HSE Your Service Your Say

HSE Anonymised Feedback Learning Casebook
Quarter 1 2022

Welcome to the quarter 1 2022 edition of the **HSE Anonymised Feedback Learning Casebook**.

The past two years have been challenging, both for those delivering, as well as those accessing health services. The HSE continued to receive feedback which was examined and responded to with the learning captured and shared. The learning gained from Patient and Service User experience helps target and prioritise improvement efforts as well as highlighting good practice to be promoted and replicated.

While the publication of quarterly casebooks for the past two years was not possible as a result of the HSE COVID response, we are delighted to revert to quarterly publications for 2022.

The publication of 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 quarter 1 2022 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 24 cases covering both complaints and compliments received by Hospitals, Community Healthcare Organisations and National Services.

The casebook contains a total of **19 complaints**; 8 complaints from Hospital Groups, 10 from Community Healthcare Organisations and 1 from National Services that were investigated and/or reviewed along with their outcomes. The casebook also features **5 compliments**, 4 from Hospital Groups and 1 from Community Healthcare Organisations which highlight the learning to be gained from positive feedback.

The main themes for the Q1 2022 edition of the casebook relate to *Communication and Information, Safe and Effective Care* and *Access,* with these mentioned in 20 of the 24 cases presented

The key categories of *Safe and Effective Care, Communication and Information* and *Access* feature in four of the compliments presented. The categories of *Dignity and Respect* and *Improving Health* also feature in the positive feedback received.

The categories of *Communication and Information, Safe and Effective Care* and *Access* feature in 15 of the complaints received. Other categories such as *Privacy, Dignity and Respect,* and *Accountability* also feature.

The dominant category for complaints remains *Communication and Information* and concern issues such as general communication skills, the provision of information and delay and failure to communicate. S*afe and Effective Care* relate to issues regarding treatment and care, discharge, diverse needs, infection prevention and control and patient property. *Access* also features prominently as a key category with issues around appointment delays, accessibility and resources and facilities.

For Dignity and Respect, issues around delivery of care and alleged inappropriate behaviour were raised while Privacy featured issues around confidentiality. Accountability concerned issues around patient feedback and Improving Health concerned catering.

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 Patient and Service User experience.

Hospital Group

Category: Privacy (Confidentiality)
Status: Upheld

Background to Complaint
A patient attends the hospital for management of a long term medical condition. Patient has not informed their family of their medical condition.

Hospital staff tried to contact patient on their mobile telephone to inform of a pending outpatient appointment. When staff were unable to reach patient on the mobile number provided, they contacted the other contact number listed (a landline) on the healthcare record. A third party answered the phone and advised that patient was not at home and offered to take a message. Hospital staff proceeded to inform the third party of patient's pending appointment in the hospital.

The patient was extremely upset and distressed that their private information was discussed with a third party.

Investigation
When interviewed, the staff member confirmed that they contacted patient's other contact number provided (a landline) when the mobile went unanswered. The staff member confirmed that a third party answered the call, advised that the patient was not available and offered to take a message. The staff member informed the third party of the patient's pending appointment. No further detail was provided.

Outcome and Learning
The staff member was reminded of their obligations under the General Data Protection Regulation (GDPR).
The landline contact number was removed from patient's healthcare record on the hospital information system.
The breach was reported to the Data Protection Commissioner.
All staff in the department to ensure completion of training in Data Protection and Good Information Practices.

Hospital Group

Category: Dignity and Respect (Delivery of care) and Improving Health (Catering)
Status: Compliment

Background to Compliment
A patient who had spent some time as an inpatient wrote to compliment the staff and the service that they had received.

Investigation
The patient wrote that the service was absolutely outstanding. The staff on the ward should be used as a textbook example of how to carry out duties while showing compassion, care, integrity and deep understanding and interest. The patient had been blown away with how they were made to feel in a bad situation. The patient also commented that the food was top class and as good as any hotel food that they have had. Well done to all.

Outcome and Learning
The compliment was shared with the ward staff and the Catering department.
The Hospital promotes a process of ensuring that all positive feedback is shared with staff within and across services as this motivates staff to continue the good work that they do and to demonstrate the impact that such care has on patients.

Hospital Group

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

Background to Compliment
A compliment email was received from a patient acknowledging the care and attention that was received over a prolonged period of time. A special acknowledgment was made to the Consultant and their team in the Intervention Radiology Department.

Nature of Positive Feedback
The patient stated that their treatment required their attendance at the Intervention Radiology Department on a regular basis. The patient advised that they were treated with great care and attention and that the dedication shown has helped them through a most difficult and challenging time. The patient advised that the efforts of the team has allowed them to live their life while awaiting specialist care abroad. The patient wished to express heartfelt thanks to the Consultant and their team and all those involved in the care received in the hospital.

Outcome and Learning
This compliment was forwarded to the Radiology Team to highlight how their holistic approach to patient care contributed to a person's wider quality of life. The service's patient focused and person centred care ethos highlights the extent to which this can have a positive impact on the whole of a person's life even when dealing with a challenging health issue. Such an approach has relevance to all healthcare staff delivering health services.

Hospital Group

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

Background to Complaint
During one of the peaks of COVID, a person wrote in a complaint relating to both their parent and spouse. The complainant stated that a member of the hospital security team in the Emergency Department asked their spouse to leave the Emergency Department which meant that their 93-year-old parent was left on their own.

Investigation
The Complaints Officer for the Directorate met with the Security Manager and discussed this complaint in detail. The incident was then investigated further. Once the investigation was completed, the Complaints Officer wrote to the complainant apologising for the experience.

The complainant was informed that the complaint had been fully investigated. The complainant was advised that a meeting had taken place with the Security Officer involved and while the Security Officer was following procedure, it was highlighted by the Security Manager that it was inappropriate or indeed unsafe to leave this older patient on their own in a busy Emergency Department. The Complaints Officer outlined that the Security Officer offered their sincere apologies to the person's parent for the way they were made feel alone and vulnerable on the night in question.

The Hospital also relayed an apology from the Security Manager for the worry and upset it caused the family.

The complainant was thanked for bringing the complaint to the attention of the Hospital as it highlighted the additional training requirements for all security staff in the Hospital Group.

