HSE Your Service Your Say

HSE Anonymised Feedback Learning Casebook 2020

Welcome to the 2020 edition of the **HSE Anonymised Feedback Learning Casebook**. The past year has been a challenging one for everybody, both for service providers and Service Users.

The HSE has faced unprecedented challenges in service delivery and while disruption and delay were experienced in 2020, healthcare staff worked hard to ensure that feedback received was examined and responded to.

The publication of quarterly casebooks in 2020 was not possible due to the impact on resources. However, the HSE wants to assure service users that feedback was processed during 2020 and that learning was captured and shared. This casebook presents just some of the feedback received and dealt with during the past year.

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 the 2020 edition, although each unique, present themes and issues that need to be examined in the context of quality and service improvement.

The casebook presents a total of 27 cases covering both complaints and compliments received by Hospitals, Community Healthcare Organisations and the National Screening Services.

The casebook contains 6 complaints from Hospital Groups, 9 from Community Healthcare Organisations and 1 from National Screening Services, which were investigated and/or reviewed along with their outcomes. The casebook also features 5 compliments from Hospital Groups and 6 from Community Healthcare Organisations which demonstrates the learning to be gained from positive feedback.

The main themes for the 2020 casebook relate to *safe and effective care*, *communication and information* and *access*, with these categories featuring in 25 cases (10 compliments and 15 complaints).

The key categories of *safe and effective care* and *communication and information* feature in the majority of the compliments presented. Some compliments relate to *dignity and respect* and *improving health*.

These same categories, *safe and effective care* and *communication and information*, also feature in the majority of the complaints received. The category of *safe and effective care* encompasses many issues that are presented in the cases such as patient property, healthcare records, processes, diagnoses, tests, infection control, etc. while communication skills was the single dominant issue recorded under *communication and information*.

The category of *access* also features in the complaint cases presented and relates primarily to the issue of having appropriate hospital facilities or resources available to meet the particular needs of Service Users as well as the issue of appointment delays.

Other categories featured are *privacy, dignity and respect* and *accountability.*

The cases presented, both complaints and compliments, offer services an opportunity to reflect on service delivery, to understand the issues experienced by Service Users, to examine the measures and initiatives used to address these and how such methods can be utilised in their area to address or prevent similar issues.

The casebook will be widely circulated to staff within the HSE and shared with Complaints Managers who will consider the learning from these cases to guide decision making to improve services and the Service User experience.

Hospital Group

Category: Dignity and Respect (Delivery of Care), Privacy (Hospital Facilities), Access (Accessibility/Resources)
Status: Upheld

Background to Complaint

The parents of a child wrote to express their distress and upset following a visit to the hospital with their child who has, among other related challenges, a neurological development disorder. Their attendance at the hospital required visits to a number of areas and departments for treatment as well as waiting periods between assessments.

Unfamiliar and changing places, people, and tasks caused significant distress for the patient, and consequently behavioural changes, which resulted in difficulties for the parents as they tried to calm and reassure their child.

Both parents expressed feeling a lack of dignity because they had to address these issues in front of other Service Users. In addition, the family felt unsupported due to a lack of assistance during the challenging episodes.

Investigation

The Complaints Officer contacted the Assistant Director of Nursing (ADoN) to discuss the parents' concerns. The ADoN met with the parents to apologise for the family's experience and to design a plan that would meet the needs of the patient and the parents for any future visits to the hospital.

The plan included the identification of a key worker that the parents could call to alert staff of an appointment or emergency visit. That key worker would then set in place a plan whereby one member of staff would stay with the family throughout their entire visit so as to avoid too many unnecessary interactions and, where possible, the family would be given an appropriate quiet space should there be a necessary waiting period during treatment. Finally, the patient would be facilitated, as much as possible, through the required services to avoid extended delays.

Outcome and Learning
Following the family's experience, the ADoN met with the hospital's Access Officer to discuss the challenges experienced by this child and family.

The Access Officer chairs a working group in the hospital called 'Access & Communication for Everyone' and an Access Team Working Group and was able to reassure that the gaps in needs highlighted by this case were captured in the aims and objectives of those groups (for example disability awareness training). A plan to deliver a process whereby patients with similar concerns would be flagged on hospital systems to make meeting the needs of these patients a more seamless process.

In addition, hospital teams were educated on the importance of showing and expressing empathy toward parents with children that suffer challenges directly related to being in the hospital environment.

Hospital Group

Category: Access (Hospital Facilities)
Status: Upheld

Background to Complaint
An Assistant Director of Nursing received an email from a parent of a Service User with complex needs and who also uses a wheelchair.

