Your Service
Your Say

Managing Feedback within the Health Services

Your Service Your Say 2022

Foreword

I am pleased to present the data on feedback received by the health services during 2022, the various efforts to deliver support and guidance to the system in the area of feedback and an update on the work of the National Complaints Governance and Learning Team (NCGLT).

2022 saw a 5% increase in complaints submitted to our health services rising from 15,235 in 2021 to 16,065 for 2022. Despite this increase, the health services continued to respond to the majority of these (75%) within the legislative timeframe of 30 working days and in line with our national key performance indicator (KPI) of 75%.

The key categories of complaint remain to be safe and effective care, communication and information, and access.

The National Complaints Governance and Learning Team continued to support services to respond to complaints and promote best practice in the area of feedback.

NCGLT monitors on an annual basis compliance with the Ombudsman's Learning to Get Better recommendations which for Hospital Groups currently stands at 75% and 88% for Community Healthcare Organisations. Casebooks, that highlight and share the learning from complaints and positive feedback, were again published quarterly throughout 2022.

NCGLT continued to expand and support the capture of complaints data on the Complaints Management System (CMS). The analysis of this data identifies trends and issues that inform and drive quality improvement and patient safety throughout the system.

NCGLT facilitated the quarterly Complaints Managers Governance and Learning Forum, a valuable platform for networking, knowledge development and shared learning for Complaints Managers who drive the feedback agenda at local level.

The National Your Service Your Say Team and the Assessment of Need Disability Complaints Team continued to respond to queries and complaints submitted by service users. While Your Service Your Say experienced a 22% decrease in activity compared to 2021, Assessment of Need Disability complaints continued to grow with a 14% increase in activity.

I acknowledge and appreciate the engagement and cooperation of the operational system to work with NCGLT to realise the potential that a positive feedback culture can deliver.

I hope that you are also encouraged and reassured of the HSE's commitment to listening and learning from your experience.

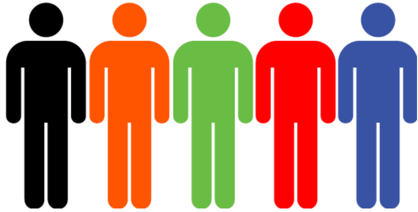
Mr Christopher Rudland
Assistant National Director
National Complaints Governance and Learning Team

HSE

Your Service Your Say

2022. . . at a glance

The health services received



16,065 new complaints

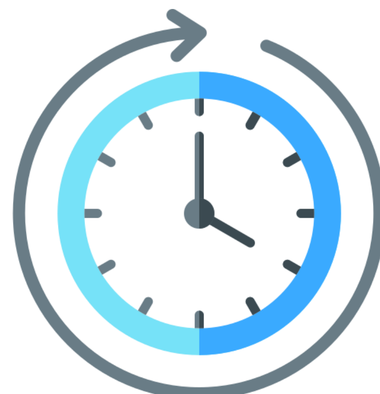
- 16,065 Stage 2 complaints recorded and examined by Complaints Officers in both the HSE and Voluntary Health Services
- 5% increase in complaints compared with 2021

- **4,835 complaints to statutory services**
- **11,230 complaints to Voluntary Hospitals and Agencies**

Causes for Complaints

- **Safe and Effective Care**
- **Communication & Information**
- **Access**
- **Dignity and Respect**
- **Accountability**

The health services responded to 75% of complaints within 30 working days (KPI of 75%).



• 6,067 staff completed HSeLanD Effective Complaints Handling • 896 staff completed HSeLanD Effective Complaints Investigation • 2,207 staff completed HSeLanD YSYS Guidance for Clinical Staff • NCGLT trained 107 CMS inputters • NCGLT trained 37 Review Officers	
	National Your Service Your Say Team **25,262** client interactions
Vaccination Client Services (VCS) responded to 1,268 email queries.	

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HSE

Your Service Your Say

1.0 Background

We would like to hear from you.

Feedback, both positive and negative, can provide unique insights into the standards of care those who use our services receive. Capturing and analysing this feedback should be central to how we learn and improve the quality of our services.

The National Complaints Governance and Learning Team is the national office tasked with developing the systems and supports to deliver on the HSE's commitment to provide an enhanced service user feedback process that is accessible, flexible and responsive as well as the mechanisms that enable the narrative and data from feedback to drive learning and quality improvement.

2.0 Complaints recorded in the Health Services 2022 (Community Services, Statutory Hospitals, Voluntary Hospitals and Voluntary Agencies)

Learning from feedback is fundamental in providing high quality services. Listening to and acting on the views, concerns and experiences of patients, service users and their families enable us to provide the best possible care. The recording, analysing and reporting of such data across our health services will ensure feedback is integral to business improvement.

In 2022, there were 16,065 complaints received by the health services. Of these, 4,835 were recorded as received and examined by Complaint Officers in the Health Service Executive with 11, 230 recorded and examined by Complaints Officers in Voluntary Hospitals and Agencies.

Under legislation and policy, Complaints Officers should attempt to complete formal investigations within 30 working days. For 2022, 75% of complaints were dealt with within 30 days or less. The HSE key performance indicator (KPI) target is 75%.

The main issues within complaints for 2022, as with past years, relate to *Safe and Effective Care*, *Communication and Information*, *Access*, *Dignity and Respect* and *Accountability.*

Compared with 2021, there was an overall rise of 5% in complaints to health services in 2022. Complaints to HSE statutory hospitals decreased by 4% and complaints to HSE Community Healthcare Organisations also dropped by 14%. However, complaints to voluntary hospitals experienced a significant increase of 23%.

2.1 Key Findings

In 2022, the total number of complaints received by the health services was **16,065**[1] up 5% from 2021.

Health Service Executive (HSE)

Of these, **4,835** formal complaints were recorded as received and examined by Complaint Officers under the *Health Act 2004* (Part 9: Health Act, 2004, and Part 3: Disabilities Act, 2005) in the **Health Service Executive**.

- Of the total number of complaints received, **286 were excluded or withdrawn** from investigation under the Your Service Your Say complaints process. Also excluded are **460 not subject to legislation**.
- Of the remaining **4,089 complaints, 2,307 (56%)** were investigated within 30 working days.

