HSE Your Service Your Say
Anonymised Complaints Casebook Q2 2019

Welcome to the second edition of the 2019 HSE complaints casebook. This casebook presents some of the various complaints investigated in quarter two 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 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
The patient was referred by their General Practitioner to the Phlebotomy Clinic for blood tests. On arrival to the Phlebotomy Clinic the patient was advised that the hospital no longer provides a walk-in service for GP referrals and appointments were now made via the online booking system. The patient complained that their GP was not aware of the new online booking system. There was a cancellation and the patient was provided with an appointment six days later. Following review of the results by the GP a repeat blood test was requested (within 2 weeks). The patient complained that the next available appointment online was 4 weeks later.

Investigation
The complaint was investigated by the Complaints Officer, the Directorate Operations Manager and the Out-Patient Manager. The complaint was upheld. A follow-up appointment was made for the patient for 2 weeks as requested by the GP. An explanation was provided to the patient and they were advised that the hospital introduced an on-line booking system to improve the service and minimise delays in the clinic. The online booking system allows GPs to request a blood test online for the patient prior to attending the clinic. Prior to the system going live, all GPs were notified of the new process. The hospital apologised that the GP was not aware of the new system.

Outcome and Learning
The hospital apologised that the patient had this experience. They were advised that the current phlebotomy service is being reviewed and it is planned to conduct a patient survey of their experience. Further communication has taken place with GPs advising of the online booking system. The communication also advises that should a GP require an urgent or repeat blood test that they can contact the Phlebotomy Department directly and they will facilitate an urgent request.

Hospital Group

Category: *Communication and Information*
Status: Upheld

Background
The patient was referred to Neurology for an EEG following discharge on a Friday afternoon. The patient was then advised to contact the Neurology Department the following Monday to confirm when the EEG would take place. This was understood by the patient to mean that they were to arrange their own appointment. When the patient called the Neurology Department, they were advised by a staff member that only a Doctor could make a referral for an EEG. This caused significant distress and confusion to the patient who felt that the hospital was not taking their care and treatment seriously. Ultimately, it was discovered that the referring doctor had in fact arranged the referral internally but they had not taken into consideration the time it would take to be received/reviewed by the Neurology Team, in light of the fact that the referral was sent over a weekend, when asking the patient to call Neurology on the following Monday.

Investigation
The complaint was investigated by the Complaints Officer, the referring doctor, and the nursing management team. The complaint was upheld. On reflection and review of the notes the referring doctor recognised that requesting the patient to contact the Neurology Department the following Monday would not have allowed sufficient time for the Neurology Department to review the referral and assign an appropriate appointment, which in turn led to the confusion caused by staff when the patient rang for the appointment. The referring doctor and the nursing management team also acknowledged the miscommunication that led the patient to believe they were to arrange the appointment themselves and apologised to the patient.

Outcome and Learning
An apology was made on behalf of the hospital for the confusion caused in relation to the patient's EEG referral and the following recommendations arose from the investigation of the complaint: (1) Education aimed at improving communication between clinical teams and between staff and patients will continue to be rolled out for all frontline staff. The HSE National Healthcare Communication Programme is also being rolled out onsite to provide education around communication during consultations with Service Users. (2) Medical and Nursing teams are to provide clarity in relation to next steps in the EEG referral pathways for patients going forward.

Hospital Group

Category: Accountability
Status: Upheld

Background
Complaint received from patient via post regarding being overcharged and billed for three nights of admission to hospital, while patient stated they were an in-patient in the hospital for only two nights and was discharged on the third day in the morning. Patient additionally stated that the two nights of admission were already paid for and they would not be paying for the third night as they were already discharged and thus should not be charged.

Investigation
After a telephone conversation with patient prior to investigation of the complaint, the patient insisted once more that they were admitted only for two nights. The PAS (Patient Access System) was checked, which showed three nights of admission, not the two nights according to the patient's statement. The information on the system that the hospital uses for all in-patient admissions and out-patient appointments conflicted with information provided by the patient. Further investigation based on reviewing the patient's nursing notes and medical chart revealed that the patient's version was correct contrary to the PAS system version where the wrong date of discharge was recorded.

