HSE Your Service Your Say

Anonymised Feedback Learning Casebook

Anonymised Feedback Learning

Casebook Q4 2023

10 Complaints

15 Cases

5 Compliments

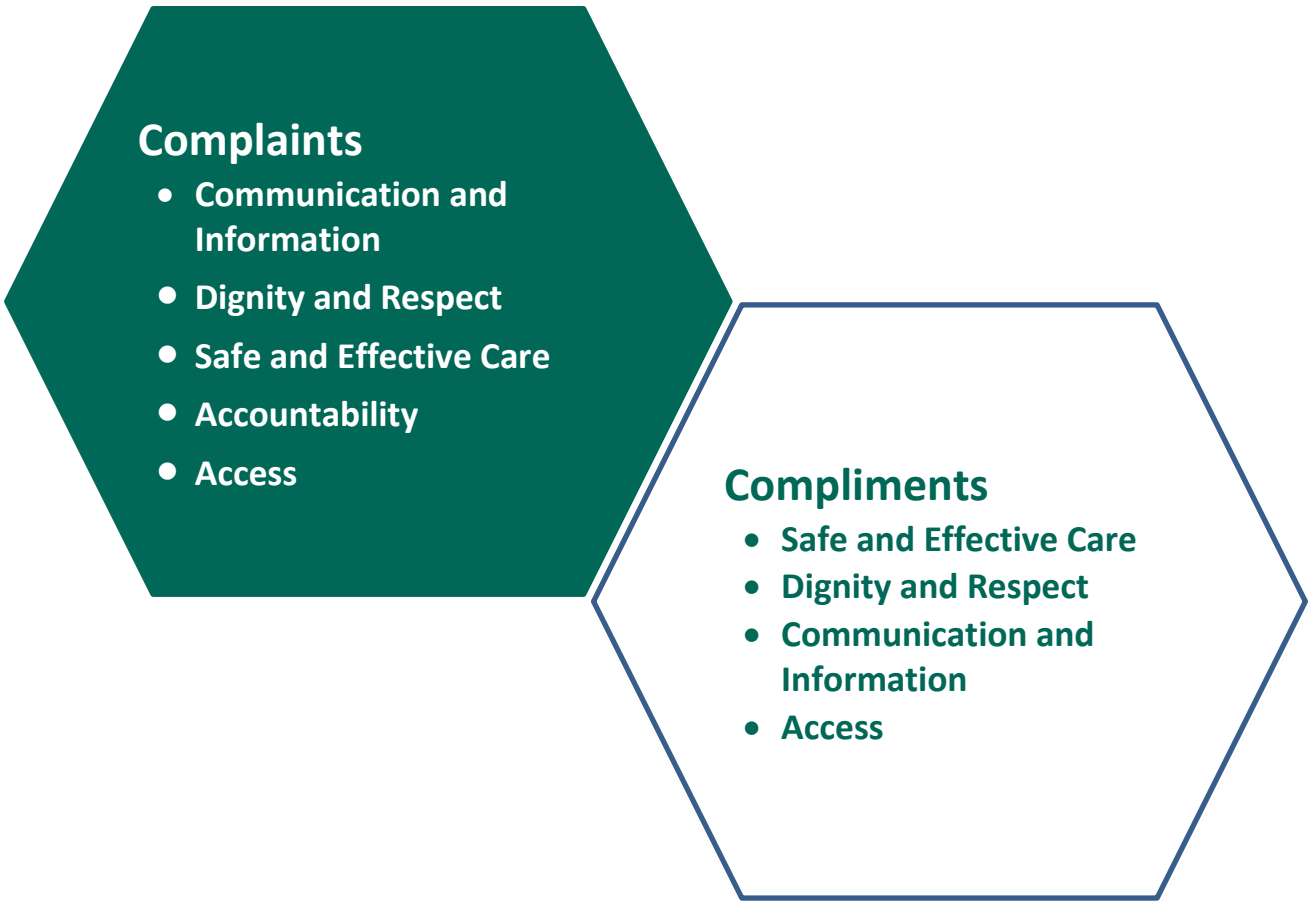
Introduction

The final quarter 4 edition of the casebook for 2023 presents a total of 15 cases covering both complaints and compliments received by Hospital Groups and Community Healthcare Organisations.

The cases presented in the casebook contain themes and issues that need to be examined in the context of quality and service improvement. The learning gained from patient and service user feedback helps target and prioritise improvement efforts as well as highlighting good practice to be promoted and replicated.