Outcome and Learning
- The Security Manager was made aware of the actions of the Security Officer in question.
- The Security Manager brought this complaint to the attention of the identified Security Officer.
- The Security Manager used this example for further customer service training for all of the Security Officers within the Department.

A follow up email was received from the complainant thanking the Hospital for the response and for the apology from the Security Officer and Security Manager. The complainant was glad to hear that the Security Officer was following the recommended COVID guidelines, however, highlighted that a bit more compassion could have been shown under the circumstance.

Another piece of learning is to be cognisant at all times of our *Values in Action* and, in particular the values; "*Am I putting myself in other people's shoes*" and "*Am I aware that my actions can impact on how patients feel*". This learning will be used in the Security Officer customer service training going forward.

Hospital Group

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

Background to Compliment
A patient was admitted to the High Dependency Unit (HDU) within the Hospital. The patient's spouse had passed away in the hospital some years previously and the family, at that time, had a very negative experience and had submitted a complaint that was managed through the complaints process.

The patient's daughter contacted the Hospital's Patient Liaison Service (PALS) to request support with access to clinical updates and support around linking with the clinical team. They also wanted to see if the recommendations following the complaint regarding their parent's care, which were provided at a family meeting, were implemented.

PALS managers supported the family throughout their time in the hospital and over the course of the week the family meet with 3 PALS managers who provided the liaison support with all teams. The Hospital explained to the staff the previous concerns and experience that the family had so they may better understand the heightened levels of anxiety that the family had around their parent in the HDU.

Nature of Positive Feedback
The patient sadly passed away and the eldest daughter phoned a week later to thank the PALS team for their role in advocating for their parent and the family in ensuring that they were supported through the final days.

Outcome and Learning
By listening to this family's experience previously and ensuring the communication deficits that occurred in the past were addressed, this family felt supported during this admission. Also, as the staff were made aware of the family's past experience and the sensitivities around their concerns, they were cognisant of the family's needs and included the family at each decision and provided consistent and regular updates.

The Hospital is actively demonstrating empathy and learning by showing that the Hospital has listened and is committed to building back any trust lost.

An additional learning point for the Hospital is to appoint a liaison staff member for families who have had a challenging experience within the hospital in the past to support them during a current admission as this may mitigate any anxieties and fears they may have.

Hospital Group

Category: Privacy (Confidentiality)
Status: Upheld

Background to Complaint
The complaint related to GDPR compliance and how personal data was being stored as a result of a request for provision of photographic ID as proof of identity when attending the Radiology Department to collect a disc with radiology images on behalf of a relative.

Investigation
It was found that the complainant presented to the Radiology Department to collect a disc with images for a relative. The complainant was asked to provide photographic ID as proof of identity of next of kin and advised that a copy of the proof of identity is recorded on the patient's record. The complainant expressed an objection to this procedure. It was advised that that it was the policy of the department to request proof of identity, copy the identification provided and record this information against the patients' record as proof as to who collected the CD. The complainant provided photographic ID as requested. The complainant questioned General Data Protection Regulations and if there was in breach of same.

Outcome and Learning
Under the Right to Erasure Articles 17 & 19 of the GDPR, the complainant has a "right to be forgotten". Following review, it was considered sufficient to document that photographic ID had been supplied rather than storing the complainants photographic ID.

The complainants' photo ID was removed from the relatives' record and a note recording the name of the person collecting the disc and confirmation that photographic ID was provided was maintained instead. A letter confirming the removal of the photo ID was issued to the complainant.

The local policy has been reviewed and updated. All staff in the Radiology Department have been informed of the procedure.

Hospital Group

Category: Communication and Information (Communication Skills) (Information)
Status: Resolved Informally

Background to Complaint
A patient's spouse sent in a complaint to the National Your Service Your Say Office and then contacted the Hospital directly.

The patient had been readmitted through the Emergency Department where they had a poor experience and alleged that the staff were rude and did not understand the presenting problem.

In the complaint submitted, the spouse advised that the patient was complaining that they:
1. Had no discharge letter on previous discharge.
2. Was given no information or advice on discharge.
3. Was still awaiting the CT of abdomen report.
4. Had received no medical update.
5. Was concerned that the antibiotics didn't relieve symptoms first time.
6. Was anxious regarding the perceived delay in treatment.
7. Is self-employed and has two young children and this was the fourth week unwell.
8. Has no idea of how the system of getting information works.

Investigation
The PALS Manager as Complaints Officer attempted to informally resolve the issues raised. The PALS Manager contacted the patient's spouse and using the 'assist model'[1] provided the reassurance that they would link in directly with the patient.

The PALS Manager linked in first with the ward and spoke to the Nurse Manager. The Nurse Manager had advised the patient to contact PALS as they wanted the complaint to be escalated.

The PALS Manager went to see the patient and acknowledged the concerns raised. The PALS Manager apologised for their experience and answered as many questions as possible but advised that further contact with colleagues would be needed to obtain all of the information requested.

The PALS Manager then contacted the relevant clinical team and asked if they could issue the CT result and review the patient and discuss a plan of care with the patient to ease concerns.

The PALS Manager explained the process to the patient who was happy with the response.

Outcome and Learning
Both the patient and their spouse both found the management of their complaint very beneficial and were happy with the outcome.

[1] The Assist Model is a best practice communication tool – more information available at https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/assist-model-of-communication-poster-june-2021-.pdf

The importance of communicating effectively with patients and their families was highlighted to all staff involved. Effective communication is one of the most important skills and alleviates a lot of concerns and worries for patients and their families.

Once the patient and their spouse was advised of the procedures and the time lines, they both felt reassured with the care that was being provided. Using the assist model is very important communication tool that enables clear two-way communication and information flow and promotes patient centredness.

Hospital Group

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

Background to Complaint
A patient with a background of an aggressive form of cancer was being treated in hospital. A complaint was received from the patient's spouse and was acknowledged by the Complaints Officer. The Hospital were subsequently advised that the patient had sadly passed away.

Following this communication, the Complaints Officer made contact with the patient's spouse to establish the main issues within the complaint.

