Care
Status: Upheld

Background to Complaint
The patient contacted emergency services as a result of what they described as flu like symptoms but with a severe headache, dizziness and very sudden onset. The NAS call taker used structured questioning and the call was dispatched to the nearest ambulance resource as a 28C02L a code indicating to the crew that the patient had stroke symptoms.

The patient complained that on arrival the crew had sat down the road from his house for a time before calling to his door. When the crew did arrive they were sullen and dismissive. On arrival at hospital whatever handover they gave caused triage staff to believe he had the flu. The patient subsequently had a CT Brain which indicated that he had a small bleed.

Investigation
The complaint was received by telephone directly to the Complaints Manager and the standard form was completed. Although the patient was insistent that this was entirely a behavioural issue it was determined that there were matters of clinical judgement also involved and these issues needed to be addressed through the incident management framework.

The clinical issues were addressed by the Operations Manager and the Education and Competency Assurance Manager and the behavioural issue by the Complaints Officer and the Operations Manager.

The investigation involved the use of an after action review in conjunction with the crew, the operations manager and an education and competency assurance manager. The Complaints Officer was the facilitator. The complaint was discussed with the crew immediately prior to the facilitated AAR and this integration of two processes worked well as it has on previous occasions.

A joint approach to the complaint was important as often behavioural issues such as poor attitude can lead to poor clinical decision-making. Identifying contributory factors i.e. a hungry and tired crew due to lack of breaks is important.

Outcome and Learning
The complaint was upheld with regard to the demeanour of the crew. They acknowledged that in the course of their 12 hour shift they had been constantly attending calls for 9.5 hours without a break and that neither of them were in good form when the encountered the patient whom they had found challenging to interact with.

They accepted that they were likely to have come across as frustrated and indeed the crew indicated that at the start of the call they had been knocking on the door of a vacant building as the address the patient had given was slightly up the road from his address due to a colloquial name for the building which was identical to the actual name of a nearby building.

The crew apologised to the patient acknowledging their behavioural failings in the apology.

In relation to the clinical issues, it was determined that the handover of the patient was in line with the handover protocol (IMISTAMBO) accompanied by a printed patient care record. The hospital staff confirmed that their triage had appropriately prioritised the patient which had led to the early CT scan and the patient accepted this explanation.

Service learning was identified and has resulted in better management of crew breaks to support them and work has commenced on an educational element designed around customer service.