Outcome and Learning
Having investigated, the complaint was upheld and the complainant's invoice was corrected. A detailed examination was conducted and findings returned to the Finance Department to demonstrate evidence of the discharge date. The investigation concluded that this was a clerical error that took place during the discharge input on the PAS System which in return caused the wrong invoice to be released to the patient. In a closing letter to the patient an apology and clarification was provided. Additionally the patient received a telephone call with an apology and an explanation of the findings. The patient was satisfied with the outcome and accepted the apology.

The Finance Department was requested to adjust /correct the discharge date on PAS. Clerical management was informed about the error that took place in order to educate staff on the importance of checking that accurate data is entered onto any system in order to avoid such mistakes in the future. This complaint showed the importance of hospital staff/clerical staff dealing with any patient information to check and ensure accuracy.

Hospital Group

Category: Accountability

Status: Upheld

Background

Complaint received from a patient regarding receiving a bill from the Radiology Department for a CT scan. The complaint arose as the patient had seen a Consultant privately and was told by the Consultant that the CT scan in the public hospital was free.

Investigation

The patient did not have health insurance and saw the Consultant privately. The patient paid for a private consultation and for procedures carried out in the public hospital where the Consultant works. The patient stated that they would not have had the CT if they had known that there was a charge involved. The patient claims that the Consultant told them that there was no charge for the CT as they had a medical card. The patient has received three bills regarding same including a final reminder saying it would be passed onto the Debt Collection Division.

Outcome and Learning

Having investigated the case, the complaint was upheld by the Complaints Officer as the patient had received inaccurate information from the Consultant. As per Health Services (Out-Patient) Regulations, 1991, S.I. No. 136/1991 '*a person availing of out-patient consultant services as a private patient of a consultant shall be deemed to be the private patient of all consultants engaged in the provision of out-patient services to that person in relation to that particular consultation.*'

The patient's bill was waived and an apology and clarification provided.

The Complaints Officer spoke with the Consultant involved regarding giving the correct information to private patients regarding procedures carried out in a public hospital. The issue was highlighted to Hospital Management to provide the correct guidance to Consultants to prevent this mistake in billing occurring again. A list of charges for common procedures was requested from the Radiology Department so that Consultants could provide accurate information to patients when discussing procedures with them.

Hospital Group

Category: Safe and Effective Care
Status: Upheld

Background
YSYS form received regarding *'room temperature during inpatient stay on Paediatric Ward. Windows sealed, baby confined to room. HSE recommended room temp for baby 16-20^0 C. Not sure of room temp but it was definitely in to the 20's'*

Investigation
An apology was given.
The complaint was forwarded to the Operations Manager to provide a response.
The Operations Manager expressed thanks for feedback and regret that ward temperatures were not at a comfortable level during this admission. The Operations Manager explained this issue is being reviewed by Hospital Management with both HSE Estates Department and local Maintenance Department. The Operations Manager provided assurance that a solution was being worked on. They explained that the windows were sealed for infection control reasons due to construction works being undertaken on the hospital campus. These works are in close proximity to the Paediatric Ward. It is anticipated that these window seals will be removed by the end of February 2019.

Outcome and Learning
The hospital continues to liaise with HSE Estates Department and local Maintenance Department to endeavour to develop a solution regarding temperature control on the Paediatric Ward. A possible solution for consideration is individual radiator temperature controls.
If window seals are reinstated for infection control reasons due to construction works on the hospital campus, signage, explaining same, would be displayed on wards.