Following an appointment in Out-Patients Department (OPD) the Service User needed to be changed and the parent was directed to a small changing room in the main waiting area in OPD. The parent described having to plead with nursing staff for an alternative and was directed to a consultation room where the Service User was able to get changed with the assistance of their parent who had accompanied them that day. The parent described it as totally unacceptable that there was nowhere suitable for changing and expressed dismay at having a sensory room available but no appropriate changing facilities or hoist system for Service Users with such needs.

Investigation
The Assistant Director of Nursing (ADoN) followed up with a phone call to the parent and listened to the experience that the Service User and their parent had that day in the hospital. The ADoN apologised for their suboptimal experience and gave reassurances that the issues raised would be addressed with staff.

The issues were discussed with OPD Nursing Staff and Neurodisability Clinical Nurse Specialists (CNS).

Outcome and Learning

The following arrangements have been put in place:

- Room to be identified for changing needs or staff to locate a room in a timely manner and give priority to Service Users with complex needs who need to be changed in a larger area
- During the Complex Needs Clinic the hoist is to be readily available for any transfer needs
- The Neurodisability Clinical Nurse Specialist (CNS) to act as coordinator of this system when needed and remind staff of this process

Learning

- Complaints are everybody's responsibility and there should be a *no wrong door* approach to complaints.
- By listening and learning from a suboptimal experience, improvements can be made to the service for other service users.
- The impact of a prompt response and effective listening can deescalate a tense situation.
- Engagement with key stakeholders in neurodisability enabled a plan to be implemented around hospital visits going forward for this Service User and other similar Service Users
- All parties were keen to ensure a smooth pathway of care to respond to the Service User's particular needs.
- All staff were reminded to be mindful of Service User's and their individual and specific needs when attending hospital appointments and to strive to meet those.

Hospital Group

Category: Access (Parking)
Status: Upheld

Background to Complaint
The parent of a Service User contacted the Complaints Officer in relation to car parking charges. The Service User was an inpatient for several months but the parents were never informed of the reduced parking rates that apply to the parents of long term patients (over 10 days). The parent advised the Complaints Officer that the significant cost involved could have been avoided if they had been provided with the correct information on arrival or at some point during the early stages of the admission. The parent requested that they be refunded the overpayment of car park charges during the Service User's admission.

Investigation
Upon receipt of the complaint, the Complaints Officer contacted the parent and apologised for the charges incurred and the lack of information regarding the reduced parking fees for long stay patients. The Complaints Officer requested a copy of receipts or statements showing the amount due to be refunded so that their request could be processed. Once in receipt of the documentation, the Complaints Officer worked with the Assistant Director of Nursing in charge of the ward and the Finance Department to determine the overpaid charges that were due to be refunded. A payment voucher was then organised. The Complaints Officer contacted the parent to make arrangements to provide the refund.

Outcome and Learning
The Complaints Officer proposed a number of recommendations that could be implemented in order to avoid, where possible, such situations arising in the future.

It was noted by the hospital that there have been several cases necessitating a refund, and as the refund process is time consuming and frustrating for parents, increased awareness of the parking rates was clearly necessary to improve the service user experience and avoid future complaints of this kind.

Recommendations, which are in the process of being implemented, include signage to be placed in the following locations:

- On the payment machine in Main Reception
- On the fees board in the car park
- In the parent rooms on the wards and in parents accommodation
- On the barrier as you enter or leave the car park
- On the car parking ticket itself

Long stay car park rates have been escalated to the Patient Flow Committee for decision on the most appropriate pathway to communicate this message to Service Users and their families.

Hospital Group

Category: Safe and Effective Care (Treatment and Care) / Communication and Information (Communication Skills)
Status: Compliment

Background to Compliment
A handwritten letter of compliment was received by the Patient Advocacy Department (PACS) from an 8 year old Service User that had visited the Plastics Trauma Clinic (PTC). In the letter, the Service User wrote, "*Thank you for helping me with my finger. You were very kind to me. You listened to stories and you were both very nice. Thank you for all your hard work and for helping the children and for helping me to be brave*."

Nature of Positive Feedback
Having received the compliment, the PACS Information Officer requested information from the clinic to find out from the team what processes or methods they used to help patients 'feel brave' when they come to hospital and whether or not there were ways that could be expanded on, or methods that could be shared to other areas in the hospital.

A member of the PACS team contacted the Plastics Trauma Clinic team and was advised that the approach taken is holistic, child-centred, and based on experience learned through each interaction with the Service Users.

The method involves engaging with each Service User on a case by case basis where their individual needs and concerns are taken into consideration through the following methods:

- Taking the time to greet each the Service User individually on arrival.
- Ensuring each Service User feels comfortable.
- Taking into account the Service User's age and capacity, the team provide each Service User with an individualised explanation on the procedure they are about to undergo.
- Encouraging and inviting questions to tap into particular anxieties through conversation and dialogue.
- Advising each Service User about what they can do during their procedure should they feel anxious or scared.
- Reassuring the Service User that the procedure will go at their preferred pace.
- Ensuring each Service User is given appropriate emotional support during the procedure.
- Inviting further dialogue post procedure to ensure the Service User is left with no unanswered questions.