The casebook features a total of **10 complaints**; 7 complaints from Hospital Groups, and 3 from Community Healthcare Organisations that were investigated and/or reviewed along with their outcomes. The casebook also features **5 compliments;** 2 from Hospital Groups and 3 from Community Healthcare Organisations which highlight the learning to be gained from positive patient and service user feedback.

Key Categories



Learning from feedback is fundamental in providing high quality healthcare services. Listening to and acting on the views, concerns and experiences of Patients, Service Users and their families enable us to guide decision making to improve services and provide the best possible care.

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

Complaints for Quarter 4, 2023
Two dominant themes for complaints, namely *Communication and Information* as well as *Dignity and Respect* are presented in this final Q4 2023 edition of the casebook with each of these categories featuring in 6 of the 10 complaint cases presented. The other main category that features is *Safe and Effective Care* followed by the categories of *Accountability* and *Access.*

Communication and Information relate to accessing and being provided with information and updates in a timely manner as well as to general communication skills such as how those using our services were spoken to. *Dignity and Respect* concern issues regarding delivery of care and end of life care including mortuary facilities while *Safe and Effective Care* relates to issues around treatments and procedures. Accountability concerns how patient feedback was managed as well as issues with patient charges while *Access* relates to appointment issues and parking facilities.

Compliments for Quarter 4, 2023
The positive feedback received mainly relates to the categories of *Safe and Effective Care* and *Dignity and Respect* with both of these categories featuring in 4 out of the 5 compliments presented. The other categories of positive feedback featured are *Communication and Information* and *Access.*

The casebook will be published on the HSE website as well as being widely circulated to staff within the HSE and shared with Complaints Managers who will consider the learning from these cases. The casebook will also be shared with patients and service users through the office of Partnering with People who use Health Services Programmes.

Hospital Group

Category: Safe and Effective Care (*Treatment and Care*); Communication and Information (*Information*) (*Delay and Failure to Communicate*); Dignity and Respect (*End of Life Care*); Accountability (*Patient Feedback*)
Status: Upheld

Background to Complaint
A complaint was received from a sibling of a patient 2 months after the patient died following a cardiac arrest in the sanitary facilities of an Emergency Department (ED).

The deceased patient had a history of advanced cardiac disease. The patient had called an ambulance following two days of continuous chest pain. Three ECG's were carried out, the third which was undertaken by paramedics 5 minutes following arrival to the ED. Within 9 minutes of arrival to ED, a Triage Nurse had received clinical handover from the paramedics and undertaken a 4th ECG, which showed Atrial Fibrillation with Premature ventricular Contractions with some Ischemic changes. Observations were stable and the INEW (Irish National Early warning Score) an alert system for healthcare staff to recognise a deteriorating patient was 0. The patient was ambulant, orientated and independent. A Nursing Care Plan was put in place. A medical doctor examined the patient 40 minutes following arrival to the ED and a routine chest x-ray was requested within 4 minutes of that medical examination. A second medical examination by another doctor took place approximately 60 minutes later. The patient was then requested to present at the x-ray department for a routine chest x-ray.

The examining Doctor who would be passing the x-ray department accompanied the patient. As the Doctor and patient headed towards the x-ray department, the patient related that they wished to use the sanitary facilities. The doctor then directed the patient to find the x-ray department independently around the corner from the sanitary facilities.

The patient failed to attend x-ray. A nurse went looking for the patient and found them collapsed in the toilet. A Cardiac Arrest call went out. Unfortunately, despite all efforts, the patient died. RIP

The patient's family arrived to the ED soon after following a call from staff.

The complaint raised a number of questions around the care and treatment of the patient, the provision of an escort to the x-ray department, the use of sanitary facilities unsupervised and the duration the patient was in the sanitary facilities before being located. In addition, the family raised concerns regarding the state of the patient when they were brought to see them, such as clothing on the floor, medical equipment attached to the patient as well as being advised of the patient's death on a busy corridor and the lack of a notice on the door within the ED Unit to alert of the death of a patient. The family also queried why staff did not inform them of the next steps.

Investigation
The complaint was investigated under Stage 2 of Your Service Your Say and the process was supported by the End of Life Co-ordinator with inputs from both medical and nursing staff.

A request for a Stage 3 internal complaint review was received from the Complainant with additional queries around how and when the patient was found, the 'major discrepancies' in the timelines both within the Investigation Report and within various patient clinical notes and accounts provided by staff; the policy and process regarding the accompaniment of cardiac patients to sanitary facilities; the clinical care provided; and the administration and management of the complaints process including the parallel incident assessment process.