The main elements are detailed below:
1. Questions about the treatment provided
2. It was felt that communication from the treating doctor was poor due to poor language / eye contact.
3. Questions about the proposed timeframe for treatment at the time and the lack of a plan subsequent to further diagnosis being made.
4. General lack of interaction, communication and planning when the patient's condition changed.

The family were very distressed and upset as the patient died during a time when COVID restrictions were in place and they felt they were not supported and not being heard, despite numerous contacts by email.

Investigation
A pre meeting was arranged by the Complaints Officer with the Consultant to discuss the main issues within the complaint and to ensure that all information regarding the patient's journey through the services would be available at the family meeting.

During the meeting, the family related their experience. The Consultant and medical team listened. The approach of the Consultant and the medical team to the meeting provided for an open and calm environment and which was respectful to the family's emotions. This allowed the time needed for the family to ask questions and raise concerns but also created an atmosphere which was supportive, enabling the family to hear the answers being provided.

Detailed explanations for clinical decisions were carefully provided by the Consultant and the medical team using language that was clear and easy to understand. Further opportunities to ask questions was given at various points and explanations, where needed, were provided.

The use of the *chunk & check technique*[2] throughout the meeting allowed the family the time to absorb the information given. The family thanked the Consultant and the team for their time and for the opportunity to have their experience heard and that it provided an element of closure.

A wholesome apology was also given by the Consultant for communication issues that the family encountered with an NCHD (non-consultant hospital doctor). The Consultant explained that since coming to Ireland, and to this teaching hospital, the Doctor has been undergoing communication skills training (both verbal and non-verbal) to overcome any cultural differences and better improve engagement with patients and families. This was accepted by the family. A commitment was made by the Consultant to go through the experience the family described about language and cultural barriers they encountered with his team and the wider medical teams in the Hospital.

The family also expressed their frustration regarding the delay in responding to their complaint. An apology was given by the Complaints Officer for this delay. The Complaints Officer explained some of the issues encountered and how these impacted on the timeframe. The apology and explanation was accepted by the family.

Outcome and Learning

The family thanked (via PALS) the Consultant and the medical team for time given to the meeting. The Hospital took significant learning from this complaint on the importance of clear, effective and regular communication during a patient's care and, thereafter with their family when requested and as appropriate.

An additional learning note is to ensure adherence to the Your Service Your Say process, which is set out under policy and guidance, for effectively managing complaints and which promote contact /meeting with patients and /or their families to discuss issues and answer questions as this can result in a more satisfactory outcome for all involved.

[2] Chunk and check technique is a communication technique used in consultations as outlined in the National Healthcare Communication Programme. This involves providing information in sections and checking if the recipient understands the information delivered.

Hospital Group

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

Background to Complaint
The Hospital received a telephone call from the spouse of a patient who outlined the difficulty they were experiencing in getting through to the ward. They stated that they had only 1 visit in five weeks and that the patient's team had not provided a recent update to the family. They explained that the family were very upset with not being able to get through to the ward, not being permitted to visit and the lack of information provided. They highlighted that the patient was very unwell and not able to retain the information given by the Team. The family felt, from their phone calls with the patient, that their appetite and mood were deteriorating and that a family visit in person was needed. The family wanted to know what was the plan of care and requested a visit and if a meeting could be arranged with the consultant.

Investigation
The PALS Manager met with the patient to provide support and ascertain how they wished to proceed. The PALS Manager then contacted the Consultant, voiced the concerns of the family and advised of their request for a family meeting. The PALS Manager also contacted the ward and discussed the family's concerns and the importance of providing regular updates as well as the importance of compassionate visits due to the deteriorating condition of the patient.

Outcome and Learning
Using the Your Service Your Say framework to assess concerns raised provides an opportunity to handle and resolve a complaint informally. This can avoid escalation to a formal complaint investigation as well as providing a better outcome for those involved.

In this case a family meeting was arranged with the Consultant and the family. A plan was put in place in the Ward to facilitate compassionate visiting and they linked in with the family to establish a schedule for same. The family were very happy to have visiting arrangements in place.

The importance of providing regular updates to Next of Kin/family from nursing, allied health and clinical teams to be established as per the Time Out Document[3].

Visiting is to be considered on a case by case basis, patients that are very unwell should always be facilitated with visits from their family. This had been highlighted to all members of the multi-disciplinary team.

[3] *'Time out': Providing Clinical or Nursing updates to support patients and their families during COVID-19 visiting restrictions'* which refers to clinicians/nursing staff taking time out from their clinical duties to engage with patients and their family members during COVID-19 restrictions.

Hospital Group

Category: Access (Appointment) and Communication and Information (Information)
Status: Upheld

Background to Complaint
A daughter wrote into the Hospital advising that her parent had received an appointment for a day procedure. In the appointment notification from the hospital, there were 2 letters in the envelope; one notifying of the appointment and another cancelling the appointment. Contact was made with the hospital secretary who confirmed that procedure was going ahead.

The parent and the daughter attended the Hospital for the procedure. The daughter advised that their parent was checked in for the procedure by a lovely receptionist. They then sat and waited until they were called in by a Senior Nurse who did initial checks and directed them to the specialist ward in a different part of the hospital. Her parent was directed to a room and left waiting for over an hour. Then a nurse came to advise that the scan could not be done as the person who normally carries out these scans was on leave.

After this delay and being advised that the procedure would not now go ahead, her parent was then approached by a Junior Doctor who asked them to participate in research.

The daughter felt that this experience demonstrated a total lack of respect for her parent who was very concerned about the procedure as well as for the personal arrangements that had to be made by the family to ensure that her parent was accompanied to the appointment.

However, the daughter did state that the nurses and receptionist she met were extremely helpful and kind to her parent and hoped that they were appreciated.

Investigation
Upon receipt of the complaint, the Complaints Officer made contact with the Clinic Nurse Manager (CNM), the Consultants Secretary and the Senior Registrar with responsibility for clinical governance of the Senior House Officers. The CNM acknowledged that it was unacceptable that there was no one qualified present on the day to do this procedure and that, once this was known, the patient should have been contacted immediately and the appointment cancelled. The CNM apologised for what had occurred and for the inconvenience caused to both the patient and the daughter.