Outcome and Learning
The team embrace this methodology as it enables them to continuously learn through the variety of perspectives and anxiety triggers of every one of their Service Users.

The Assistant Director of Nursing, together with the PACS Information Officer, asked the team to consider ways that they could expand on their work of making Service Users 'feel brave' when they visit the clinic.

Consequently, the team are currently developing a leaflet that will help their Service Users to manage their anxiety even before they arrive at the clinic. The content for the leaflet is being populated from nursing experience in the Plastics Trauma Clinic and through feedback from their Service Users and the Youth Advisory Council. Its purpose will be to ensure each Service User knows that they are in control of their situation, they are being heard, that they feel empowered to express their anxiety in a positive way, and that their fears and anxieties are normal and will be completely supported by the nursing team.

Once Service Users have been referred to the Plastics Trauma Clinic, they will be directed to the leaflet which will be available on the Hospital website and in the clinic waiting areas.

Hospital Group

Category: Safe and Effective Care (Treatment and Care)
Status: Upheld

Background to Complaint
The parent of a Service User that uses a number of services in the hospital contacted the Hospital's Patient Advocacy Service with a request that a review of process be undertaken by the relevant management team following a recent stressful experience where the Service User and their parents attended for their regular appointments. On the day in question, the Service User required two different tests, i.e. blood tests and an MRI. As both tests were taking place on the same day the parent asked staff if the Service User could be cannulised (device inserted to allow fluids to be taken or given) so as to avoid unnecessarily distressing the Service User by having to insert a needle two times. Putting the question to staff from both services, the response given to the parent was that the request could not be accommodated, with staff saying, '*we don't do that here*'. In the correspondence to the Hospital's Patient Advocacy Department, the parent reasoned that by being unwilling to 'think outside the box' staff were not putting the needs of the Service User first.

Investigation
Upon being notified of the complaint, the Assistant Director of Nursing (ADoN) responsible for the Phlebotomy Service addressed the issue with the Clinical Nurse Manager III (CNM3) who in turn discussed the issue with the MRI and Phlebotomy nursing teams. In an effort to turn a negative experience into a positive improvement, the team focused on the question, '*well, why don't we do that here?'* In doing so, the objective became establishing a collective approach to implementing an improved experience going forward for Service Users that require both blood tests and an MRI on the same day. Consequently, the relevant ADoN's, together with their respective Clinical Nurse Specialist teams, agreed on a number of recommendations that could be implemented in order to avoid, in so far as is possible, distressing Service Users that have to regularly attend appointments for both blood tests and MRI on the same day.

Outcome and Learning
The hospital thanked the parent for raising this issue with them and apologised for their experience on the day.

As a result of this issue being raised the Hospital examined its processes and pathways and the following recommendations were identified and are either all implemented or in development.

1. The ADoN team to provide an educational session to nursing teams involved aimed at improving communication with parents. ***Implemented***
2. A change in the patient pathway to be made whereby, once notified by the parent, the nursing teams would ensure that the patient was cannulised at the same time as blood tests were taken. ***Implemented***
3. A new poster to be developed by the ADoN and the nursing teams to prompt parents to let staff know that they require both services on the same day. ***In development***
4. Enhanced communication introduced by involving the CNS Team to prompt parents of the options now available to them. ***Implemented***

Hospital Group

Category: Improving Health (Holistic Care)
Status: Compliment

Background to Compliment
Email from family member of a deceased Service User in relation to a hospital art project which the deceased Service User had the opportunity to contribute to.

Nature of the Positive Feedback
The family member thanked the coordinators of the art project for including the Service User's vision in that project and taking great care to do so. The family member commented on the art work and how the *'variety of designs and colours, yet consistency of size and shape signifies to me that we as people are all on different journeys, each one is unique and yet included and just as important'*.
The family member also stated that the Facebook posts showing the art work are very important and are shared with family as a lovely reminder of their loved one. She commended the project stating that it was such a beautiful idea and thanked everyone involved in it.

Outcome and Learning
The Lead for the art project in recognising the importance of ensuring that the Facebook posts would not be missed by family members, put arrangements in place between the Arts and Communications department to ensure the families were notified of expected dates of social media posts. The effective use of social media can be an accessible medium for sharing moments of enjoyment which in turn are re-shared with many.

This expression of thanks highlights the importance of the holistic approach to health and how complimentary therapies, such as this Arts and Health project, can offer benefits to the wider family and not just the Service User, even though they are the only ones directly involved.

This Arts and Health project is also a clear example of how collaboration and clear communication between departments upholds the vision of 'People Caring for People, to live better lives'.