While the criteria for a Stage 3 Internal Review were not met as per the requirement set out under Part 9 of the Health Act 2004, the issues raised by the complainant were recognised by the hospital as being valid and needing further explanation.

A Co-ordinator was therefore appointed to work with the Complaints Officer to examine the issues raised and to provide any additional clarifications not set out in the original investigation report to the family. Again, the End of Life Co-ordinator assisted in this process.

The Co-ordinator contacted the Complainant to advise of the process and to provide them with their contact details as a contact point for them.

The Co-ordinator noted that the complaint investigation report was issued after a period of 3 months. However, this delay was not referenced in the cover letter nor was there evidence that an apology for the delay was extended to the family. There was also no evidence of telephone communication with or holding letters issued to the family. In addition, it was also noted that there was no expression of sympathy, with regard to their recent bereavement, extended to the family. The Co-ordinator also noted diction and spelling errors within the cover letter and the report. While an apology had been included in the cover letter for the 'deficits in nursing care' it was identified that this was based on an unqualified and unjustified medical opinion as there were no actual deficits identified in nursing care.

In addition the Co-ordinator noted that while separate medical and nursing reports were attached to the Stage 2 complaint investigation including the End of Life Co-ordinator's detailed report setting out all the actions taken as a result of the complaint, only the medical report was referenced in the cover letter that accompanied the investigation report.

Following further enquiries by the Co-ordinator, it was identified that there was no collaboration between Medical and Nursing professionals prior to issuing the Stage 2 Report. It was further identified that a medic, who did not provide care to the deceased, provided an unqualified opinion on nursing input which was adopted in the complaint investigation report by the Complaints Officer and issued to the family, which further complicated matters and added to their upset.

The Co-ordinator also found clear conflicting timelines with regard to the time of and response to the cardiac arrest, within the report, which caused a lot of distress to family members as it added to their belief that their loved one had lain on a bathroom floor alone for a much longer period of time than was the case.

The Co-ordinator requested a response from the Complaints Officer in relation to some of the issues raised.

Together with the assistance from the End of Life Co-ordinator, including a thorough review of the medical records and re-engagement with various personnel involved with the patient's care, a 'forensic' clarification report addressing all issues was produced. The report provided explanation, clarification, accountability, apology, and reassurance of change and improvements, supported with a detailed plan of action to address issues that were found to have fallen short of appropriate standards.

Several phone calls were made to the Complainant over the course of the investigation to reassure them of the ongoing and background work that was necessary to produce a robust report to clarify all issues.

It became apparent however, as engagement progressed, that despite frequent and transparent communication, and the Complainant providing feedback that all communication was clear and understood by them, that the Complainant was not retaining the information provided or understanding the explanations provided or that the process underway that would culminate in a thorough final report. Ongoing correspondence although accepted by the Complainant was at odds with the understanding demonstrated by them when verbally engaging with them.

As it became clear that there were communication issues at play, the Co-ordinator ensured that a very comprehensive, detailed and clear report, which had the input of the End of Life Coordinator, and which responded to all issues and provided a clear progress update on quality improvement initiatives implemented or partly implemented to date, issued to the Complainant.

A cover letter was included which invited the Complainant to read and reflect on the response, discuss with family and revert back to advise if they wished to meet to gain further clarity/explanation on any issues.

Further contact was received from the Complainant together with new questions relating to issues which had been addressed within the follow-up clarification report.

To address any remaining questions that either the Complainant or a family member had and perhaps were not aware of responses already provided, the Complainant together with any support person of their choosing was invited to meet with the Co-ordinator and the End of Life Co-ordinator. The Complainant was also advised of the Patient Advocacy Service.

The Complainant availed of the meeting and attended with their daughter and a Patient Advocate from the Patient Advocacy Service. While the meeting was emotional and at times, challenging, it allowed for any remaining issues to be discussed with clear explanations provided. The input from the Patient Advocate was very helpful and appreciated. The expertise of the End of Life Coordinator also greatly contributed to the understanding of events.

The meeting was minuted and issued to family. Details regarding a Stage 4 independent review was made clear being mindful of the limitations regarding clinical judgment, which are outside the scope of the Ombudsman to examine.

Outcome and Learning

While the criteria for requesting a Stage 3 internal complaint review were not met, on this occasion it was recognised that the questions and concerns raised were valid and would benefit from additional examination and explanation so a Co-ordinator was assigned to examine the investigation conducted.

