HSE Your Service Your Say
Anonymised Complaints Casebook Q1 2019

Welcome to the 2019 HSE complaints casebook covering the first quarter of the year. This casebook presents some of the various complaints investigated in that period and their outcomes.

The publication of this casebook is part of the HSE's commitment to use complaints as a tool for learning and to facilitate the sharing of that learning. In addition, the publication of the casebook fulfils a recommendation by the Ombudsman in his report, *Learning to Get Better* and further progresses the HSE's promise to fully implement all recommendations from the Ombudsman's report pertaining to the HSE by the end of 2019.

We hope that this casebook and subsequent quarterly casebooks will continue to develop during 2019 and that Anonymised Complaints Casebook 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

Access: Delayed access to and waiting time at Out Patients Department Clinic
Status: Upheld

Background
The patient was referred by their GP to a specialist Out-Patient Service. Due to the demands on this service, the waiting time was 24 months for a new appointment. The patient waited 24 months to be seen. Due to an administrative error an incorrect appointment issued. The patient arrived and was advised that the appointment date and time was incorrect. The patient received an apology and a new date and time for two weeks later. On arrival the waiting time to see the Consultant was approximately 2 hours 30 minutes. The patient complained about the time waiting for an appointment (24 months), incorrect date issuing and length of time waiting to be seen in the out-patient clinic.

Investigation
The complaint was reviewed by the Complaints Officer, the Operations Manager for the Service and the Specialist Consultant. The complaint was upheld. It was acknowledged that an administrative error had occurred and was apologised for; it was also acknowledged that it was unacceptable to have to wait 2 years to be seen. It was further acknowledged that waiting 2 hours 30 minutes to see the Specialist Consultant was also unacceptable.

Outcome and Learning
The hospital apologised to the patient that they had this experience. The hospital advised that they were taking a number of interventions to try and improve access to the service and patient flow. With the recruitment of a number of new staff it envisaged that administrative services would improve and the waiting times to access the services will be reduced. The patient was also reassured that the team are working to improve patient flow through the clinic. An explanation was given as to services provided in the clinic and why the administrative error had occurred. The target is to see and discharge the patient within a 2 hour timeframe. Unfortunately the hospital did not meet the target of 2 hours in this case and the patient was re-assured that work is on-going to address this.

Community Healthcare Organisation

Consent and Communication: Mental Health Services
Status: Not Upheld and Partially Upheld

Background to Complaint
Complainant raised concerns when information he sought from psychiatric services on behalf of a third party was refused.

Investigation
The complaint investigation considered the relevant policy around consent and the provision of information and confirmed that the third party had declined consent to share information in this instance; as a consequence the complaint being refused access could not be upheld.

Outcome and Learning
The complainant was unhappy that the initial complaint was not upheld and sought a review. The review identified a further aspect to the complaint that related to communication. This had not been identified or addressed as part of the initial complaint process. The review process upheld the initial decision and also provided a response in relation to the communication aspect of the complaint which was partially upheld.

The key learning therefore related to ensuring and checking that all aspects of a complaint are identified at the outset, addressed and given appropriate consideration, with explanations in this regard also provided to the complainant for completeness.

Community Healthcare Organisation

Access: Access to services, Disability Services
Status: Not Upheld

Background to Complaint
Complainant raised concerns when access to local disability support services for her son were transferred to a different team as a result of her changing schools to better meet his educational needs.

Investigation
The complaint investigation considered the relevant policy and determined that the allocation of services was in keeping with standard practice and that access to services had been appropriately allocated based on school rather than home address.

Outcome and Learning
The complaint should have been progressed via the appeals process and not as a complaint. On request for a review of the outcome the correct pathway was identified. The case was referred as an appeal, the outcome of which, acknowledged that the policy, while appropriately applied, was coming under review and pending the outcome of this review the complainant could retain access to the services of the support team local to the home address as requested.

Key learning relates to providing additional support at the initial assessment phase to assist in the determination of the appropriate and correct application of relevant pathway at outset.