The two contradicting letters, that were issued in the same envelop, were discussed with the secretary who advised that this was human error and was very upset for the confusion and inconvenience caused. The secretary acknowledged that this was unacceptable. The Senior Registrar advised that all Senior House Officers have now been advised to ensure that even though the Hospital is a teaching hospital that any research to be carried out must abide by the established Hospital research ethics guidelines. The Senior Registrar apologised that the parent was asked to participate in research after being delayed for so long and especially after procedure had not taken place. The Senior Registrar also apologised for any disrespected shown.

Outcome and Learning
Resulting from this complaint the CNM has advised that a process has been put in place to ensure that procedure schedules are cross checked to ensure there is a qualified practitioner available to perform these scans.

The secretary has advised that she has learnt from this complaint and it has reminded her to be more vigilant when sending out appointment letters.

All Senior House Officers have been reminded of the need to ensure that they and all their staff are aware of and understand their responsibilities under the Department of Health, 'Supporting a Culture of Safety, Quality and Kindness: A Code of Conduct for Health and Social Service Providers', (May 2018).

Hospital Group

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

Background to Complaint
The parent of a cardiology patient contacted the Complaints Officer in the Hospital in order to raise concerns about the treatment and care the child received. The patient attended the Hybrid Cardiac Catheterisaton Laboratory (HCCL) in the Hospital for a cardiac procedure that was performed under 'conscious sedation'. The parent was concerned that the child did not receive one to one attention from a dedicated nurse at all times and that this resulted in the child feeling alone and emotionally and physically uncomfortable during the procedure.

Investigation
Upon receipt of the complaint, the Complaints Officer contacted the Assistant Director of Nursing (ADON) and the Consultant Cardiac Surgeon to advise of this parent's concerns. The Complaints Officer telephoned the parent to apologise for the poor experience and to thank them for their feedback which had been shared with both the ADON and the Consultant.

Both the ADON and the Consultant confirmed they would review what happened and would look at implementing changes.

Outcome and Learning
Genuine remorse was expressed by the clinical team. A sincere apology was made as the nursing care experienced by the patient was not the allocated 1:1 nursing care that would be expected.

Giving consideration to this patient and the needs of the many more patients who would need procedures under conscious sedation, the ADON undertook to implement changes as follows:

- The ADON met with HCCL Management regarding the issues raised and the concerns of the parent.
- HCCL staff were re-educated by the Clinical Nurse Manager II about the importance of an allocated nurse being present with the patient throughout the procedure.
- The allocated nurse to introduce themselves to both the child and the parent prior to the procedure as it can be challenging to differentiate the staff in the HCCL as the attire is the same.

The hope was that these measures will improve the patient experience of all children attending the HCCL for conscious sedation going forward. The parent was thankful that the feedback had been taken on board and had effected positive change. A subsequent similar procedure for the same patient took place a few weeks afterwards and with the changes having been implemented, the patient and parent experience was hugely improved and very positive.

Hospital Group

Category: Safe and Effective Care (Diverse needs)
Status: Compliment

Background to Compliment
A compliment from the parent of a child who attended the Surgical Day Unit (SDU) for dental surgery. The parent had written into the Hospital to advise that the child has autism and that they were nervous and worried about how the day would go based on the child's additional needs.

Nature of Positive Feedback
After the procedure, the parent contacted the Hospital again to express how grateful and happy they were following their child's attendance. They reported that they experienced kindness, patience and understanding from all staff they encountered and highlighted how theatre staff lowered the lights in theatre and cleared out non-essential staff in an effort to ensure the child was not overwhelmed. This lead to an experience where the child was relaxed and happy. The parent wished to express their gratitude and relay that all the staff involved should be proud of their efforts to ensure the child's needs were met so well.

Outcome and Learning
The Consultant Dental Surgeon thanked the parent for their feedback and passed on the compliment to the team.

The Consultant Dental Surgeon advised that over 25% of their patients have Autism Spectrum Disorder (ASD) or sensory processing issues and the department is keenly aware of the impact of attending hospital for a procedure for these patients. The team, which includes the Dental & Anaesthetic Consultant, dental nurses, anaesthetic nurses and porters, discuss a co-ordinated plan for each child's visit, discussing their journey from the SDU to theatre and if necessary will offer a 'dry run' to some patients.

The Dental Consultant advised they were awarded a diploma in Autism Studies and that they actively use and share this knowledge with the team in order to provide an understanding and calm environment for patients.

Further to this, a number of staff have completed specialist training with the Crisis Prevention Institute on skills for clinical holding, which was found to be hugely beneficial in understanding and managing the needs of children with ASD. This training was an invaluable tool for all staff involved in patient care from SDU to theatre and, in particular, portering staff, who embraced this training which enabled them to focus on specific patient needs while delivering gentle and compassionate care.

The Dental Consultant advised that compliments such as this underscore the very real value of being able to understand and accommodate the additional needs of patients and positive outcomes are made possible through educating and training staff to understand specific patient needs.

Building on this, the team would welcome Autism champions to be established within the hospital and specialist training on skills for clinical holding to be refreshed and extended to additional staff.

Community Healthcare Organisation

Category: Communication and Information (Information)
Status: Upheld

Background to Complaint
Complainant presented for a COVID19 Test at a test centre which they had booked online. However when they arrived for their appointment the centre had closed for the day and the test could not be carried out.

Investigation
The Complaints Officer assigned to the complaint liaised with the Complainant for further information. The Complainant advised that they had arrived for their appointment at 17:10, and that the online booking system had shown appointments available until 18:00 that day. On arrival at the Test Centre the Complainant was advised that it was now closed for the day. An appointment for the following morning was offered to the Complainant.

The Complaints Officer contacted the Test Centre Coordinator for a review of what happened. The Test Centre Coordinator advised that on the day in question the centre had to alter its opening times. However, the online booking system had not been updated to reflect the change in opening times.

The Test Centre Coordinator advised that changes to the opening hours is not common but when this does occur there is a standard operating process in place to follow. On this particular occasion there was an oversight by the Deputy Coordinator on duty and a resultant failure to follow the standard operating process.

Outcome and Learning
The Test Centre Coordinator apologised for the oversight. The Complaints Officer acknowledged the inconvenience caused to the Complainant on having to return to the Test Centre in order to have the test carried out and that this could have been avoided if the online booking system had been updated to reflect the change in opening hours on the day in question. The Complaints Officer reiterated the apology offered by the Test Centre Coordinator.