The vibrant Arts and Health programme in the hospital should be maintained and developed, and evaluated to ensure its continued positive impact on Service Users, their families and staff.

Hospital Group

Category: Safe and Effective Care (Treatment and Care) (Infection Prevention and Control)
Status: Upheld

Background to Complaint
A letter was received into the Patient Advice & Liaison Service (PALs) from a Service User who attended the Emergency Department (ED) following a work place accident. The Service User complained about the waiting times and also in the correspondence expressed concern with regard to social distancing in the ED waiting room. The Service User also pointed out that that there were '*no COVID-19 protocols in place apart from stands with sanitizer*'.

Investigation
The PALs department promptly acknowledged receipt of the correspondence within the recommended timeframes and forwarded a copy of the correspondence to the ED for review and response.

In the response issued to the Service User, the Assistant Direct of Nursing (ADoN) thanked the Service User for taking the time to provide feedback and went on to explain that it was very important to receive such feedback so that the hospital can learn from the Service User's experience.

An apology was given to the Service User as they did not have a positive experience.

The Assistant Director of Nursing (ADoN) outlined the attendances to the ED on the date in question and the resulting impact on patient flow. The ADoN expressed regret for the delay experienced by the Service User and assured them of the Hospital's commitment to constantly striving to improve.

The ADoN also referred to the Service User's concerns surrounding social distancing and advised that, since their correspondence was received, pods have been installed in the waiting area to ensure that social distancing can be maintained more effectively. The ADoN also advised of other measures put in place, which included:

- Increased cleaning schedule
- Additional sanitiser stations
- Clear signage at reception with regard to queuing
- Clear signage at reception with regard to COVID-19 cautions
- COVID-19 posters in prominent positions

Outcome and Learning
To demonstrate the value and importance placed on feedback as a means of service improvement, the hospital is committed to acknowledging where services fall short, or are perceived to fall short, offer a genuine apology for the experience and promptly address concerns raised in a comprehensive manner and within timeframes.

By embracing this approach to feedback, the Hospital is aiming to promote trust and confidence in its delivery of high quality and safe services.

Hospital Group

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

Background to Compliment
Service User was experiencing self-neglect and was referred to Primary Care Social Services. The Service User was subsequently admitted to hospital for care.

Nature of positive feedback
At the request of the neighbour of the Service User, Community Services contacted the hospital to advise of the change in the Service User since the admittance to hospital and the work of the discharge co-ordinator in relation to follow up care. Following discharge from hospital, the Service User now takes an interest in the community, engages more with people and goes out for messages. Previously, it had been years since the Service User had been out of the house or even spoken to anyone. The neighbours stated that these were major steps for the Service User.

Outcome and Learning
The neighbour believes that the respect, care and compassion that the Service User received from hospital staff has made a positive impact on their health and well-being. The Service User mentions so often how grateful they are for everything that was done, the neighbour wanted this passed on to the hospital staff.

This compliment highlights the importance of person-centred care and the positive impact that staff can have on an individual's recovery.

Hospital Group

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

Background to Compliment
First time Service User of maternity service during COVID-19.The Service User was anxious and scared and wasn't sure what to expect not only because this was their first baby but also was delivering during a pandemic.

Nature of positive feedback
The Service User praised the midwife that attended and stated that they were a credit to the hospital. The Service User felt that the midwife, understanding the anxiousness of the situation, both first baby and COVID-19, provided a level of care that was above and beyond. The Service User also commended the midwife for the respect shown and for keeping them informed. The midwife provided a level of care and attention that enabled the Service User to feel safe, supported and reassured. The Service User expressed their gratitude for the positive experience in an otherwise anxious and stressful time.

Outcome and Learning
The impact that an individual member of staff has on the Service User experience cannot be underestimated. When staff embody the HSE core values of care, compassion, trust and learning, the Service User has confidence in the care received, contributes to a better experience and can lead to a better outcome.

Hospital Group

Category: Safe and Effective Care (Treatment and Care) and Dignity and Respect (End of Life Care)
Status: Compliment

Background to Compliment
Family of a Service User (RIP), who passed away in hospital, were able to say their goodbyes through a zoom call set up by staff.

Nature of positive feedback
The family thanked the hospital's PALs team who went above and beyond to make the final hours of the Service User special with a zoom call to relatives in another country. The family stated that the PALs team showed great care and sensitivity to the family as well as following up on other issues for them. The family stated that they are very grateful for the input that PALs Team had in their loved one's final hours and that it was very reassuring to have the support of PALs during that difficult time.

Outcome and Learning
The care and compassion shown to the Service User provided comfort during their final few hours. The PALs service also supported the wider family which had a very meaningful impact on their experience at a difficult time. The commitment to and delivery by staff of person-centred care can have offer a Service User dignity and respect in their final hours and be a lasting source of comfort for a family even in the most difficult of circumstances.