Hospital Group

Category: Safe and Effective Care
Status: Ward cleaning: Partially Upheld and Behaviour of Staff: Upheld

Background
YSYS form received regarding *'cleaning of the ward during visiting hours. Staff using personal mobile phones to have non work-related conversations'.*

Investigation
An apology was given and regret expressed that service did not meet expectations.
The complaint was forwarded to the Household Services Manager to provide a response.
Household Services Manager addressed the issues raised at the staff meeting. The Manager advised that cleaning is continuously needed due to patients being discharged over the course of the day and rooms/beds require cleaning and disinfection. However, there would be an effort made to minimise cleaning during visiting hours although rooms for disinfection will need to be prioritised.

Outcome and Learning

- Advised staff of the need to be mindful of noise levels when carrying out ward duties
- Staff to endeavour to carry out cleaning duties outside visiting times where possible
- A reminder that the use of personal mobile phones was unacceptable and not permitted when working

Hospital Group

Category: Safe and Effective Care
Status: Upheld

Background
The patient was brought to the ED by ambulance having complained of severe headache for the previous six hours. The patient was assessed by medical staff and blood tests were carried out. Based on the information available a diagnosis of sinusitis was made. The patient was discharged home in the care of their family and analgesia prescribed. The patient was readmitted some days later and a diagnosis of subarachnoid haemorrhage was confirmed on CT scan. The family lodged a complaint with the hospital based on the standard of care provided and level of investigations carried out.

Investigation
Although there were elements of clinical judgement involved in this complaint the decision was taken to jointly investigate with the Complaints Manager, Quality & Safety Coordinator and Clinical Director. The investigation upheld the complaint in that the patient had not received a satisfactory standard of care based on the fact that they were not reviewed by a senior doctor, had not been referred to the medical team and consideration had not been given to requesting a CT scan of the patient's brain. The family met with the clinical staff involved in a facilitated process and a fulsome apology was provided by the Consultant doctor and the Hospital Manager.

Outcome and Learning
The family specifically requested that the events be used as a learning opportunity and asked how this might be achieved. The Quality and Safety Manager arranged to carry out an After Action Review (AAR) of the patient's ED presentation with the staff involved including triage nurse, treating doctors and nurse management. The AAR was facilitated by Quality and Safety personnel and as agreed, a summary report of the discussions was sent to the Complainant and family members.

Hospital Group

Category: Communication
Status: Partially Upheld

Background
A patient attended a clinic for a scan. The patient complained following the scan of their poor experience stating that a staff member was extremely rude which upset and angered the patient.

Investigation
The complaint was investigated by the Complaints Officer and the Clinic Manager. The complaint was partially upheld. On investigation it was noted that the patient had attended for the scan with small children due to a child-minding issue. The staff member performing the scan found it difficult to concentrate on the scan with young children requiring attention. It is the hospital policy not to have small children in the room during scanning. Whilst the staff member was frustrated at the time she did not recall being rude to the patient. However, on reflection the staff member said that they could have been more sympathetic to the patient's circumstances and will bear this in mind in future.

Outcome and Learning
It was agreed with the Clinic Manager that clear signage needs to be put up in the area to reflect the policy of the hospital regarding the presence of small children in the scanning room. The patient information leaflet should also be amended to highlight and reflect this policy. The hospital apologised to the patient but explained that there was a policy regarding this in operation. The patient was informed, however, of the improvements that would be put in place to highlight this policy. The patient was thanked for bringing this matter to the hospital's attention. The patient was happy with this and asked that it was explained to the staff member carrying out the scan about the sensitivity of the situation and that they could be more empathetic. This was agreed and the patient was happy with the response.

Hospital Group

Category: Communication and Information
Status: Upheld

Background
A complaint was received from a sibling of a patient who had multiple appointments scheduled for the same day. They were extremely unhappy and upset with their wait time for the multiple appointments. In addition, they were also upset at being stopped by a Security Guard while leaving the centre.

Investigation
The Complaints officer contacted the sibling of the patient who had submitted the complaint and also spoke with both the clinic receptionist and the Security Guard.
The Security Guard was apologetic for having stopped them when leaving the centre as there was no cause to do so as they were leaving and the interaction at the reception area was concluded. The Security Guard did believe that this 'stop' was not conducted in a rude manner.
The Complaints Officer apologised on behalf of the hospital for the Security Guard's actions and for the experience while attending for multiple appointments.
The sibling of the patient suggested signage to assist patients with multiple appointments.