[1] The data presented in this report is collected from Complaints Officers who make regular returns to the National Complaints Governance and Learning Team (NCGLT). Data relating to statutory HSE services is taken primarily from the Complaints Management System (CMS) which is the national database management system developed to support the HSE's complaints management process to track Stage 2 formal complaints managed under Your Service Your Say: The Management of Service User Feedback for comments, compliments and complaints Policy 2017.
The remainder of statutory services' data and much of voluntary hospitals and agencies' data is taken from data sheets returned directly by these services to the National Complaints Governance and Learning Team. The data presented is a combination of both the CMS data returns and the data sheets.

Voluntary Hospitals and Agencies
Of the total complaints received by health services, there were **11,230** complaints recorded and examined by Complaints Officers in **Voluntary Hospitals and Agencies**.

- Of the total number of complaints received, **10,903** were investigated. The other **327** were either excluded or withdrawn.
- Of those investigated **8,867 (81%)** were addressed by a Complaints Officer either informally or through formal investigation within 30 working days.

2.2 Overall Findings

Summary Table of Variance

Summary Table of Variance	2022	2021	% Change
HSE Statutory Hospitals	**3,415**	**3,550**	**-4%**
Voluntary Hospitals within Hospital Groups	**7,300**	**5,921**	**23%**
HSE Community Healthcare Organisations	**1,099**	**1,272**	**-14%**
HSE National Ambulance Service	**46**	**-**	**100%**
Primary Care Reimbursement Service (PCRS)	**250**	**205**	**22%**
National Screening Service (NSS)	**0**	**300**	**-100%**
National Forensic Mental Health Service (NFMHS)	**25**	**88**	**-72%**
Other Voluntary Hospitals and Agencies	**3,930**	**3,899**	**1%**
Total	**16,065**	**15,235***	**5%**

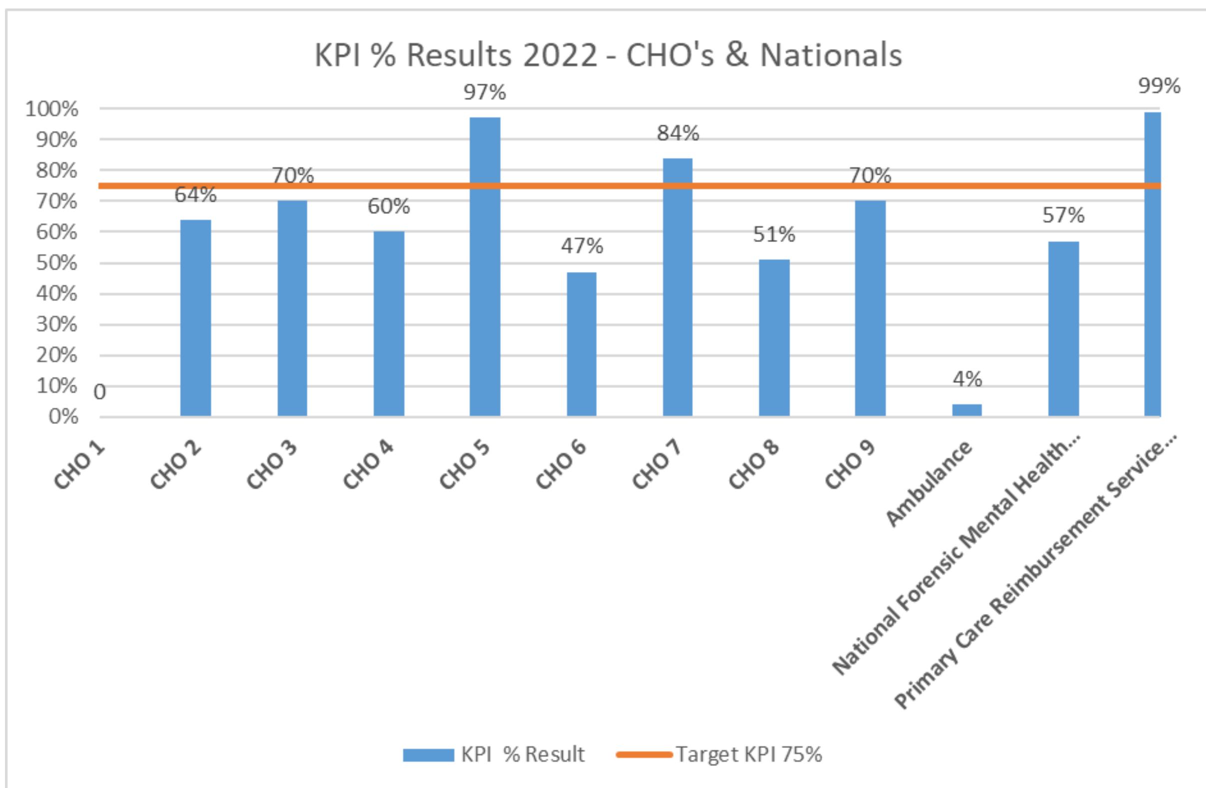
Table 1: Summary of % Variance of Complaints recorded 2021 to 2022

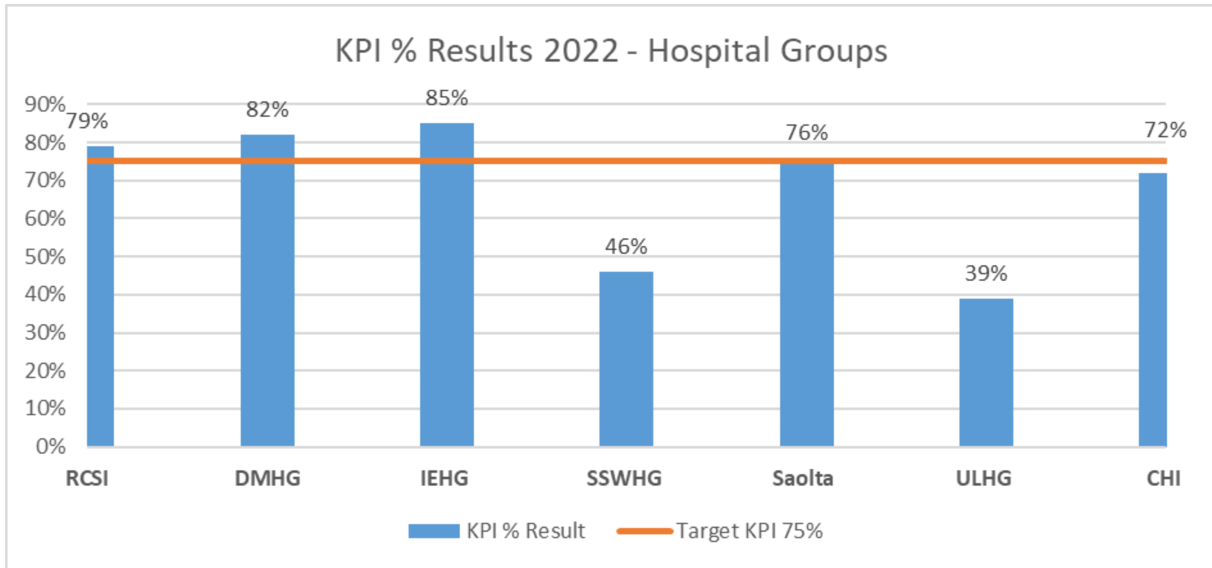
2.3 Key Performance Indicator (KPI)