The Test Centre Coordinator spoke to the team about the feedback and reiterated the importance of adhering to the test centre operating hours unless absolutely necessary to alter. Any changes to service provision, including operating times should be carried out as per the standard operating procedure in place.

The Complaints Officer upheld the complaint but given the measures already in place by the Test Centre Coordinator, did not make any further recommendations.

The complaint highlighted the need to ensure that all staff are familiar with and adhere to standard operating procedures as these ensure best practice. Through discussing this feedback with the team, the impacts of decisions and changes can be appreciated from the service user perspective and ensure that the service user experience is kept to the fore in terms of the overall service provision at the Test Centre.

Community Healthcare Organisation

Category: Safe and Effective Care (Treatment and Care), Access (Accessibility / Resources), Accountability (Patient feedback) and Communication and Information (delay and failure to communicate)
Status: Upheld

Background to Complaint
A Service User with a diagnosis of Myalgic Encephalomyelitis (ME), a neurological disorder, was reliant on community services for support to maximise quality of life.

The Service User tried to raise many issues over a period of years at both local and national operational level which were not addressed. This resulted in the commissioning of a comprehensive independent investigation. The report from that investigation focused on CHO, Hospital and national services, addressing HSE operational processes and care provision.

The Service User monitored the implementation of the recommendations set out in the report with an expectation of evidence of learning and sharing from the report in line with best practice as set out in the Ombudsman's Reports, Learning to Get Better (2015) and Learning to Get Better Progress Report (2018). Some of the key issues in the report were effective communication and that an expression of dissatisfaction should be processed as a complaint under Your Service Your Say.

The Service User experienced a lack of effective engagement and submitted a complaint, and subsequently a complaint about the non-processing of the first complaint then other further complaints as the implementation process did not evidence learning. A total of 16 complaints were submitted. The Service User stated that none of these were responded to appropriately either by being not being processed under or adhering to the Your Service Your Say framework.

The Service User said "*hopes were smashed in the post report period due to lack of engagement and action*" as the key messages from the Independent Investigation Report were not evident in practice and there was no evidence of learning.

The Service User was unaware who their complaints had been passed to and who, or indeed if anyone, was taking responsibility for them. Letters were issued from the HSE but these did not comply with the YSYS policy which the Service User had expected. The ownership of the range of issues the Service User raised was not clear.

Investigation
An investigation, covering the issues that arose in each of the 16 complaints, was carried out under Stage 2 of the complaints management process as set out under the Your Service Your Say (YSYS) policy.

The Terms of Reference included:
- The application of YSYS Policy (2017) to the 16 complaints submitted,
- Adequacy of communications by the HSE with the complainant
- Involvement of the Service User in addressing the issues raised in the complaints.

Outcome and Learning

A significant issue identified throughout was the lack of awareness across the HSE with regard to the specific neurological disorder, Myalgic Encephalomyelitis (ME). Recognising that this disorder can lead to a significant deterioration in quality of life and function, it is imperative that services learn to identify the needs associated with this disorder and respond sensitively and appropriately.

The recommendations included:

- From the original complaint: to ensure public value from the independent investigation, the remaining actions from the report are to be implemented without further delay. An effective implementation process should evidence close communication and engagement with the Service User by adhering to the principles of co-design, co-production and co-evaluation. An important resource is the Health Services Change Guide, "People's Needs Defining Change" - https://www.hse.ie/eng/staff/resources/changeguide/

From the subsequent complaints received, it is recommended that

1. HSE YSYS Policy and Guidance Manual should identify a clear process for tracking complaints that are not resolved within 6 months.
2. HSE training on complaints management and the YSYS Policy / Guidance Manual should emphasise the following:

    - the benefit of direct engagement to deal with issues at a local and informal level - this cannot be overemphasised
    - where expressions of dissatisfaction arise, these should be regarded as complaints and addressed under the YSYS Policy as this provides a clear process for management and review, if needed
    - be solution focused and strive to avoid escalation
    - Empathy is key – recognise how the Service User feels, i.e. put yourself into the shoes of the Complainant and understand things from their perspective.

Inadequate practice can be changed to positive and appreciated practice if issues raised are examined and responded to in line with the principles and processes set out under the Your Service Your Say policy and guidance manual.

Community Healthcare Organisation

Category: Communication and Information (delay and failure to communicate) and Access (accessibility / resources)
Status: Compliment

Background to Compliment
Compliment regarding the outcome of a complaint made by a Service User which resulted in service improvement and a significant improvement in the Service User's quality of life.

A Service User had contacted the National Your Service Your Say office in December 2020 to complain that community physiotherapy services had ceased in March 2020 and had not yet been reinstated. The Service User considered access to routine physiotherapy vital to their overall wellbeing and management of their condition. As a result of the service disruption, the Service User stated that their quality of life had diminished considerably as their condition was worsening due to lack of treatment. The Service User had received no indication of how long the service would be closed for, and no alternative treatment or service options had been offered.

The complaint was investigated by a Complaints Officer under the Your Service Your Say policy. It was found that the temporary closure of the community physiotherapy in March 2020 was due to staff redeployment to the national COVID 19 response efforts. Communication with services users who were affected by the closure had not taken place due to the haste of the redeployment roll out and the evolving COVID 19 situation nationally. The Complaints Officer made recommendations in the areas of communication and service provision. The recommendations were accepted by the Head of Primary Care and implemented, and the service reopened shortly after this.

Nature of positive feedback
In February 2022, the Physiotherapy Manager in Charge received a call from the Service User to say that the reinstatement of the physiotherapy treatment changed their life. The Service User stated that they had no pain now, that their condition had improved significantly and that they now only require treatment twice a year. The Service User states that they are out walking every day and feeling really good about themselves and life. Previously, the Service User stated how they had needed treatment every month and was in constant pain and unable to walk other than around the house.

Outcome and Learning
The key learning is that there is opportunities with complaints to achieve real service improvement and positive outcomes for service users.