Hospital Group

Category: Safe and Effective Care (Health Care Records)
Status: Upheld

Background to Complaint
A family member of a deceased Service User (RIP) made a formal complaint that discussions between doctors and the family member about the Service User's condition were not recorded on the Health Care Records (HCR). The family member advised that the failure to accurately record these conversations, actions and observations added to the upset and grief.

Investigation
The Complaints Officer contacted the clinical team involved in the Service User's care. It was evident from the investigation that discussions between doctors and the family member of the Service User concerning the Service User's condition were not recorded on the Health Care Records (HCR).

Outcome and Learning
As a result of this complaint a learning notice was developed and distributed throughout the hospital and wider Hospital Group.

The learning notice highlighted the following points:

- The salient points discussed with patients/and or relevant person must be documented in the patient's Health Care Record.
- Staff should refer to the HSE Standards and Recommended practices for Health Care Management 2014
- Staff should refer to Article 5 of the GDPR Principles relating to processing of personal data.

The complaint reinforced the requirement for all conversations, actions and observations regarding a patient to be recorded in the patient's Health Care Record.

Community Healthcare Organisation

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

Background to Complaint
Routine appointment changed from out-patient face-to-face review with the Team to phone consultation at the request of the Service User. The Team secretary tried to contact the Team Doctors to advise them of the change in the nature of the appointment but was unable to make contact as the Team were busy with appointments all day.

Consequently the review did not take place at the scheduled time. Subsequent efforts to make telephone contact between the Service User and the Team and the Team and Service User all failed. As a result of the review not taking place, the Service User did not receive a repeat prescription.

Investigation
The matter was investigated under the HSE's *Your Service Your Say* Policy and procedures for the management of service-user feedback.

It was noted that the Clinical Director had advised the complainant of access to her GP as the primary point of contact for renewal of prescriptions. The Psychiatry Out-patient Department is a secondary care clinic and at all times Service Users remain under the care of their GP's.

Outcome and Learning
The Team Secretary should liaise closely as required with Out-Patient Department Receptionist during Out Patient clinics to be alerted of any changes as early as possible.

If the Team / Team secretary cannot make contact with a Service User by telephone, then a text message should be forwarded to that Service User to advise them of this and also outline the message that needs to be communicated to them.

This learning was fed back to the various Out-Patient Department teams within the service.

Community Healthcare Organisation

Category: Safe and Effective Care (Patient Property)
Status: Not Upheld

Background to Complaint
The complaint related to the Service User's experience during an admission period with the Mental Health Service and in particular to damage and staining that was said to have happened to clothing that was sent for laundering during that time.

Investigation
The investigation of the complaint established that the laundry issue had not been raised locally by the Service User at the time. The initial complaint had been made through the National Your Service Your Say office. Unfortunately this meant that there had been no opportunity to address the issue for the Service User by local management as they were unaware of the issue.

The Complaints Officer examined the complaint and established that the laundering process for this service was out-sourced. The Complaints Officer noted that no issue had been raised with the laundering company when the clothing was initially returned. While it was accepted that the clothing was damaged and stained at the time of the complaint, no conclusive determination could be made as to the specific circumstances of how or when this might have happened. Procedurally therefore, the complaint could not be upheld.

The Service User requested an internal review. The Review Officer also examined the matter and upheld the original outcome; that no determination could be made in respect of the circumstances whereby the clothing was damaged and therefore that aspect of the complaint could not be upheld.

Though no determination could be made the Review Officer considered the circumstances overall and made a recommendation to the Area Administrator that the costs incurred by the Service User in respect of the damaged clothing be reimbursed. This recommendation was implemented at that time and the Service User was satisfied with the outcome.

Outcome and Learning
Key learning from this case was that local measures should be in place for the timely monitoring of quality assurance issues around laundry returns for service users from external service providers. This would support the local service in engaging on behalf of the service user with any external provider around appropriate action to establish the circumstances of events and make good the damage or otherwise offer redress.

The Assistant Director of Nursing agreed to review quality control measures for use with outsourced services and a laundry return checklist was proposed as a tool to support this measure.

Community Healthcare Organisation

Category: Access (Appointment Delay)
Status: Upheld

Background to Complaint
The complaint was made by the parent of a Service User who had to wait 40 minutes when attending for a vaccination appointment at a municipal facility in Tralee.

Investigation
The Complaints Officer considered all the circumstances and established that the vaccination arrangements were being implemented at the time in compliance with increased infection control protocols in response to the COVID-19 emergency. As a consequence the administration processes were not fully developed and, in this instance, there had been an oversight in the preparation and availability of documentation for the Service User's appointment that contributed to the delay.

That aspect of the complaint was upheld and a recommendation was made to ensure that measures to address the issue, such as signage to prompt staff on duty in that setting around documentation requirements, were implemented at the time.