The process and the follow up meeting proved to be very healing for the family and the Hospital involved and trust was improved.

Several quality improvement actions resulted from this complaint:

- The Emergency Department (ED) Family Room reverted back to family use from its alternative function during COVID. Grants from Hospice have been secured which has funded the refurbishment of the family room to provide necessary comforts; couches/coffee machines etc.
- An End of Life Pack has been produced containing a booklet on death, next steps, role of the Coroner, End of Life Coordinator, contact details, information on counselling services, etc., card and letter from ED staff to family expressing condolences etc.
- An End of Life Symbol is now available to display in ED as required - 2 hearts/ invisible Ink handprints.
- A clothing bag with universal End of Life symbol to return clothing/jewellery/belongings to deceased to family members.
- 'Difficult Conversations' training is underway with great uptake by staff.
- Open complaint management to include subject experience which translates as 'Recommendations' being implemented and real learning
- Your Service Your Say process to be strengthened across the Hospital Group

Hospital Group

Category: Communication and Information (*Information*) (*Communication Skills*); Access (*Parking*)
Status: Upheld

Background to Complaint
A patient emailed the hospital to submit a complaint. The patient reported that they had an appointment for treatment as an outpatient and upon arrival they attempted to enter the hospital's car park. The patient stated that a member of the hospital's security team approached them and prevented them from entering the car park. The patient was dissatisfied with the manner in which the member of staff spoke to them.

Investigation
The complaint was brought to the attention of the Facilities Management Operational Manager and the Contract Security Manager who examined the matter.

It was explained that on the day the patient attended for their outpatient appointment, members of the security team had been placed at the entrance ramp of the car park to prevent building contractors, who were working on the hospital campus at the time, from using the car park as an 'all-day' car park. This action was taken to ensure a maximum number of parking spaces would be available for patient use.

As the patient arrived in a tradesman's van and work clothes the security team member assumed that they were working on site and declined their entry. The situation escalated and words were exchanged.

Outcome and Learning
The issue was addressed with the member of the security team and managed in accordance with hospital policies and procedures. A formal written response was provided to the patient on behalf of the hospital which included an apology from the member of the security team and the managers.

The learning from the complaint was shared with the security team members. It highlighted both the importance of conducting oneself in a professional manner and the importance of good listening and communication.

Hospital Group

Category: Communication and Information *(Communication Skills) (Information*); Safe and Effective Care *(Treatment and Care);* Dignity and Respect *(Delivery of Care)*
Status: Upheld

Background to Complaint
The parent of a patient emailed the complaints department to register a complaint regarding an interaction with a clinician in the Emergency Department (ED). The parent was dissatisfied with the clinician's bedside manner, tone of voice and felt they displayed a lack of empathy and a lack of patience when speaking with their child who had an injury to their hand. The parent also raised concerns that their child had been put through a painful procedure without anaesthetic.

The following issues were identified:

- The parent felt the clinician's approach and manner was abrupt and lacked empathy and patience.
- The clinician gave the child a choice of the procedure options available to treat their injury, and this frightened and distressed the child.
- The parent was disappointed that their child was put through a painful procedure without anaesthetic.

Investigation
The Complaints Officer shared the parent's experience with the ED management team. The ED Department Lead examined the complaint and spoke to the treating clinician and an Advanced Nurse Practitioner (ANP), to get a deeper understanding of the details of the ED attendance.

Outcome and Learning
A formal written complaint response was issued to the family.

The ED Lead explained that the ANP gave the child a choice in treatments because offering autonomy in healthcare decision-making is considered best practice for children above a certain age; this helps them to feel somewhat in control of a situation that can be otherwise frightening. In cases where treatment options offer the same outcome and in consultation with their parent/guardian, children of a certain age can appreciate being given a choice.

The complaint response included an apology that the parent felt the ANP's manner was not kind. The ED Lead assured the parent that on speaking with the ANP, this was not intentional; the ANP had been trying to gain the child's confidence and when that did not appear to be happening, the ANP tried to put them through as little discomfort as possible by performing the procedure quickly to minimise distress.

Regarding the parent's concerns that the procedure was performed without anaesthetic, the ED Lead assured the parent that an inhaled anaesthetic gas was used. The ED Lead acknowledged that this could have been communicated more effectively as it was evident from the complaint that this was not made clear to the parent at the time. The ED Lead advised that going forward to improve communication, they would utilise a sedation information sheet to aid in explaining the properties of inhaled anaesthetic gas to service users and their families.