While the COVID 19 response effort necessitated temporary closure of many services deemed 'non-essential', the prolonged closure had significant impacts on many people who were left without routine services that were essential for their quality of life. Notwithstanding the evolving and unprecedented nature of the pandemic, the importance of communicating with service users to provide reassurance that 'normal services would (soon) resume' following months of service closures had to be recognised and actioned. This complaint gave rise to this requirement but also highlighted the impact of those closures and their essential nature to those availing of them. The service subsequently resumed and communication issued to everyone impacted by the temporary closure. The full circle of feedback occurred with a compliment from the same Service User who raised the complaint in the first instance.

The feedback process allowed a Service User to raise an issue affecting their care. The CHO, in providing a responsive, compassionate and open approach to feedback, enables services to listen to their service users and to respond to their needs thereby improving care and service delivery.

The above feedback demonstrates that negative feedback in the form of a complaint can have positive result.

Community Healthcare Organisation

Category: Safe and Effective Care (Discharge) and Communication and Information (Information)
Status: Upheld

Background to Complaint
A multi-disciplinary team meeting agreed home support hours to be provided for a Service User, as well as the provision of specialist equipment, following discharge from acute hospital to home.

The complaint was about the lack of community home support, contact and support by Public Health Nursing service and provision of equipment agreed as part of that discharge process.

Investigation
The circumstances were examined and it was established that there was ineffective communication between hospital and community services in the Public Health Nursing department about the resources to be provided following discharge to the community.

Contributory factors identified were:
- A delayed discharge,
- The service user being discharged to a different community area than that to which the planned services had been notified,
- Staff shortages – significant levels of absenteeism due to high rate of COVID infections and quarantine requirements

An apology was made in respect of the shortcomings identified.

Outcome and Learning
A recommendation was made and implemented whereby liaison engagement protocols between the acute and community services was reviewed to ensure that all existing communication protocols are fully observed.

In particular that:
1. written information is provided to families following any discharge planning;
2. the contact details for relevant key health care professionals are included in the written information;
3. advice on what home support or specialised equipment is included in the written information;
4. contact details relevant to the provision of these resources is included in the written information.

Community Healthcare Organisation

Category: Communication and Information (Information) and Safe and Effective Care (Patient Property)
Status: Upheld

Background to Complaint
A complaint was received from a patient's family that raised specific questions around patient's condition and medical treatment during the time leading up to their death. They were unhappy with the communication and the subsequent notification of the patient's death. In addition, an issue was also raised regarding the return of the patient's property to the family where soiled clothing had been returned.

Investigation
The Complaints Officer contacted the Clinical Director and was directed to the Consultant involved with the patient. The Consultant submitted a detailed report providing answers to specific questions raised by the family around medical treatment**.**

The Consultant's report addresses the concerns raised regarding the medical treatment provided and also detailed that a Social Worker had spoken with the patient's nominated contact following their death. The Consultant also offered to meet with the family to discuss the issues further.

The Assistant Director of Nursing was contacted regarding the patient property (clothing) that was returned to the family unlaundered.

The Assistant Director of Nursing advised that protocol, which stipulates that soiled clothing be put in an alginate bag to be collected for the laundry was not followed. The clothes were put in the wrong bag and regretfully, on this occasion, were not laundered.

A cover letter and final report, which included a report from the Consultant and an apology from the service regarding the soiled clothing was issued to the family, who were satisfied that their issues were addressed.

Outcome and Learning
The importance of communication and manner of same.
Staff to be aware of all policies, procedures, protocols and guidelines (PPPGs) governing service provision. PPPGs must be adhered to at all times and compliance to be monitored.

Community Healthcare Organisation

Category: Dignity and Respect (Delivery of care)
Status: Upheld

Background to Complaint
A Service User was moved to residential placement from supported living provided by a Section 38 agency.

The Service User had originally been moved by the Section 38 agency from their apartment (under tenancy with the local County Council) into a residential house with two others during a time of stress. The Service User was now ready to return to their own apartment but discovered that their tenancy had been handed back to the County Council.

The Service User complained that they had not been consulted appropriately prior to this move and that their will and preference had not been adequately explored.

Investigation
The investigation into this complaint involved a review of the reports recommending this move by the multidisciplinary team. The Complaints Officer also requested a report from Section 38 agency, which should have been completed prior to the move, outlining the will and preference of the Service User in terms of this move.

In addition, the HSE Disabilities Services allocated an independent social worker to meet with the Service User to listen to their concerns.

Outcome and Learning
The Complaints Officer established that the Section 38 agency had not completed an interview/report on the Service Users will and preference prior to the move. The action was taken based on the recommendations of staff.

The Complaints Officer upheld the complaint.

Decisions made relating to adults, where there is capacity, must be made in consultation with them and with due consideration to their will and preference**.**

Community Healthcare Organisation

Category: Access (Appointment – other) and Communication and Information (Communication Skills)
Status: Upheld

Background to Complaint
A Service User complained that they was refused a PCR COVID test when they attended the testing centre with family members and after travelling a long distance while symptomatic. The Service User had an appointment for two days later in the same testing centre. The Service User stated that staff dismissed the request without compassion or understanding for the circumstances. The Service User asked to speak to someone in charge but unfortunately did not remember the name of the person that they spoke with. Although the Service User stated that they were visibly upset they were told to move on. There were four other cars at the time in the testing centre. The Service User attended a different testing centre closer to home and found staff there were helpful and kind. The Service User was facilitated with a test immediately.

Investigation
The Complaints Officer contacted the Service User to clarify the issues, offer an apology and reassure them that their complaint would be investigated. The Service User reiterated the level of upset experienced and stated how they felt treated as a number and not an individual. The Service User was very grateful for recognition of their complaint.

The complaint was brought to the attention of the Testing Site Lead. On investigation into the availability of appointments it was found that appointments were limited at this time due to a surge in COVID transmission and high demand for testing. A decision was made to cease 'walk in' slots to protect scheduled appointments and reduce waiting times. The appointment calendar was monitored continuously to ensure all available appointments were open for referrals. None were available at this time. It was noted that the Service User did had a scheduled appointment albeit for two days later.

Outcome and Learning
A recommendation was made that no one should be refused a test without conferring with the Site Manager or a deputy, should the Site Manager be unavailable, who has the authority to make decisions based on service user needs. Staff must also identify themselves to clients when dealing with any escalations.