Community Healthcare Organisation

Communication: Complaint not progressed correctly
Status: Upheld

Background to Complaint
Service User felt that support, confidentiality and advice were not given to them when making a complaint at the point of contact.

Investigation
Service User's file was examined and staff interviewed.

Outcome and Learning
Training on the role of staff in the handling of Point of Contact complaints and on the revised Your Service Your Say policy was given to staff.

Point of Contact complaints training should be completed by all current staff and by new staff when commencing in the area as part of their induction. The online HSELanD module is available to all staff and should be utilised pending training provided by Consumer Affairs. In addition, an annual assessment of training needs should be conducted to identify the required relevant training for staff to attend or to complete on HSELanD.

Community Healthcare Organisation

Communication: Inconsistent notification to a person subject to a preliminary screening of case closure
Status: Not Upheld

Background to Complaint
A letter was issued shortly after a preliminary screening notifying the person who was the subject the screening that the case was closed, however no similar letter was issued following closure of second complaint which was also closed following a preliminary screening.

Investigation
The file was examined. The relevant national policy, Safeguarding Vulnerable Adults at Risk of Abuse policy was also consulted. It is stated in the policy that it is not standard for a letter to be issued to the subject of the screening following the closure of a preliminary screening.

Outcome and Learning
A recommendation was made that consideration should be given to include in the national policy, Safeguarding Vulnerable Adults at Risk of Abuse, a standard procedure of issuing a letter to the person(s) subject to a screening if the case is closed following a preliminary screening.

This recommendation is on the agenda for the next meeting of the National Safeguarding Office.

Community Healthcare Organisation

Communication: Recording of meeting minutes
Status: Upheld

Background to Complaint
Clarification regarding a point of discussion was sought by a person following their attendance at a meeting.

Investigation
The file was examined. It was confirmed that a meeting took place but no minutes/notes of the meeting were found and so the issue could not be verified.

Outcome and Learning
The service has put in place a process where minutes of meetings between HSE and family members or any other persons are taken and re read at the meeting prior to closure. An agreed version of the minutes are typed and circulated as soon as possible to all present so as to ensure that a full and accurate account of the meeting is available.

Ensure staff and managers are familiar with the HSE Communications Toolkit and the guidance provided. Highlight this resource at induction. Ensure that key guidance documents are reviewed by staff. An annual assessment of training needs should be conducted to identify the required relevant training for staff to attend or to complete on HSELanD.

It was also recommended that the issue should be brought to the attention of the National Communication Unit for review as publishers of the *Minute Taking* document in February 2009 which is on the HSE website.

Community Healthcare Organisation

Access: Building Access and Parking
Status: Partially Upheld

Background to Complaint
A support group raised the issue that the chairs and room provided in a health centre were not comfortable. The issue of car park charges was also raised. In addition the lift in the centre was very narrow (especially for buggies) and there were no tea/coffee facilities.

Investigation
Issues examined with regional group coordinator and with relevant health centre staff.
It was acknowledged that the room provided was not adequate due to the shortage of space in the centre.
The lifts were measured and found to be compliant with regulations. Parking was operated by a private provider.
The Group Co-ordinator is following up on the tea/coffee issue with a private café operator.

Outcome and Learning
Small changes can make a difference.
The issues took time to resolve but the Group were updated and informed regularly of progress and this was welcomed and appreciated.

Community Healthcare Organisation

Access: Access to PHN Services
Status: Partially Upheld

Background to Complaint

A post-natal patient who was also post-surgical intervention was denied access to PHN services.

Investigation

The service user and the various health professionals were consulted in relation to the care to be provided.
The service user was satisfied for PHN services to be provided and requested that measures be put in place to ensure that this would not happen again. The Service User was able to discontinue paying for private care and received compensation for fees paid.

Outcome and Learning

PHN services were issued with a memo regarding the provision of and entitlement to certain services for post natal patients. Any issues regarding the scope of practice for PHNs in this regard can be discussed with their line manager.