The complaint highlights the importance of delivering a person centred approach, being mindful of tone and manner, and carefully explaining care options, and how this can impact on the experience of service users and their families.

This complaint showed that while the ANP was taking the child's confidence and emotional needs into consideration, it was not effectively communicated to the parent which resulted in a negative experience for them.

The ED Lead thanked the family for their feedback, which has contributed to the ED team ensuring the use of written information for parents/guardians when using inhaled anaesthetic gas. They expressed their regret for the family's negative experience and extended their apologies.

Hospital Group

Category: Dignity and Respect (E*nd of Life Care);* Safe and Effective Care (*Treatment and Care)*
Status: Compliment

Background to Compliment
A patient passed away after a short stay in hospital. Following the patient's death, a family member wrote to the hospital.

Nature of Positive Feedback
The family member informed the hospital that their loved one had experienced excellent care and that the family were given the information they required during their loved one's final journey. At all times their loved one was treated with dignity and respect, their pain was managed effectively and personal care maintained. The family member also commented on how the doctors and nurses cared for both the patient in those final days and the family members too.
The family member thanked the staff for the care they provided and their dedication to both the patient and their family

Outcome and Learning
The impact and significance of supporting family members during a patient's end of life care is emphasized in this compliment. The compliment was shared with the staff who cared for the patient as it reinforces learning, identifies their strengths, motivates and encourages them to continue the provision of good care.

Hospital Group

Category: Safe and Effective Care (*Treatment and Care*); Communication and Information (*Information*) (*Communication Skills*); Dignity and Respect (*Delivery of Care*)
Status: Compliment

Background to Compliment
Following a number of attendances to the Outpatient Department (OPD) for wound care management, a parent wrote in to compliment the entire service and in particular three staff members who they had consistently engaged with during each OPD attendance. The parent wrote to express their "gratitude for the exceptional care and attention" that their child received, and how they believe it is "vital to celebrate the incredible work" that the clinic provides**.**

Nature of Positive Feedback
Of the entire team, the parent wrote to commend them of their "*outstanding commitment to providing the best possible care for their young patients*". The parent noted that although the patient's wound was in an intimate area, staff made them feel comfortable and approached their care discreetly and caringly which put their child at ease. They highlighted a number of other items which positively impacted their experience:

- They were always made to feel welcome from the moment they entered the clinic.
- Staff always displayed patience and compassion, "*turning what could have been a daunting ordeal into a manageable and even positive one*".
- All staff took time to explain each step of the process to both parent and child, including time to explain and demonstrate care techniques and answering any questions or concerns the parent had.
- The parent greatly appreciated being provided with dressing supplies to keep up with wound management at home in between appointments.
- Whilst on holiday in the middle of their care journey, the parent was able to maintain contact with the clinic with any concerns they had and always received prompt feedback from staff.
- The clinic maintained a clean and safe environment which contributed to the family's trust in the service during visits.

Outcome and Learning
The compliments were forwarded to the staff involved and to their line management. The feedback pillars of Dignity & Respect alongside Communication & Information are clearly demonstrated by staff in this compliment and helped turn a difficult experience into a positive experience for both parent and child. The parent commended the care they received as making a positive impact on their child's wellbeing and recovery, and how the staff's "*dedication and commitment shine through at every step, and our family is grateful for the positive experience we had".*

Hospital Group

Category: Accountability (Finance)
Status: Not Upheld

Background to Complaint
A person, who is a retired GP, attended the Emergency Department (ED) and refused to pay the ED charge. The person believed that as a retried GP they could self-refer themselves to the ED and so did not need a separate GP referral letter.

Investigation
The finance department was consulted in relation to the charging of the ED fee and any exemptions applying.

Outcome and Learning
It was advised that in order for a person to be exempt from the fee they must either attend with a referral letter from a practising GP or be in possession of a full medical card. In addition, it was advised that GPs cannot self-refer.

The complaint was not upheld and the fee remains due.

It is important that clear information is available and accessible to persons attending the Emergency Department regarding charges and exemptions.

Hospital Group

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

Background to Complaint
A complaint was received from a parent of an adult child who was an inpatient in the hospital. The complaint set out how the parent had asked the treating doctor of the adult child what was wrong with their child and advised how the doctor had been abrupt with them and told them that they would need to ask their child.