The National Key Performance Indicator (KPI) in relation to complaints is defined as the ***percentage of Stage 2 formal complaints submitted to the HSE that are investigated by appointed Complaints Officers within the 30 working day legislative timeframe.***

The national KPI target is set at 75%. The overall national KPI return for 2022 is 75%.

Complaints resolved by Complaint Officers ≤30 working days



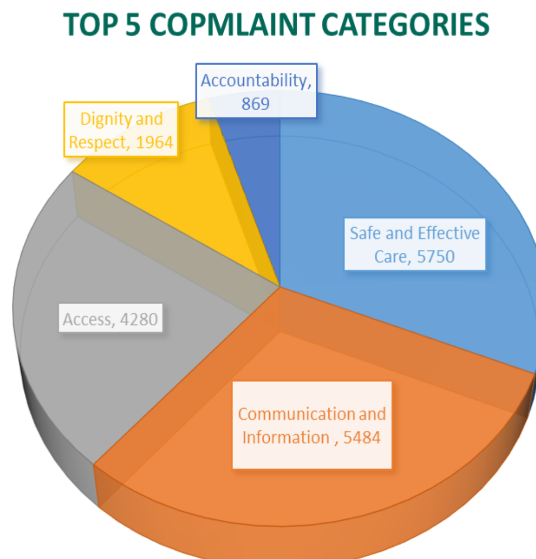


2.4 Category of Complaint

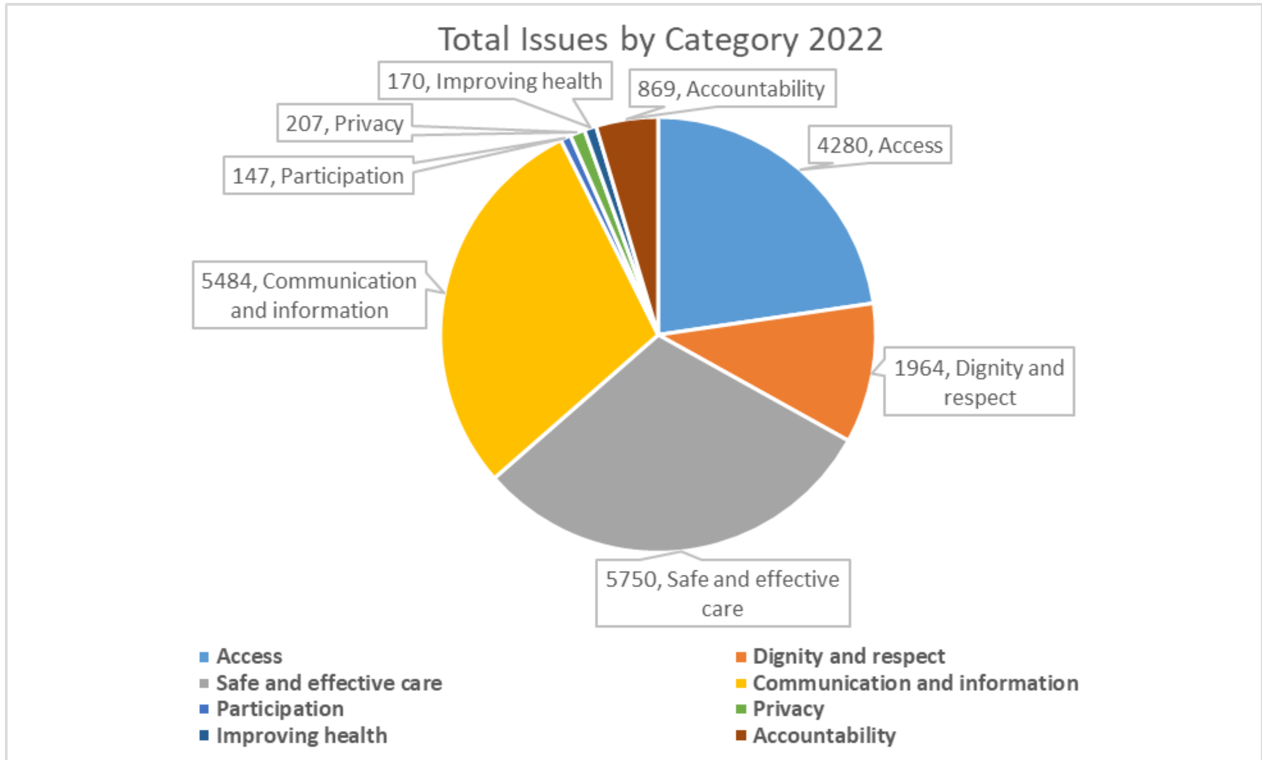
Note: Many complaints contain multiple issues and therefore fall under more than one category

The top **5** causes of complaints contained an issue relating to the following classification:

1. Safe & Effective Care (5750)
2. Communication and Information (5484)
3. Access (4280)
4. Dignity and Respect (1964)
5. Accountability (869)



Number of issues recorded under each complaint category



2.5 Complaints Management System

The Complaints Management System (CMS) facilitates the capture and aggregation of comprehensive complaints data from Community Healthcare Organisations, Hospital Groups and National Services to enable analysis and comparison. This supports learning from complaints by enabling the reporting of issues and trends at various levels throughout the HSE and ensuring that evidence based best practice is shared across services to assist in decision-making and the targeting of resources to deliver quality improvements and better health outcomes and experiences for those who use our services.