The Service User was informed of the findings and advised that that Testing Site Lead regretted the Service User's experience on the day and offered a sincere apology for same, which the Service User accepted.

The second testing centre was informed of the positive feedback received regarding their service.

During periods of high peak activity, it is especially important to remember that each Service User is an individual with individual circumstances. Staff were made aware of how their actions and words impact on others, especially in stressful situations. This message was highlighted at morning huddles.

Issues around availability of appointments were discussed daily at local service level and at management level to ensure that the Service User is central to service delivery and that every effort is made to address the needs of service users in a safe and quality environment.

Community Healthcare Organisation

Category: Access (Accessibility / Resources) and Communication and Information (Information)
Status: Upheld

Background to Complaint
A parent made contact to advise that her child, who has autism and is non-verbal with significant learning difficulties, needed to have bloods taken. The parent advised how they had enquired if there were any visuals explaining the step by step approach that could be expected at the appointment or if they could be directed towards any relevant documentation from the HSE that supports people with learning difficulties in getting blood tests done and if there were any recommendations for primary care service providers regarding same.

The parent explained that if the child wasn't prepared for what to expect the experience would not be a good one. The parent stated that restraining the child would be out of the question as any negative and traumatic experience would understandably, set a precedent and would result in refusal to comply or accept medical assistance in the future.

The parent also advised that they had googled for video or step by step visuals of how the blood test would be done and ways of making it easier for people with learning difficulties but to no avail.

The parent also commented that the same issue arose with the COVID-19 vaccination process; there were no visuals explaining the step by step approach and what to expect when they attended the centre and so it took a while to get the child into the room and to let the nurse carry out the vaccination.

The parent stated that it was not acceptable that public health services are not accessible/ inclusive of all people.

Investigation
The Complaints Officer was aware that in similar scenarios (and depending on the child), a child may be distracted or pre-occupied with the use of headphones and music etc. and also learned from one of the Disability Managers that a numbing cream could also be administered at the point of the injection thereby lessening any pain and reducing the trauma.

The Complaints Officer contacted the Children's Network Disability Team (CDNT) for the catchment area in which the child resided and raised the issue with the Children's Disability Network Manager.

The Children's Disability Network Manager suggested that the parent could make a social story using visual aids and also provided a sample of a social story that another Hospital had created to assist families to prepare for blood tests.

The Complaints Officer relayed this information to the parent and also suggested contacting their GP who may have additional guidance as they would be familiar with carrying out similar procedures for children with Autism Spectrum Disorder.

The parent reverted to advise how they got on at the Hospital but reported that the context and needle was different than the one shown on the social story and that unfortunately, the child panicked and refused to let the nurse come close.

The parent explained how they conducted their own research and provided the Complaints Officer with a copy of *Blood tests for people with learning disabilities: making reasonable adjustments* from Public Health England as an example of what could be done to facilitate access.

The parent hoped that by relating her experience that this would help improve/change the service to be mindful of the differing needs of service users and to be more accessible/ inclusive.

Outcome and Learning
The experience shared by the parent with the service highlighted:

- that creating a negative experience of being around doctors and nurses can have a detrimental impact on a person (loss of control, abuse, fear, harm)
- hospital staff need to build a trusting and safe environment for people with learning disabilities
- empathy is key. "*How would you feel if someone was doing something to you without taking the time to explain it to you in a way you could understand it?*"
- hospital services should make reasonable adjustments for people with learning disabilities, with support and recommendations from the disability services
- information and support for families of service users should be readily available and published online
- the social stories should reflect the context and execution steps

The parent also highlighted that their child is not an exception and that many parents share the same concern.

The Complaints Officer anonymised and circulated this issues raised in this case including the literature from Public Health England to the Senior Disability Management Team within the CHO with potential learning also for other services which would be shared by the Head of Service as appropriate.

The Complaints Officer also contacted the *Intellectual Disability Liaison Nurse* within the acute hospital attended by the child to highlight the issue and to ascertain if they have pathways in place or if they had developed aids or social stories, links etc. to assist service users (adult and children), their parents and/or advocates in preparing for visits to clinics and hospitals that could be shared.

The *Patient Advice and Liaison Service* within the hospital have advised that they will ensure that this feedback is shared with the relevant department and personnel.

Community Healthcare Organisation

Category: Access (Accessibility / Resources)
Status: Partially Upheld

Background to Complaint
A complaint was made in relation to the slow progress being made on the reopening of a day care centre in the area. The Complainant wanted to know what the delay was in reopening the centre and why the works, that were being carried out, were not done while the centre was closed during the COVID 19 Lockdown.

Investigation
The Complaints Manager contacted the Manager of the service who advised that the day centre operated in a building that is owned by another organisation and not the HSE. The HSE had not expected to not have access to this building for this long a period. In addition, work to the building, which was necessary under Health and Safety, had also taken longer and was outside of the control of the HSE. The timeframe for completion was pushed out at short notice to the HSE. The Manager advised that a meeting was arranged with the organisation who owned the building and that a date for the reopening would be set at this meeting

Outcome and Learning
The Complaints Officer apologised to the Service User for the disruption and inconvenience cause by the delay in the re-opening of the day centre. The Complaints Officer advised the service that Service Users of the day centre should have been advised of the delay and kept updated on progress, where possible. In addition, Service Users should have been advised of other services that they may be able to avail of in the absence of their usual day care centre.

The Complaints Officer highlighted to the service the importance of communication between the HSE and its service users regarding any impacts on service provision.

Community Healthcare Organisation

Category: Assess (Appointment) and Safe and Effective Care (Treatment and Care)
Status: Partially Upheld

Background to Complaint

A Service User wrote to highlight frustration with the length of time they had to wait to access the service. The Service User sated that they were waiting 8 months for an appointment. They also advised that they were unhappy with the treatment provided and expressed concerned that it did not provide sufficient relief from pain. The Service User also expressed their dissatisfaction with the long waiting time, approximately 3 years, to get an appointment to see a rheumatology consultant in the acute hospital.

Investigation

The Complaints Officer examined the issues impacting on access to the service such as,

- Numbers of monthly referrals over the preceding months.
- Staffing levels.
- Staff being redeployed to COVID testing/vaccination centres.
- Treatment of urgent clients only for periods during 2020 when lockdowns were in place.