Investigation
The Complaints Officer spoke to line manager of the treating doctor. The Complaints Officer was advised that as the patient was an adult with full capacity, the doctor would have needed the consent of the patient to discuss their condition and treatment with their parent. Unfortunately, the doctor did not have this at the time they were approached by the parent. It was also advised that the doctor wished to apologise if they came across as abrupt as this was not intended.

Outcome and Learning
The situation regarding patient privacy and rights under GDPR including the requirement for consent was outlined to the parent to explain why the doctor was unable to discuss the patient's condition or treatment when asked.

While the complaint was not upheld as the doctor acted in line with patient privacy rights and data protection legislation, it highlighted the need to provide full explanations for decisions so that a person can understand the reasons why an action can or cannot be taken.

Hospital Group

Category: Accountability (Finance)
Status: Not Upheld

Background to Complaint
A patient complained that they were billed for two visits to the Emergency Department for the same issue.

Investigation
The Complaints Officer examined the patient's visits to the Emergency Department. It was determined that there was a period of three weeks between the initial and subsequent attendance. The Complaints Officer then consulted with the Finance Department regarding the charging of fees and any exemptions applying. The Finance Department advised that return visits to the ED for the same issue are not liable for a fee if the patient returns within 7 days.

Outcome and Learning
While this complaint was not upheld as the visit fell outside of the 7 days, it has been recommended that consideration to be given to extending the return period for the same issue without incurring additional charges.

Hospital Group

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
A complaint was received from a person who had been removed from a waiting list.

Investigation
The Complaints Officer followed up with the Central Referrals Unit and discovered that this person was just one of many who had been erroneously removed from the waiting list due to a national validation error. The Central Referrals Unit advised that the error had been identified and that issue was being resolved.

Outcome and Learning
The Complaints Officer apologised to the person for any upset caused and advised that the issue was a result of a national failure in the system and that there was nothing that the hospital could have done locally to have avoided this. The patient was reassured that they would be re-instated on waiting list.

Better communication between national and local systems to advise of any issues or technical difficulties will enable local services to be proactive in providing information and reassurance to those affected.

Community Healthcare Organisation

Category: Dignity and Respect *(End of Life Care)*
Status: Upheld

Background to Complaint
A Complainant raised a complaint with the Consumer Services Office regarding their dissatisfaction with the condition of the mortuary at a Community Hospital where they had recently attended following the death of a family member at the hospital. The Complainant outlined that while the hospital care and facilities were of a high standard, the mortuary was not. The Complainant outlined that they and their family spent a morning at the mortuary and observed the following;

- No heating
- Seating consisted of hard, uncomfortable wooden benches
- Walls and floor were bare and unkempt, with paint peeling off the walls in places
- No toilet facilities

In summary, the Complainant stated that the mortuary reflected badly on the management of the facility.

Investigation
The Complaints Officer (CO) assessed the complaint and acknowledged receipt, initially by email and then contacted the Complainant by phone to discuss the matter and outline the investigation process. The CO then liaised with the Service Manager who had responsibility for the facility and provided them with a copy of the written complaint.

The CO arranged to meet with the Service Manger on site to view the mortuary. It was agreed by both the Service Manager and the CO that the environment was not comfortable or comforting, and that improvements could be made.

Outcome and Learning
The Service Manager undertook to address the matter by taking the following actions:

- Obtained funding for the repainting of the mortuary, to be overseen by the Maintenance Manager, with a specified date for completion.
- Employed an electrician to review the heating in the mortuary with any faults detected to be rectified as a matter of urgency and, if no faults detected, the Service Manager to approve funding for additional electric heaters.
- Requested the Director of Nursing liaise with the Undertakers who use the mortuary to ensure that prior to any removal that the heating be switched on for a number of hours. This will ensure that the mortuary is a comfortable temperature for family members in attendance.
- Approved funding for pictures, flower arrangements and candles for the mortuary to provide a more comforting environment.
- Instructed the Director of Nursing regarding the provision of access to toilets for members of the public who attend the mortuary. It was agreed that the Director of Nursing would advise the Undertaker at the time of removal of what toilet facilities are available so that the Undertaker can inform visitors, as required.

The CO arranged for a meeting with the Complainant and the Service Manger to discuss the complaint and subsequent actions taken by the service.

The meeting was very positive. The CO outlined the actions taken by the Service Manager to address the issues identified with the mortuary. The Service Manger provided an apology for the experience the Complainant and their family had when using the facility, and at an already difficult time for them. The Service Manager also expressed their thanks for the feedback and discussed the direct improvement measures that had been implemented as a result of the Complainant's feedback.