Complaints Management System (CMS) Training

Complaints Officers and Support Staff trained in the Complaints Management System in 2022	CMS General Training	Report Training
Hospital Group		
CHI	0	0
ULHG	4	6
Saolta	17	4
SSWHG	3	5
DMHG	6	2
RCSI	9	0
IEHG	11	2
Community Health Organisations		
CHO 1	0	0
CHO 2	19	1
CHO 3	1	1
CHO 4	0	0
CHO 5	1	0
CHO 6	10	1
CHO 7	1	0
CHO 8	12	3
CHO 9	6	0
National Services		
PCRS	7	0
NAS	0	0
NSS	0	0
NFMHS	0	0
NHWD (National Health & Wellbeing Division)	0	0
Total 2022	**107**	**25**

2.5.1 Complaints Management System (CMS) Steering Group

A CMS Steering Group was established to provide governance and direction for the implementation and further development of agreed modules of the Complaints Management System. Each member of the CMS Steering Group is a nominated lead and represents their own Community Healthcare Organisation, Hospital Group or National Service.

The group also functions as an approval committee for change requests from users of the CMS before changes are forwarded to the NIMS Steering Group and State Claims Agency for implementation on the system.

The CMS Steering Group work was paused during the COVID-19 pandemic. It is planned to resume in 2023.

3.0 Self-Assessment of Compliance with the Ombudsman's Learning to Get Better Recommendations

In 2015 the Ombudsman conducted an investigation into how Irish public hospitals handle complaints. He published his findings in *Learning to Get Better, An investigation by the Ombudsman into how public hospitals handle complaints' (LTGB) and* set out 36 recommendations in total applying to the HSE, both at operational and strategic level as well as to the Department of Health.

The HSE conducts an annual self-assessment on its compliance with the LTGB recommendations applying to the operational system.

3.1 Hospital Group: Compliance Position 2022

Of the 29 recommendations applying and averaged across all hospitals, the Hospital Groups have assessed that they are fully compliant with **75%** (22/29) of these. This is a 1% increase from 2021. Efforts to improve compliance saw a decrease in recommendations assessed as partially compliant, falling by 2% from 24% in 2021 to **22%** for 2022 (6/29). While the overall compliance position is improved, recommendations assessed as non-compliant remained at **3%** for 2022.

Lowest levels of reported full compliance with recommendations under Access and Learning.

75% full compliance with all 29 recommendations assessed across Hospital Groups.

Recommendation 6 (volunteer advocacy), 34 (learning implementation plan) and 35 (sharing good practice) were most commonly assessed as non-compliant.

Compliance with all 29 recommendations has increased by 1% for 2022 versus 2021.

Your Service Your Say

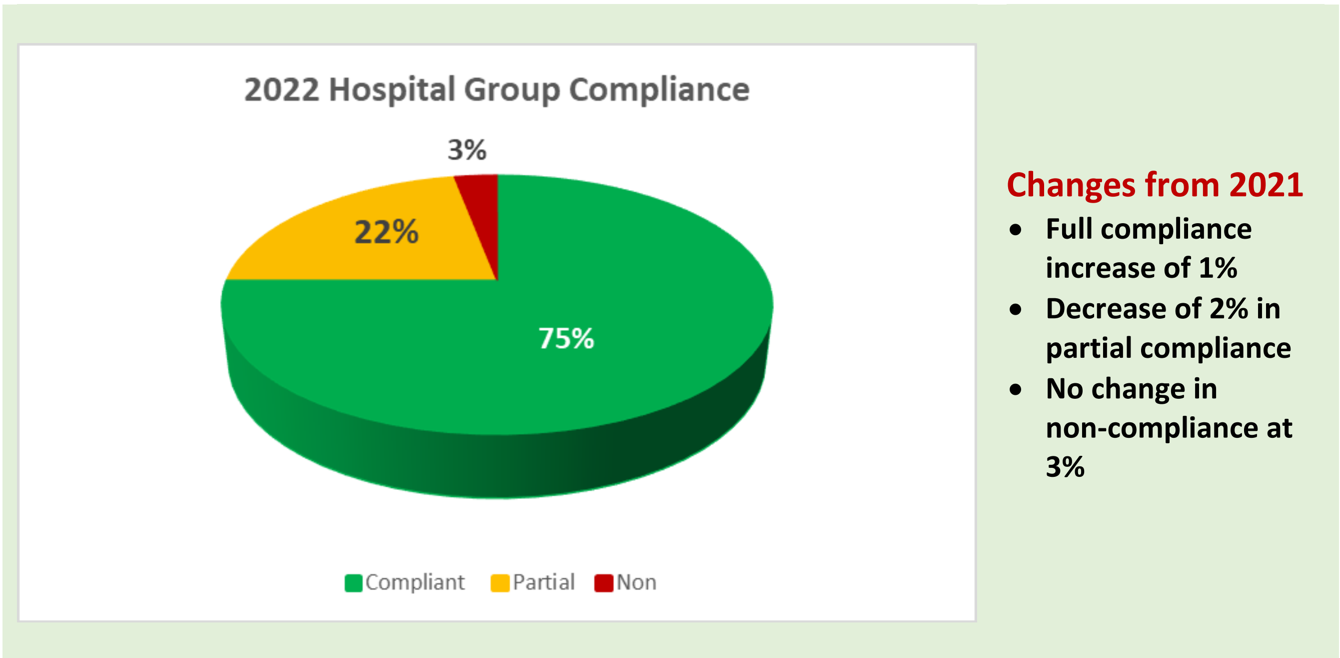


Chart showing (averaged) compliance level assessed by Hospital Groups for 2022

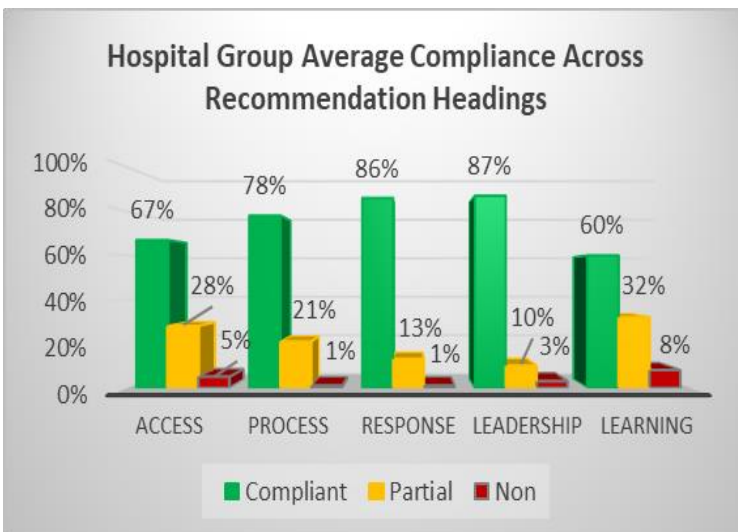


Chart showing averaged compliance levels assessed by Hospital Groups for 2022 for each recommendation category