Outcome and Learning
Signage has now been placed in waiting areas advising patients with multiple appointments to bring this to the attention of the receptionist.
Both the sibling and the patient were satisfied with the outcome of the complaint.

Community Healthcare Organisation

Category: Safe and Effective Care
Status: Partially Upheld

Background to Complaint
A Service User raised concerns about gaps in documentation relating to correspondence on a referral for her child in relation to a speech and language assessment.

Investigation
The complaint investigation considered the circumstances of the complaint in relation to the available documentation and identified inconsistencies in relation to standard practice on the recording of communication between professionals in this area of allied healthcare.

Outcome and Learning
The resulting service improvement was the enhancement of local monitoring protocols to ensure effective implementation of standard practice around the documentation of referrals and the recording of related communications.

Community Healthcare Organisation

Category: Dignity and Respect
Status: Upheld

Background to Complaint
On admission to an acute in-patient facility all of the Service User's property was recorded. However, on discharge all of the Service User's property that was logged on admission was not returned.

Investigation
It was found that there is a procedure in place to record all Service Users' property on admission in a patient property log and that the Service User is given a copy of same.

On discharge there is no procedure in place to record what property was returned to the Service User. As there was evidence that the Service User had this item of property on admission and there was no evidence that it was returned on discharge, the complaint was upheld.

Outcome and Learning
On discharge, the record of the Service User's property received on admission should be checked against the property returned at discharge and any discrepancy should be resolved prior to discharge.

The Service User was financially reimbursed for the cost of the property.

A process is being developed to record all Service Users' property returned on discharge and to link this with the record of property received on admission.

Community Healthcare Organisation

Category: Communication and Information
Status: Upheld

Background to Complaint

A number of complaints with a similar theme have been received. The complaints are about contacting the HSE with a query and not getting a reply, being told they are through to the wrong department and being given another phone number to ring, getting the voice mail of one individual, leaving numerous messages but not getting called back or being then told that the person who deals with that is on leave. Service Users were very annoyed and frustrated. One particular complainant was trying to contact a service and the only contact information provided to the public was a phone number. Similarly when a clinician from this service required some information, the service would not provide an email address. Having only one method of communication does not suit all people.

Investigation

Services Users and care partners requested the use of electronic communication and this was fed back to the service. The Complaints Officer recommended that a generic email account be added to the service to which all appropriate staff would have access to and ensures that the account is monitored each working day. Individual work email addresses are not to be used for this purpose. Individual accounts will need the 'Out of office' response with a return date (if possible) and stating that this email is not monitored and to signpost those to the generic email account that is monitored.

The relevant manager was provided with ICT forms by the Complaints Officer to enable the creation of a generic mailbox. This email address was also noted on the HSE website as the service contact information.

Outcome and Learning

1. Help the Service User, find out where/who is best to help and then direct the person or have the appropriate person contact the person within a timeframe.
2. Creating a generic mailbox allows a number of staff users within a service access to communications. This will need to be monitored daily by staff regardless of who is on leave or not working.
3. All queries can be responded to quickly and efficiently and will improve customer service and our response to the public.
4. The creation of this mailbox does not over burden specific members of staff receiving emails.

A generic mailbox facilitates communication with this service without delay and helps reduce negative experiences for all stakeholders.

Community Healthcare Organisation

Category: Communication
Status: Upheld

Background to Complaint
A Service User requested that when dealing with their application for an E111 card that they are dealt with in the Irish language. The Service User was advised that there were no staff members available to converse “as Gaelige”.

Investigation
Following investigation, which included the undertaking of a telephone survey regarding staff responses to requests for communication in the Irish language, it was found that that staff were unaware of the availability of or contact details for the Irish Language Officer.