The Complainant expressed their satisfaction that this feedback had resulted in service improvement that would benefit other bereaved families who required to use the facility, and gratitude that their feedback had been taken seriously and addressed without delay.

The CO issued a closure letter to the Complainant confirming that the complaint had been upheld and again outlining the service improvement measures that had been implemented within the service.

The CO requested that the Service Manager redact the complaint and the outcome letter, and share with the Team at the Community Hospital at the next Team Meeting, to ensure service learning and to highlight the positive outcomes that can be achieved as a result of feedback.

Community Healthcare Organisation

Category: Access *(Appointment)*
Status: Resolved Informally at Point of Contact

Background to Complaint
A relative phoned very upset and distressed as they were unable to access a dentist from the Dental Treatment Services Scheme (DTSS) locally for a family member who was in severe pain. As they could not get access to the service, they wished to go private and requested HSE reimbursement.

Investigation
The relative was listened to sympathetically by the Dental Staff Member who received the call and an apology was relayed for any upset that had occurred. The Staff member advised the relative to visit with the family GP in respect of pain management. Acknowledgement was shared in respect of the difficulties that dental patients are experiencing with increased waiting lists (private and public) and long delays in accessing dental care with many patients having to travel increased distances to access DTSS dentists who may have available appointments. The relative was advised that eligible patients can access care at any DTSS dentist in the Republic of Ireland and also advised that, unfortunately, there is no facility to claim reimbursement from the HSE for professional services from a private dentist.

The Dental Staff Member advised that she would send the DTSS listings for the family member's Community Healthcare Organisation (CHO) location and also for all neighbouring CHOs directly to the relative.

The relative later phoned the dental department to advise that they had secured a dentist for their family member and expressed immense appreciation for the Dental Staff Member who attentively delivered the information to help them to do so.

Outcome and Learning
- In line with the Ombudsman's 'No Wrong Door' complainants must be allowed the flexibility to lodge a complaint or express dissatisfaction with a service and at any service point.
- As with the advice given in the MPS A.S.S.I.S.T model of communication the Staff Member responded appropriately to the issue and assisted in achieving a positive outcome.
- The Dental Staff Member dealt with the relative sympathetically, fairly and promptly in line with the HSE's Code of Standards and Behaviour.

Community Healthcare Organisation

Category: Communication and Information (*Communication Skills*); Dignity and Respect (*Delivery of Care*)
Status: Informally resolved at Point of Contact

Background to Complaint
A Service User attended the Gay Men's Health Service (GMHS) for vaccinations and was allocated a Nurse for the consultation. Following the appointment, the Service User presented to reception and asked if it was possible to talk to someone about the consultation. The Clinical Nurse Manager II (CNM II) met with the Service User in a consultation room where the Service User expressed dissatisfaction with the events that had taken place, expressing that they felt they had been spoken to in a demeaning way. The Service User did not like needles and during the consultation had requested to have a syphilis test done. The nurse agreed to this but remarked on a missed last appointment for syphilis follow up blood test. Following this, when the nurse announced that the vaccinations would be given the Service User felt anxious about receiving them and felt there was no empathy shown by the Nurse. This was at odds with previous interactions with other staff in the service.

Investigation
The CNM II apologised on behalf of the service to the Service User for their experience. The CNM II assured the Service User that their concern would be followed up with the nursing Staff Member. An opportunity to make a formal complaint was also offered. The Service User however did not wish to do so and was satisfied that their informal complaint was listened to and dealt with.

Outcome and Learning
The CNM II followed up with the nurse who gave the consultation. The nurse described the Service User as being nervous and had offered them to lie on the couch for the phlebotomy and vaccination. The nurse did not feel that they spoke in a demeaning way and noted that the Service User was sensitive about the vaccination.

- This interaction highlighted the need to act in a professional manner at all times while being sensitive and accommodating to the individual needs of Service Users. It is important that the best interests of the Service User underpins the care provided.
- This complaint also highlighted the importance of appropriate response and redress at point of contact in compliance with the HSE's national policy for responding to feedback, Your Service Your Say.
- The complaint served as a reminder to staff of the HSE's Code of Standards and Behaviour when dealing with sensitive situations.
- The completion of effective complaints handling training which highlights the benefits individual behaviour and good staff interactions has on service user experiences.
- The fostering and encouragement of positive attitudes towards complaints will ensure that the service is open to feedback and is responsive to complaints.