To investigate the concerns raised over the treatment provided, the Complaints Officer consulted the Physiotherapy Manager who advised that the:

- Clinician providing the treatment had discussed the case with the senior physiotherapist and a treatment plan was agreed
- Clinician discussed with the Service User the best approach to long term management of pain and how to enable them to best manage pain and flare-ups.
- Physiotherapy Manager discussed with the clinician and the senior physiotherapist the case, the various client discussions that had taken place and the advice and treatment given.

Regarding the issue pertaining to access to Rheumatology services in the acute hospital, it was deemed outside the Complaint Officers remit to investigate and the Service User was advise to contact the Hospital directly.

Outcome and Learning

In relation to the Service User not getting sufficient relief from pain, it was advised that the treatment offered comprised of three sessions. The Service User had attended two sessions and subsequently cancelled the third. Unfortunately, this issue could not be upheld as completion of the full treatment course was required to successfully treat the pain.

In relation to the waiting times, the Complaints Officer established that the waiting times for physiotherapy services were greatly affected by the COVID 19 pandemic. Waiting times had increased in this service area from 14 weeks in March 2020 to 31 weeks in February 2021 (the month when the service user was referred).

Between the time of referral and the time the client was assessed, there was a reduction in staffing numbers (staff leaving through career break, career progression and redeployed to vaccinations) which had a knock-on effect on waiting times.

The increase in referrals to the service, together with the low levels of staffing, and restricted access to services as a result of lockdowns during 2020 resulted in a lengthy waiting list.

The Service advised that they recognised that the wait time was in excess of what the Service User expected and what should have been provided and was outside of normal service wait times. The Service endeavours to ensure that clients can access their services in a reasonable time frame, and they expressed regret and apologised that this was not the Service User's experience on this occasion.

The service outlined how all services faced unprecedented challenges in 2020 and into 2021 due to the Coronavirus pandemic and that this had affected both staff and service users. However, as staffing levels improve it is hoped this will address the lengthy waiting lists and that this issue will be improved over the coming weeks and months

The Complaints Officer upheld this element of the complaint and apologised to the Service User for their experience.

Community Healthcare Organisation

Category: Safe and Effective Care (Infection Prevention and Control) and Dignity and Respect (Alleged Inappropriate Behaviour)
Status: Upheld

Background to Complaint
A complaint was received regarding the way a security guard was wearing a mask at a COVID Test Centre and subsequent attitude when asked by the Service User to wear the mask properly.

Investigation
Security services at some COVID test centre locations are contracted out by the HSE to private companies. The investigation of the complaint involved discussions with the security provider regarding the roles and responsibilities of staff including expected conduct whilst carrying out duties on behalf the HSE.

The feedback was relayed to the Community Testing Team Manager and to the staff members on duty at the time of the appointment. The security provider also followed up with the staff in question.

Outcome and Learning
Security staff personnel have been reminded of the importance of the correct and appropriate use of PPE in line with Infection Prevention Control (IPC) Guidelines by Community Testing Management. Further training in the area of IPC has also been provided to all team members across Community Testing Services.

The matter also highlights the need for all HSE services, when utilising private companies, to ensure that those companies are fully aware of their responsibilities and expected code of conduct when acting on behalf of the HSE.

National Service

Category: Access (Facilities)
Status: Upheld

Background to Complaint
A number of complaints were received from patients following a reduction in access to television channels.

Due to the nature of the patient profile and illness, a number of patients would be long term with some being in acute/secure units. Understandably the loss of access to TV Channels was having a greater impact on patients during COVID 19 Restrictions. Recreational activities had ceased as per Public Health Guidelines. There was a phased easing of restrictions and return to activities during the latter part of the quarter.

Investigation
The television system within the facility was old and in need of an upgrade. However, the issue only arose due to the external provider upgrading their system making the equipment in the facility no longer compatible.

As the service is due to be relocated shortly to a new premises, an upgrade in equipment was not previously approved based on value for money, especially as the new premised would be equipped with compatible devices. However, due to external circumstances and delays in transition to the new premises, a solution was now required and therefore agreed for the benefit of all patients.

The complaints procedure was followed to address the complaints already received. A communication was also issued to all patients from the Head of Service apologising to all affected patients and assuring them that a solution was being sought and that they would be kept informed of progress. This reassured patients that the issue was being actively addressed and also helped to stem any further complaints being made on the issue.

The IT Manager worked with the office of the Head of Service to implement an urgent and cost effective solution. This included reviewing options from the existing provider to upgrade the equipment on site, as well as all options from other providers. Key factors in considering the options included how long the process would take to restore a full range of channels to patients, as well as having regard for the intended transition to the new premises during 2022. Not only did the solution have to address the issue short term, but also long term.

Outcome and Learning
Following this review, the provider and upgrade of equipment was agreed. This would restore the full choice of channels to patients.

From receipt of the first complaint to full restoration of service, the process took 14 weeks. This was longer than scheduled due to external factors affecting the provider as well as equipment availability.

During the implementation process and especially when delays were encountered, communications and updates were issued to patients to keep them informed. Updates were also issued to the relevant regulatory body and HSE Community Operations, as they had received a complaint from one patient in regard to this issue.

Once the television system was fully restored, the service received a compliment from one of the patients who had been extremely frustrated, especially when there was delays due to external factors.

This Patient and others were included in the selection of channels, so they were involved in the latter stage of process which also helped to alleviate some frustrations and further complaints. One patient especially enjoyed watching a particular type of programme and a suitable channel was added for them as it helped relax and de-stress the patient.

The process highlighted the little things that everyone enjoys in their daily routines and that some home comforts, etc. are essential for quality of life, especially for the patients, service users and residents who live in such facilities and/or avail of our services.

Further Learning to take forward:

- Open & transparent communication to Patients and Service Users, keeping them informed of change.
- Involving Patients/Service Users, where appropriate and adhering to Safety & Security Protocols. The service operates a co-production approach at monthly Community Meetings meaning that patients have a forum to raise any issues with Unit Managers to have these addressed, where possible, and a solution found before becoming an official complaint.