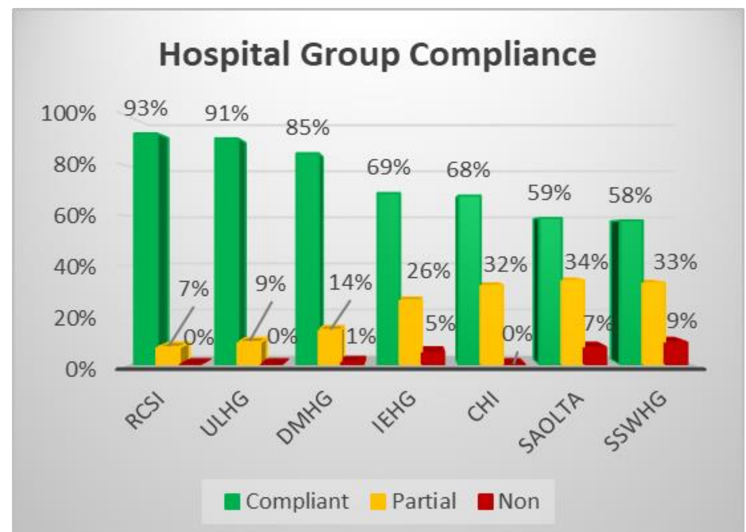


Chart showing individual Hospital Group compliance rating returned for 2022.

HG
No Full Compliance Self-Assessed

HG
High Compliance
RCSI - 27
ULHG - 26
DMHG - 24

HG
Non Compliance
SSWHG – 2
Saolta - 2
IEHG -1

Common Non Compliances: #6, #34 and #35

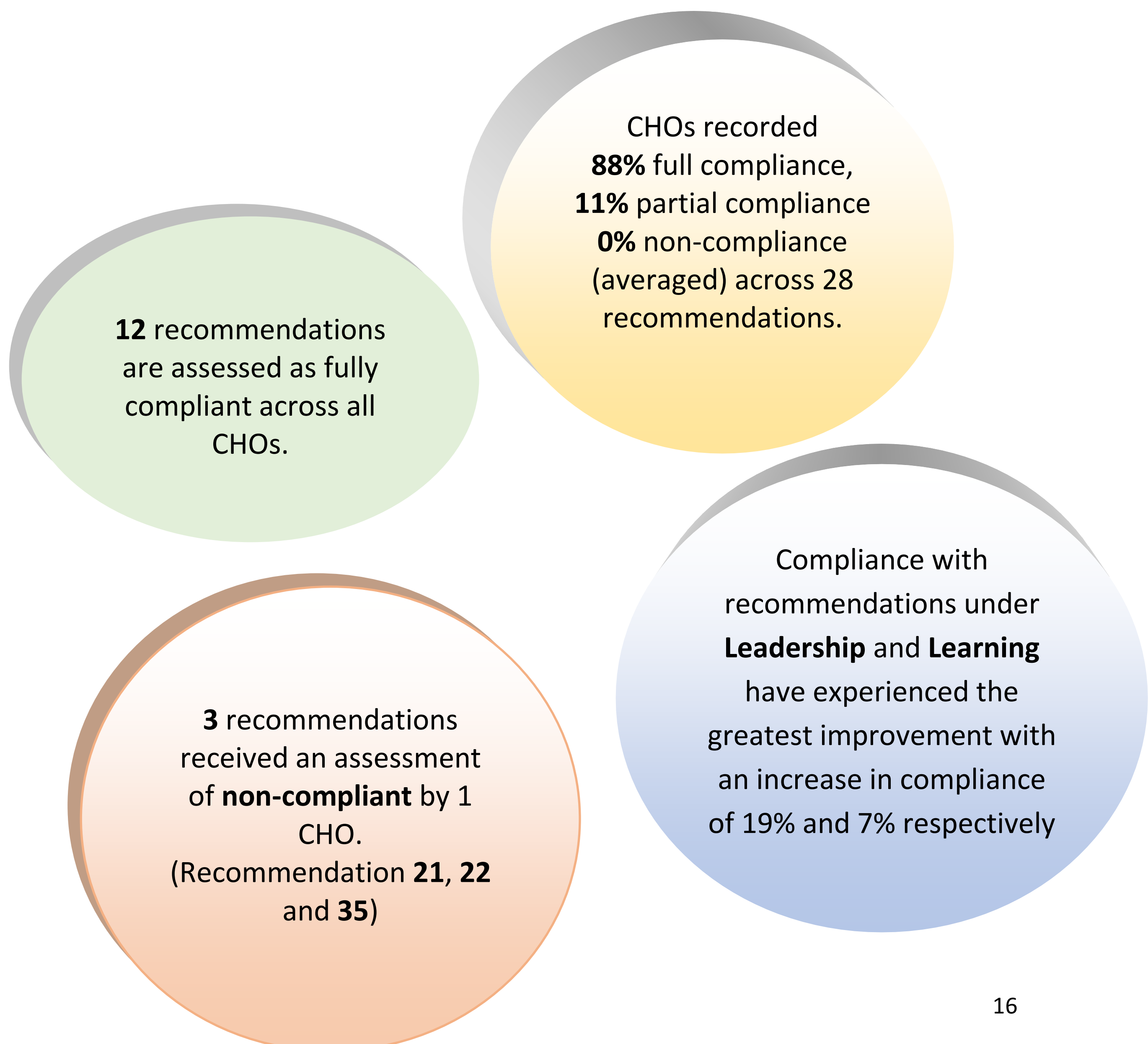
3.2 Community Healthcare Organisation: Compliance Position 2022

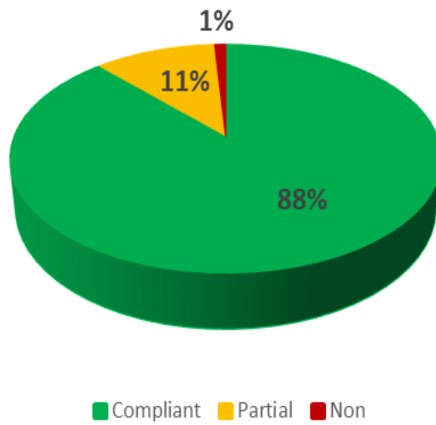
Of the 28 Learning to Get Better recommendations applying, Community Healthcare Organisations have assessed that they are **88%** fully compliant (25/28) and **11%** partially complaint (3/28) and **1%** non-compliant, although this pertained only to one CHO.