Community Healthcare Organisation

Category: Access *(Appointment)*, Communication and Information *(Communication Skills)*
Status: Compliment

Background to Compliment
A compliment was received by the Superintendent Registrar of the Civil Registration Service giving high praise for the level of service and personal treatment provided by a member of the team. A couple had an unfortunate mishap while travelling on the day of their ceremony and resulted in missing their allocated time. The staff member was calm with the main focus on the safety of the couple and reassuring relatives and friends as they waited. The ceremony was fitted in at the end of a busy Friday schedule and the staff member stayed late to accommodate.

Nature of Positive Feedback
The couple gave high praise for the event stating, '*The ceremony itself was very personable and we cannot thank the staff member enough for their kind, compassionate nature and giving up some of Friday afternoon to help us out.*'

Outcome and Learning
The Superintendent Registrar acknowledged the feedback with appreciation and relayed its content to the team member and staff within the service.

- The HSE and individual services welcomes all feedback due to the importance it provides both from a learning and a service growth perspective.
- The circumstances described were challenging for the service users on the day and staff interactions with them, their family members and friends reflected and upheld the professionalism, ethos and the ethics of the service and the Health Service Executive.
- The feedback from the service users and time taken to provide feedback presents a significant role in assisting quality improvement initiatives and this was acknowledged and appreciated by the service.
- The comments and feedback from service users and the sharing of the healthcare consumer experience demonstrates the HSE continuous service improvement cycle and plays a crucial role in the delivery of quality improved services.

Community Healthcare Organisation

Category: Dignity and Respect *(Delivery of Care)*; Safe and Effective Care *(Treatment and Care)*
Status: Compliment

Background to Compliment
A Service User was an acute admission to the services of Psychiatry of Later Life for the treatment of a progressive illness and spent their remaining time there as an inpatient.

Nature of Positive Feedback
The family praised the wonderful facility calling it a 'jewel' and expressed gratitude for the service. The family highlighted that the care, attention and genuine empathy that service users in the facility experience is beyond description, and that the staff are tremendous. The family expressed how the nurses, assistants and doctors are all approachable and patient-centred in caring for those using the services. They stated that in such difficult and challenging times, when healthcare workers are stretched to their limits, it is heartening to see such dedication and kindness. The staff make the difficult times bearable for both service users and their families. The family went on to express their thanks to the care assistants who sit with service users all day and all night, the nurses, who tenderly care for their needs and the doctors who treat each person with dignity and respect. The family could not have wished for better care and warmth for their loved one.

Outcome and Learning
The compliment was shared with the staff of the facility and highlighted the impact that delivering a high level of care and compassion can have for both service users and family members and how it enhances the quality of the experience for everyone involved.

The service continues to promote and support such a high standard of patient centred care where every person is treated with the dignity and respect they deserve.

Community Healthcare Organisation

Category: Dignity and Respect *(Delivery of Care)*; Safe and Effective Care *(Treatment and Care)*
Status: Compliment

Background to Compliment
A Service User who had been availing of Day Hospital services was later admitted to The Psychiatry for Later Life Services as their illness progressed. The Service User spent many years in the care of The Psychiatry for Later Life team until they passed.

The family of the Service User composed and submitted a poem with an image of the facility in the background as a thank you to all the staff, and to acknowledge the care received by their loved one. The family asked for the poem to be displayed in the facility.

Nature of Positive Feedback
The family said the poem signified the care and love their loved one had received as an inpatient. The Poem beautifully represents the care provided, the myriad of tasks undertaken and how personal it is to the person receiving that care:

> *These are the hands that touch you first, feel your head,*
> *find the pulse and make your bed.*
> *These are the hands that tap your back, test the skin, hold your arm,*
> *wheel the bin, change the bulb, fix the drip, pour the jug, replace your hip.*
> *These are the hands that fill the bath, mop the floor, flick the switch, soothe the sore,*
> *burn the swabs, gives a jab, throws out sharps, designs the lab.*
> *And these are the hands that stop the leak, empty the pan, wipe the pipes,*
> *carry the can, clamp the veins, make the cast, log the dose and touch you last.*

Outcome and Learning
The poem was shared with staff and displayed as requested in the facility. The poem reflected how even the smallest of tasks was noticed and appreciated by service users and their families. The service continues to promote and support the provision of this high level of care and compassion, treating every person with the dignity and respect they deserve