The administrative shortcoming was also acknowledged and an apology was given.

Outcome and Learning
While it was acknowledged that the administration of the vaccination programme, under additional constraints in the context of the pandemic, possibly contributed to the circumstances of this delay, key learning was taken and an appropriate recommendation implemented around effective signage to prompt staff and prevent a recurrence.

Community Healthcare Organisation

Category: Accountability (Patient Feedback)
Status: Upheld

Background to Complaint
A complaint was made by a Service User following admission to a mental health facility. A further complaint about a lack of response to the first complaint was made by the Service User while still an in-patient.

Investigation
The Complaints Officer investigated the circumstances giving rise to the second complaint and established that the initial complaint had been filed with documentation in the clinical notes of the Service User instead of being referred for follow up by a Complaints Officer. This resulted in a non-response to the Service User.

The second complaint was upheld and a recommendation was made that local management take action to remind relevant staff of procedural requirements around the recording of complaints and particularly that documentation be filed separately and aside from resident care plans.

The error was acknowledged and an apology was given.

The Complaints Officer also duly investigated the initial complaint and considered all concerns in accordance with relevant organisational procedures. On completion of that investigation a written outcome was issued to the complainant.

Outcome and Learning
The key learning taken in this instance was the need for improved staff awareness around the appropriate filing of complaint documentation and the recommendation above was implemented accordingly.

Community Healthcare Organisation

Category: Communication and Information (Communication Skills)
Status: Not Upheld

Background to Complaint
A complaint was made by a parent of a Service User following their recent appointment at a primary care service where the parent alleged that the staff member did not listen when the parent advised how best to communicate with the Service User. The parent also stated that the communication skills of the staff were very poor in communicating with a Service User who has special needs.

Investigation
The Complaints Officer met with the staff member and requested a response. As both the staff member and the parent of the Service User had different perceptions on the nature of the exchange, and as neither account could be verified, the complaint could not be upheld.

Outcome and Learning
However, as a result of the complaint being raised the service manager reviewed how the service was being provided. Following that, the service created information leaflets to be sent in advance of an appointment to explain what will happen at the appointment, who the Service User will meet and what to expect. It is hoped that this improvement measure will make it easier for parents and Service Users coming into the service.

Community Healthcare Organisation

Category: Access (Accessibility and Resources)
Status: Upheld

Background to Complaint
A Service User attended for COVID-19 test in a drive through testing centre. While there they needed to use the toilet. Unfortunately, there were no public toilets in place at the testing centre.

Investigation
The Complaints Officer brought the complaint to the attention of the manager. The manager reviewed the facilities at testing centre and confirmed that there was no public toilet in place.

Outcome and Learning
The complaint was upheld and a toilet was put in place for public use.
The criteria considered when planning a pop-up service should address all the needs of Service Users.

Community Healthcare Organisation

Category: Safe and Effective Care (Diagnosis) and Communication and Information (Communication Skills)
Status: Compliment

Background to Compliment
Service User struggled with anorexia for a number of years. The Service User stated that their condition went undiagnosed for a long time due to a system which uses weight as the main diagnostic tool. However, following a referral into the system from their GP, they were fast tracked through the service.

Nature of positive feedback
The Service User wrote to the service to express their thanks and admiration for the eating disorder outpatient team.

The Service User felt they were afforded the time and space to be fully open and honest and to better themselves. The Service User commented that the HSE staff member was intelligent, genuine and accommodating. The Service User feels supported and now has the confidence in their ability to completely care for themselves. The Service User feels that a robust recovery is now possible due to the intervention of this team.

Outcome and Learning
The Service User expressed that more funding and resources should be devoted to Eating Disorder services such as this team to support their compassionate, non-diet approach, which sees the individual behind the illness, while using experience, education and communication to understand complex mental illnesses.

Community Healthcare Organisation

Category: Safe and Effective Care (Test)
Status: Compliment

Background to Compliment
Service User started experiencing COVID-19 symptoms and contacted their GP who arranged a COVID-19 Test.

Nature of positive feedback
Service User contacted their local Community Healthcare Organisation following the test to say that they found the whole process so quick and straightforward. However, the Service User wished to particularly compliment the CHO staff member who administered the COVID-19 Test for their compassion and empathy. The Service User felt completely at ease as the person was so friendly and informative. The Service User wishes to thank that staff member and all other staff at the test centre.

Outcome and Learning
The feedback was shared with all test centre staff highlighting how the compassionate and informative engagement led to such a positive experience for the Service User in an otherwise stressful situation.

Community Healthcare Service

Category: Safe and Effective Care (Infection Prevention and Control)
Status: Upheld

Background to Complaint
A Service User was required to attend a community testing hub to receive a COVID-19 test. The Service User stated that they observed two members of staff, identified as stewards, who were not wearing PPE. All other health professionals at the hub were adhering to Infection Prevention and Control (IPC) guidelines and the Service User felt that the stewards should have been wearing PPE, so as not to put themselves and others at risk.