Full compliance has risen to 88% for 2022 after having remained static at 82% for 2020 and 2021, mainly due to resources being focused on the COVID response during those years.

With more recommendations assessed as fully compliant for 2022, partial compliance decreased, falling to 11% in 2022 from 18% in 2021. Non-compliance was only returned by one CHO against three recommendations and resulted in an overall statistical return of 1% for non-compliance.

No set of recommendations under the headings of Access, Process, Response, Leadership and Learning were assessed as fully complaint across all CHOs.





Changes from 2021

- **Increase in *Full Compliance* – from 82% (2021) to 88% for 2022**
- **Expected decrease in *Partial Compliance* from 18% (2021) to 11% (2022)**
- **Slight increase in *Non-Compliance* from 0% (2021) 1% for 2022.**

Chart showing compliance level assessed by Community Healthcare Organisations for 2022

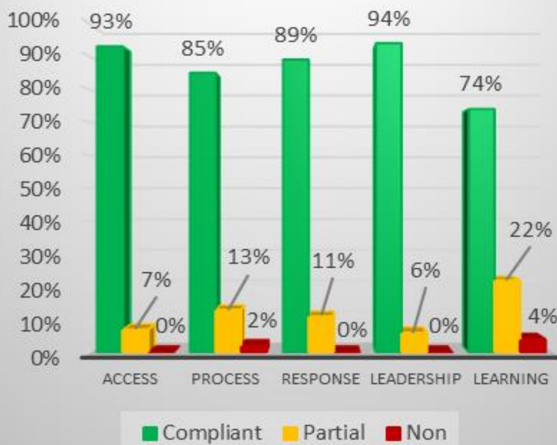


Chart showing averaged compliance levels assessed by Community Healthcare Organisations for 2022 for each recommendation heading category

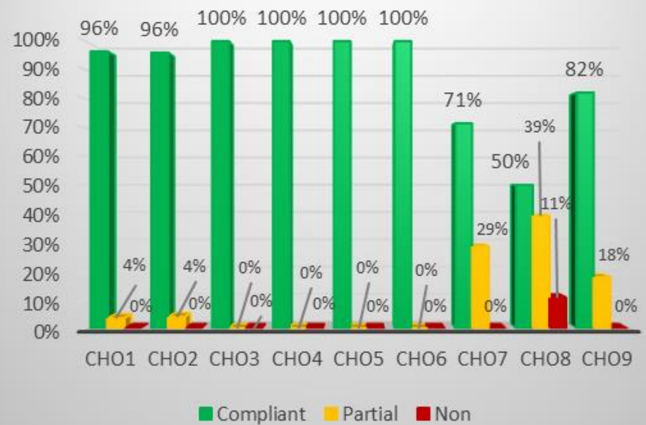


Chart showing individual CHO compliance rating returned for 2022.

CHO
Full Compliance
CHO 3 - **28**
CHO 4 - **28**
CHO 5 - **28**
CHO 6 - **28**

CHO
High Compliance
CHO 1 - **27**
CHO 2 - **27**

CHO
Non Compliance
CHO 8 - **3**

Non Compliances: # 21 (induction module); #22 (audit); #35 (Complaints Officer Forum/Sharing of good practice)

3.3 NCGLT Audit of Compliance

The Ombudsman's templates are based on a Hospital Group's or Community Healthcare Organisation's self-assessment of their own compliance rating with a recommendation using the criteria for assessment set out in the template for guidance.

To provide assurance to the system that the compliance rating specified is accurate and reflects practice, NCGLT will conduct an audit of the returns to validate the rating of compliance stated. A sample of Community Healthcare Organisation returns will be selected and the evidence used to determine the compliance rating will be examined. An audit report will be issued to the areas selected and to the national system.

While such audits were initially scheduled for 2022, due to resources these have been deferred until later in 2023.

Your Service Your Say

4.0 The National Complaints Governance and Learning Team

The National Complaints Governance and Learning Team (NCGLT) is a national unit tasked with developing the systems and supports to deliver on the HSE's commitment to provide an enhanced service user feedback process that is accessible, flexible and responsive as well as the mechanisms that enable the narrative and data from feedback to drive learning and quality improvement.

NCGLT provides a range of services broadly covering policy development, assurance & governance, training and development and data analytics.

NCGLT also facilitates the quarterly National Complaints Managers Governance and Learning Forum providing a platform for shared learning, peer support and networking for Complaints Managers across Hospital Groups, CHOs and national services.

NCGLT continued to utilise technology solutions to deliver training for Review Officers under Stage Three of the Your Service Your Say Policy and support staff to respond to feedback by developing and hosting online e-learning modules and webinars on HSeLanD. During 2022 a total of 9,170 HSE staff completed the online YSYS training modules. NCGLT delivered Review Officer training to 37 appointed Officers and trained 107 inputters on the Complaints Management System (CMS).

NCGLT published four quarterly editions of the National Your Service Your Say Anonymised Feedback Learning Casebook for 2022. The casebook featured a total of 82 cases, both complaints and compliments, received and responded to by Community Healthcare Organisations, Hospital Groups and National Services.

While general Audits were deferred for 2022, NCGLT undertook a specialist audit /review at the request of the Office of the Ombudsman.

NCGLT operates two national frontline complaints services that are co-located between Naas and Limerick as well as a national query portal for the COVID-19 vaccination programme.

4.1 Complaints Governance

4.1.1 Complaints Managers

To provide visible leadership, and ensure governance in the area of feedback (comments, compliments and complaints) at a local level, and as recommended within the Ombudsman's Learning to Get Better report, the appointment of Complaints Managers, within Community Healthcare Organisations, Hospital Groups and National Services was supported and accordingly mandated by the HSE.

Complaints Managers are involved in education, training and reporting arrangements around Your Service Your Say. They ensure implementation of HSE's feedback policy and that the system is functioning in line with policy, with key staff, including clinicians, supported to understand how to handle complaints. They provide assurance, through casebooks, that learning from feedback is captured and shared and supports quality improvement initiatives and report locally on the effectiveness of the Your Service Your Say process. Complaints Managers are also responsible for assigning Review Officers to complaints following a request for a review.