Outcome and Learning
An apology was issued to the Service User on behalf of the organisation and the Service User was reassured that corrective action would be taken and that future communications received through Irish would be responded to in Irish.

A general email was issued to all staff members and for display on all noticing boards, regarding the process to be adopted when requests for services were received “as Gaelige”. This included the contact details of the Irish Language Officer.

When closing off the complaint, a copy of the staff email was issued to the Service User to verify that the corrective action had taken place. The Service User expressed their gratitude that the complaint had been taken seriously and that it had led to a service improvement.

Community Healthcare Organisation

Category: Safe and Effective Care
Status: Upheld

Background to Complaint
A Service User had been seen by a healthcare professional and had found the interaction very beneficial. They had found the staff member to be professional and helpful. However the staff member then failed to log an appointment for a follow up service on the IT system. This led to an 11 day delay and left the Service User feeling very upset and vulnerable.

Investigation
The investigation found that the staff member had failed to log a follow up appointment on the IT system. This had resulted in the Service User not receiving a follow up appointment. The Service User had to contact the service themselves to enquire regarding the follow up appointment, at a time when they were in a weak and vulnerable position.

Outcome and Learning
On making contact with the service, the Service User was immediately offered a follow up appointment. The Service User availed of the appointment and was complimentary of the follow up care received. Both the service and the staff member apologised unreservedly to the Service User for the errors made.

A learning notice was circulated to all relevant staff in relation to the importance of recording all clinical contacts on the IT system. The policy for recording clinical information was also circulated. In addition, refresher training on the system was organised. Regular audits will be undertaken to check and ensure compliance.

The Service User expressed their gratitude that the complaint had been taken seriously and that it had led to a service improvement.

Community Healthcare Organisation

Category: Communication and Safe and Effective Care
Status: Upheld

Background to Complaint
A Service User was unhappy about the delay in receiving feedback in relation to a school visit completed by a Senior Occupational Therapist about her child's diagnosis.
The Service User also raised concerns in relation to the manner in which she was informed of her child's diagnosis.
Concerns were also highlighted regarding the management of resources (no cover arrangements in place for the Senior OT during absence and long delays in obtaining report).

Investigation
The Service User was contacted to ascertain what occurred.
A review of the client's file and relevant documentation was also undertaken.
A clinical meeting with the treating Senior OT also took place.
In addition a review of staffing levels in the service at the time was conducted.
There was also a review of processes regarding informing families of diagnosis.

Outcome and Learning
Following investigation into the serious concerns raised by the Service User about manner in which the Senior OT informed them of their child's diagnosis, this aspect of the complaint was upheld. The Service will ensure that the *National Best Practice Guidelines for Informing Families of their Child's Disability* is fully implemented and supported.

Following a meeting with the Senior OT it was clear that there was a direct correlation between the concerns raised by the Service User and the therapist having to take unplanned emergency leave that regretfully resulted in a significant delay in the family receiving timely feedback. The investigation found that a backlog of work accrued for the therapist during the leave period also impacted directly upon the timelines for completing work. This should have been explained to the family to inform and alert them of the delay.

While unexpected emergency leave can happen, all families impacted should be informed. The investigation also identified that there was an increase in workload due to unplanned leave which meant that further delays were experienced.

It is recommended the OT department update its policy around unplanned leave to ensure that families are informed if their OT has had to take extended unplanned leave and any impact that this may have on services and issuing of reports. Further training and additional formal support via clinical supervision will also be part of the procedure to ensure safe clinical practice and timely interventions.

Community Healthcare Organisation

Category: Communication and Safe and Effective Care
Status: Partially Upheld

Background to Complaint
In 2016 the Service User's GP referred them to a Clinical Psychiatrist for a mental health assessment. A report was issued to the GP by the Psychiatrist following this assessment. The Service User did query from the GP if everything was okay and was advised that it was but was not aware of the existence or content of a report on the assessment. The Service User only found out about the assessment report two years later as part of an FOI request.