Investigation
The Complaints Officer forwarded the complaint to the testing centre coordinator and the Community IPC Nurse Manager to examine and identify the processes that are in place to ensure that the appropriate PPE and physical distancing measures are being followed by all staff based at the testing hub. The Complaints Officer also contacted the Service User to seek additional information and to reassure them that their complaint was being investigated and that they would be provided with a full report on conclusion of the investigation.

Outcome and Learning
To ensure compliance with the guidance issued by the National Public Health Emergency Team (NPHET), the following measures have been taken:

- Communications have been issued to the testing hub concerned with regard to social distancing guidelines;
- Further guidance sought from Infection & Prevention Control and additional steps taken to ensure that an incident such as this does not re-occur;
- Guidelines issued to all HSE testing hubs/centres to ensure that physical distancing requirements are being adhered to by all staff, both those who are in direct contact with members of the public and those who are not;
- Guidelines to all testing hubs/centres to ensure that any staff member who is in direct contact with a person presenting for testing uses appropriate PPE, such as a face covering.

Community Healthcare Service

Category: Communication and Information (Delay and Failure to Communicate and Information)
Status: Partially Upheld

Background to Complaint
A complaint was received from a family member on behalf of their late relative regarding their transfer from a community hospital to a private nursing home during COVID-19. The main issues were the rationale behind the decision to move their relative from a community hospital bed to a private nursing home bed, the lack of communication with the family and visiting/access restrictions at the nursing home.

Investigation
The Complaints Officer raised the complaint with the Directors of Nursing of both the community hospital and nursing home concerned, asking them to address and explain the concerns raised in the complaint. The Complaints Officer also contacted the family member to seek clarity on the complaint and to reassure them that an investigation was being carried out and that they would be issued with a full report on conclusion of the investigation. Comprehensive and detailed responses were provided by both Directors of Nursing and both also offered to meet with the family again to explain the decision and address the family's concerns.

Outcome and Learning
During the investigation it was established that a meeting had taken place between the family members and the community hospital prior to the transfer. It was noted that during that meeting reasons for the transfer were outlined, questions answered and that the family indicated their understanding of what was happening and the rationale behind it. While this part of the complaint was not upheld the Complaints Officer made a number of recommendations to strengthen communication and understanding, as well as provisions around access to loved ones during the ongoing pandemic.

- To meet with families prior to the transfer of their loved ones to another health facility, to explain the decision and to listen to any concerns or questions the family may have.
- To develop and maintain alternative ways of communicating with families during COVID-19 visiting restrictions, via regular newsletters, video calls, frequent telephone calls, window visits.
- To establish a designated visiting room within the nursing home that it is appropriately equipped with all the necessary infection prevention and control precautions, including clear plastic screens.

Community Healthcare Service

Category: Access (Appointment) / Communication and Information (Delay and Failure to Communicate and Information)
Status: Upheld

Background to Complaint
The Service User's vital specialist physiotherapy treatment ceased abruptly in March 2020 without any prior notification. No communication was issued from the service to the Service User as to why the service ceased and they were not offered any alternative treatment options. As a result of having no treatment, the Service User's condition deteriorated.

Investigation
The Complaints Officer assigned to the complaint met with the Service User to clarify the issues raised. The Service User requested that the service be reinstated for both themselves and other similar service users who depended on it.

The Complaints Officer then liaised with the Service Manager who confirmed that the service had ceased abruptly and that no notification had been issued to service users at the time. This was due to the sudden redeployment of the two staff as a result of COVID-19 and that the duration of the redeployment was unknown at the time.

It has since been confirmed that the redeployment is for a period of 2 years and the Service Manager is making efforts to have one of the posts filled through a temporary assignment. The Service Manager also confirmed that the Service Users will be without any treatment in the interim of the posts being filled.

Outcome and Learning
The Complaints Officer made the following recommendations:

- To contact all Service Users affected by the cessation of the service to inform them of the current situation, apologise for the lack of communication and disruption to their treatment, and outline a proposed timeframe for when they might expect their treatment to resume
- To put in place a system whereby Service Users are informed of any change to their appointments or treatment plan, and to ensure that communication takes place with Service Users where there are disruptions or changes to the service.
- To ensure that specialist services are made available to Service Users who require them for the duration of the COVID-19 redeployment.

Redeployment of staff, due to COVID-19 has left a gap in the some service provision. Notwithstanding the need for the HSE to respond to the COVID-19 pandemic, the need to provide vital services across other areas must continue. The haste with which the COVID-19 redeployment of staff across health services took place has impacted existing service provision. However communication with those affected is imperative and must be issued, both in the first instance and by way of regular updates.