4.1.2 National Complaints Managers Governance and Learning Forum

To support Complaints Managers in the execution of their role, NCGLT facilitates the hosting of the National Complaints Governance and Learning Forum; attendance at which is mandatory.

The National Complaints Managers Governance and Learning Forum, established in 2016 and held on a quarterly basis, offers a valuable opportunity for shared learning, problem solving, discussion around issues, expert input into specialist topics as well as an arena for exploring areas for development to ensure the continuous evolvement of our feedback processes.

Complaints Managers share key messages and learning from the Forum, including matters identified or arising with their respective Senior Management Teams at Community Healthcare Organisation, Hospital Group and National Service level for consideration and action as appropriate.

The Forum offers Complaints Mangers an opportunity to relate their experience of responding to and managing feedback from an operational perspective and flag issues for further discussion. Members also have the chance to network with peers and build informal as well as more formal connections that will support them in their role.

In 2022, the Forum was held in March, May, September and November.

Case Study Presentations

Case studies are an integral part of the learning agenda that is fostered and facilitated at the Forum.

NCGLT would like to thank the following for presenting the learning arising from examining complaints as well as positive feedback received.

- Community Healthcare West
- Ireland East Hospital Group (IEHG)
- CHO 1
- Cork Kerry Community Healthcare
- Royal College of Surgeons in Ireland (RSCI)
- National Screening Services
- Children's Health Ireland (CHI)

Guest Presenters

Presentations on specialist topics or from partner agencies feed into the professional expertise and the continuous development of the feedback service within the HSE.

NCGLT would like to offer thanks to the following guest presenters:

- Dr Virginia Minogue (VM), HSE R&D (Chair) and Ms Mary Morrissey (MM), Psychology Lead, HSE R&E (Co-Chair) of the Research Translation Dissemination and Impact Implementation Group.
- Ms Louise Loughlin, National Manager, National Advocacy Service for People with Disabilities and Patient Advocacy Service
- Ms Amy Carroll, Spark Innovation Programme and formally Clinical Placement Co-ordinator, Maternity Department, St Luke's Hospital Kilkenny (IEHG)

Special thank you to the Ombudsman

NCGLT and members of the National Complaints Managers Governance and Learning Forum were delighted to welcome Mr Ger Deering, the newly appointed Ombudsman to address the Forum held in May. We want to thank Mr Deering for taking the time to address members and setting out his priorities that include learning from feedback, supporting the continued publication of the quarterly HSE national casebook and maintaining the effort to achieve full compliance with the recommendations set out in the 2015 *Learning to Get Better* report.

Mr. Deering expressed satisfaction that the HSE's efforts to encourage, respond to and learn from feedback is showing benefits and is feeding back into and improving the health system.

All minutes from the National Complaints Managers Governance and Learning Forum are available on www.hse.ie/yoursay

Forum Attendees

While the National Complaints Managers Governance and Learning Forum is attended by Complaints Managers nominated at CHO, Hospital Group and National Service level, the Forum also has representatives from Consumer Affairs, the Office of the Ombudsman, and, on occasion, the Ombudsman for Children, national advocacy groups and service users.

NCGLT would like to thank Ms Rosalie Smith Lynch who is the nominated representative for Consumer Affairs at the Forum. Consumer Affairs provides training, support and advice to Complaints Officers on complaint investigations. Consumer Affairs is also the key contact for the Office of the Ombudsman for any external review by that office.

NCGLT would also like to give a special thanks to Ms Geraldine McCormack from the Office of the Ombudsman. As a member of and contributor to the Forum, Ms McCormack keeps members updated on developments within the Office of the Ombudsman, assists the HSE in furthering progress in the area of feedback and compliance with the recommendations set out in Learning to Get Better while addressing any practical issues arising at the operational level.

Attendance

The Forum is scheduled on a quarterly basis and attendance is mandatory. For those who send apologies a nominated representative can be sent in their stead. Please see summary table of attendance for 2022.

Your Service Your Say

2022 Complaints Managers Governance and Learning Forum Attendance

NCGLF	Total Attended	% Attended
Hospital Groups		
Ireland East Hospital Group	4	100%
South / South West Hospital Group	2	50%
Dublin Midlands Hospital Group	3	75%
Children's Health Ireland	3	75%
Saolta University Healthcare Group	3	75%
RCSI Hospital Group	4	100%
UL Hospitals Group	4	100%
Community Healthcare Organisations		
CHO Area 1	4	100%
Community Healthcare West	3	75%
Mid West Community Healthcare	2	50%
Cork Kerry Community Healthcare	3	75%
South East Community Healthcare	2	50%
Community Healthcare East	3	75%
Dublin South Kildare & West Wicklow Community Healthcare	3	75%
Midlands Louth Meath Community Healthcare	4	100%
Dublin North City and County Community Healthcare	4	100%
National Services		
Internal Audit*		
Communications*		
Mental Health	3	75%
National Ambulance Service	2	50%
Acute Hospitals	4	100%
Primary Care	3	75%
Older Persons	3	75%
Public Health	3	75%
PCRS	4	100%
Community Operations	1	25%
Consumer Affairs	3	75%
Other Attendees		
Office of the Ombudsman	2	50%
Ombudsman for Children's Office*		

**Attend as requested by Forum*

4.1.3 Complaints Officers and Review Officers

In the HSE, Complaints Officers and Review Officers are appointed into their role and act independently and with the authority of the Chief Officer of a Community Healthcare Organisation, Chief Executive Officer of a Hospital Group or National Director of a National Division in the investigation / review of a complaint.

NCGLT developed guidance to support and ensure appropriate governance regarding the appointment of Complaints Officers and Review Officers.

Appointment Orders including Appointment Revocation Notifications must be sent to the Complaints Officer / Review Officer with a copy sent to the following:

1. the **Complaints Manager** for filing or held by the Chief Officer / Chief Executive Officer / Chief Operations Officer / General Manager (as appropriate) / National Director where no Complaints Manager is appointed.

2. **National Complaints Governance and Learning Team at** nationalcglt@hse.ie **only** where the Complaints Officer or Review Officer is accessing the Complaints Management System (CMS) as part of the governance for the CMS and where the Review Officer is attending for Review Officer training.