The Service User was unhappy about this and also disagreed with the content of the report and the diagnosis given. The Service User expressed serious concerns relating to use of words in the assessment report used by the Clinical Psychiatrist and wanted the report eradicated from their medical file.

The Service User also raised concerns that personal information was discussed at a consultation where a family member was present and that constituted a data breach.

In 2018 the Service User submitted Part 12 of the Disability Form to their GMS GP for completion. The GP's colleague completed this and returned it to the Department of Social Protection (DSP). The Service User wrote to the practice manager to complain about how the Part 12 report was drafted and how their mental health was referenced. The Service User also expressed further concerns regarding personal data breach as the personal data of family members was sent to the DSP without consent.

Investigation
It was decided to investigate this complaint despite it being outside the timeframe set out by the legislation, due to the fact that the Service User had only recently became aware of the existence of the assessment report.

The complaint was investigated by a Complaints Officer within Mental Health as well as a Complaints Officer within Primary Care.

The Service User was advised that the assessment report related to the clinical judgment of the Clinical Psychiatrist. Under Section 48 of Part 9 of the Health Act 2004 a Complaints Officer is precluded from examining matters relating solely to the exercise of clinical judgement. However, under the Your Service Your Say Policy a response can be sought from a clinician. Unfortunately, when a response was sought from the Consultant Psychiatrist, the mental health service informed the Complaints Officer that the Consultant Psychiatrist had been a locum at the time and that they had moved on from the HSE. Despite several attempts the Consultant Psychiatrist could not be located.

The Service User was advised that an FOI request could be submitted in relation to the report seeking '*to have personal information held on them corrected or updated where such information is incomplete, incorrect or misleading'* but that the file could not be eradicated as requested.

The alleged data disclosure incident at a consultation was also examined but as this occurred in a scheduled meeting, where additional attendees were invited by the Service User, this element was not upheld.

Investigation continued
The Complaints Officer for Primary Care contacted the Head of GMS Services for their report on the concerns raised about data protection and Part 12 of the Disability Form that was submitted to the Department of Social Protection.

In relation to the concerns about how Part 12 of the Disability Form was completed, this was amended as far as it was possible as per the Service User's wishes

In relation to the information released to the Department of Social Protection; on the application for the disability allowance, part 11 relates to '*Permission to release medical information*' and states, ' *I permit my doctor to provide you, the Department of Social Protection with medical information that may be required for my application for disability allowance'* . It also states '*which will allow your doctor to give this Department the necessary medical information for your application for disability allowance'*. The part of the complaint was not upheld.

In relation to the treatment of the Service User by their GP, the Complaints Officers found that the GP engaged appropriately with the Service User regarding their concerns and queries and sufficient safeguards were in place to ensure that no personal information was disclosed without the prior knowledge and consent of the Service User.

The Service User sought a HSE internal stage 3 review following which no element of the complaint was upheld. The Service User was advised of their right to seek an independent review, under Stage 4, from the Office of the Ombudsman.

Outcome and Learning
This complaint was received two years after the initial report was created. Under section 47 of part 9 of the Health Act 2004, a complaint must be made within the specified period (12 months) but under subsection (3) a Complaints Officer may also extend the time limit where warranted. In this case it was decided to proceed with the complaint as the Service User had only recently become aware of the existence of the report through an FOI request.

Because of the time delay the investigation was complicated with key staff unavailable for input. It was important to set out the limitations of such investigations with the complainant at the outset.

Although a Complaints Officer is precluded from examining a matter relating solely to the exercise of clinical judgement in accordance with Section 48 of Part 9 of the Health Act 2004, under the HSE's Your Service Your Say Policy, provision is made for a Complaints Officer to engage with clinicians to seek a response to a clinical judgement issue or to request a clinical judgment report.

Although no element or issue within the complaint investigated/reviewed under Your Service Your Say was upheld by either the Complaint Officers or Review Officers, it was acknowledged that there were delays in responding to letters that the Service User submitted. This was found to be as a result of sick leave and Christmas closure. An apology was issued for same.