Community Healthcare Organisation

Category: Communication and Information (Communication Skills) and Safe and Effective Care (Treatment and Care)
Status: Compliment

Background to Compliment
Service User and their parent attended a public health nursing service.

Nature of positive feedback
Service User and parent expressed their gratitude for manner in which they were treated by the public health nursing staff. The Service User and their parent expressed how anxious and apprehensive they were when they attended the service in the beginning. They mentioned how the professionalism of the staff and their willingness to assist alleviated any anxiety. The constant and warm encouragement received along with professional advice greatly contributed to the Service User's recovery.

Outcome and Learning
The feedback was shared with staff of the public health nursing service to acknowledge how they created a safe and welcoming environment that enabled the Service User to feel comfortable and achieve the best outcome. Behaviour which demonstrates the core values of the HSE (care, compassion, trust and learning) can deliver a positive and meaningful experience for the Service User in an otherwise anxious situation.

Community Healthcare Organisation

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

Background to Compliment
Service User attending a physiotherapy service with a complicated medical history.

Nature of positive feedback
Service User thanked the physiotherapy staff for the compassionate way in which care was delivered. The Service User highlighted that staff communicated very clearly and were both patient and pleasant. This gave the Service User confidence.

Outcome and Learning
The positive feedback was shared with staff reinforcing the value of communication and highlighting the impact of positive behaviour on a Service User's experience and well-being.

Community Healthcare Organisation

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

Background to Compliment
Service User attending public health nursing service for a development check-up with their 2 year old child.

Nature of positive feedback
Service User thanked the public health nurse for the support and great advice given in relation to breastfeeding. The Service User, who is breastfeeding their 2 year old child, was delighted to receive such encouragement and positivity from the Public Health Nurse. The Service User stated that this was exactly what was needed to help normalise and sustain breastfeeding.

Outcome and Learning
The feedback was shared with staff demonstrating how positive and compassionate engagement supports and promotes health and wellbeing.

Community Healthcare Organisation

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

Background to Compliment
A Service User underwent significant surgery to their foot that required intensive nursing care including regular monitoring of and dressings for several months.

Nature of Positive Feedback
Following completion of the period of care, the Service User went back to the service in person to thank them for the high standard of care that they received and praised the nursing staff who were extremely kind and professional. The Service User felt that the care and attention received from the treating consultant and the high standard of aftercare provided by the nursing service saved the foot and aided a return to health and mobility.

Outcome and Learning
The Service User mobilises with the aid of a walking stick but is slow and requires determination. The impact of the kindness and professionalism was demonstrated in the Service User's effort to physically attend the service once more just to thank staff.

The care, compassion and professionalism of treating staff can greatly impact and aid a Service User's recovery, delivering a positive experience and a better outcome.

National Screening Services

Category: Access (Appointment Delay) and Communication and Information (Information) and Safe and Effective Care (Treatment and Care)
Status: Upheld

Background to Complaint
Population-based screening services had been paused for a part of 2020 in response to national measures to manage and curb the COVID-19 pandemic. The CervicalCheck Programme paused its invitations from 30th March 2020, before recommencing in a phased manner on the 6th July, 2020.

A Service User contacted the screening information line and expressed concerns regarding access to their cervical screening appointment. The Service User wished to make a complaint regarding the delay in receiving their invitation for scheduling a screening appointment in a timely fashion. The Service User wished to escalate the complaint further as a date for the screening appointment could not be provided during the call.

Investigation
The complaint was notified to the Quality Assurance team and the Programme Management. The complaint was logged on the internal Quality Management Information System and managed under the HSE Your Service Your Say policy, 2017 and a response issued to the Service User.

Outcome and Learning
Outcome
The response to the Service User provided a detailed explanation around the need for pausing the service in line with the public health advisory and guidance from the Government. The response also advised that a planned and structured restart process was in place to ensure adherence to social distancing and other measures for the safety of Service Users attending for appointment. This means that Service Users will have had to wait a little longer to receive screening invitations. The National Screening Service apologised for this delay. Reassurance was provided that the health, safety and wellbeing of Service Users continue to be the National Screening Service's top priority.

The response also advised the Service User when they could expect to receive a screening invitation letter under the screening restart plan.

The programme continued to monitor the situation and the Service User's letter of invitation was issued one week ahead of the planned date under the restart programme.

Learning
- The case highlights the need for clear communication with the Service User to explain the cause for difficulty in accessing a specific service, in addition to the information being made available on multiple public domains of communication. It is a reminder of putting into practice the HSE core values of *care, compassion, trust and learning*.
- While the screening information line is managed by a third party, the National Screening Services embrace the 'no wrong door' approach. Therefore, instead of redirecting the Service User, which could have inconvenienced them, the Service User was reassured that their complaint would be relayed to the relevant team in the screening programme for management and response.