Under Section 19 ***Public Awareness of Complaints Procedures*** of the Health Act 2004 (Complaints) Regulations 2006, online service information is to contain a section on, or link to, how to provide feedback and the procedures involved as well as a listing of the **names and contact details** of appointed Complaints Officers and **names only** of appointed Review Officers.

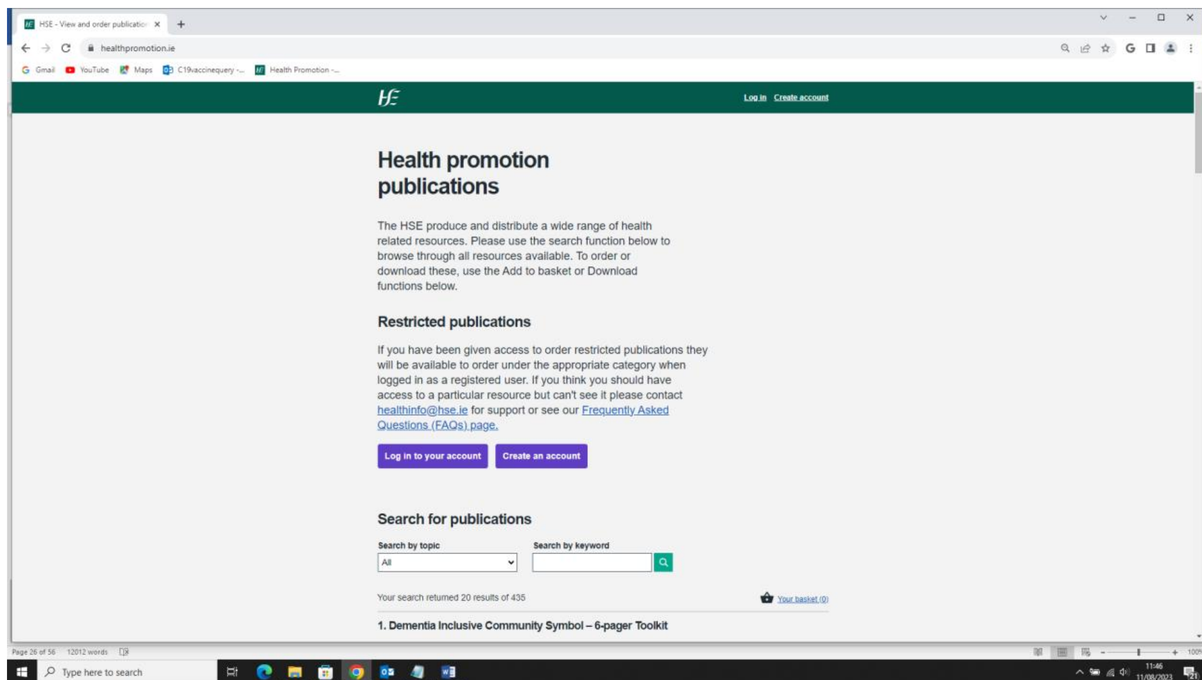
4.2 Your Service Your Say Materials

All published materials are available to order from www.healthpromotion.ie

To order materials, log into www.healthpromotion.ie and follow the instructions on screen.

Your Service Your Say publications are only available to order by healthcare staff. You will need to register for an account to access these.

If you have previously registered for an account, enter in your login details and enter *Your Service Your Say* in the search box. All publications available to order will be returned.



If you do not currently have a registered account and require one, please select 'Create Account' or if you think you should have access to a particular resource but can't see it please contact healthinfo@hse.ie for support.

Materials available to order from the site include:

- Your Service Your Say Adult Information Leaflet
- Your Service Your Say Children's Information Leaflet
- Your Service Your Say A3 and A4 English Poster
- Your Service Your Say A3 and A4 Irish Poster
- Your Service Your Say Feedback Box Stickers

Materials available to download are:

- Your Service Your Say Policy Document

Feedback boxes are not available to order from the site. Please source these locally.

Posters
In addition to the above materials, NCGLT have developed a suite of posters.

- **Assessing a Complaint:** Designed to assist staff in relation to complaints that cannot be managed under Part 9 of the Health Act 2004 and therefore cannot be investigated under the Your Service Your Say policy.
- **Complaints Management Pathway:** Designed to provide an overview of the four stages in the Your Service Your Say process and the key steps to take at each stage along with the timeframes applying.
- **Timeframes for the Complaints Management Process:** Designed to provide a guide for each person involved in the Your Service Your Say process regarding the legislative and policy timeframes applying to the various stages of the complaints management process.

Posters are available on request from NCGLT or alternatively a PDF version can be downloaded by following this link:
https://www.hse.ie/eng/about/qavd/complaints/ysysguidance/appendices/

4.3 Training

NCGLT develop and deliver training programmes in order to support staff in their efforts to respond to and deal with complaints from point of contact through to the internal review stage as well as delivering train the trainer workshops.

HSELanD is an online learning forum developed and run by the Health Service Executive. Access to hseland.ie is available over the internet, on a secure site. It is available to all Healthcare Professionals in the Republic of Ireland, both within Health Service Executive (HSE), Voluntary Hospital Sector, and associated Non-Government-Organisations (NGO's).

By providing guidance through this online platform, NCGLT hoped to increase the access by staff to training as well as offer greater flexibility over that access.

The following webinars remain available to staff to support them in managing complaints as well as guiding them through the complaints process.

- Assessment of Need and Complaints Awareness Training
- Complaints Management System Training
- Learning from Complaints
- Telephone Etiquette and Tips for Managing Unreasonable Caller Behaviour
- Your Service Your Say Review Officer Training
- Resilience Training

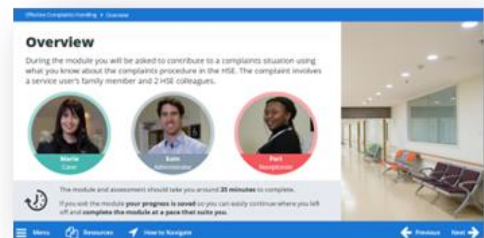
3.4.6 HSELanD Complaint Modules

Staff can access the following NCGLT complaint modules on HSELanD.

- Module 1: Effective Complaints Handling
- Module 2: Effective Complaints Investigation
- Module 3: Your Service Your Say: Complaints Handling Guidance for Clinical Staff

The Nursing and Midwifery Board of Ireland (NMBI) has awarded one continuing education unit (1 CEU) to each module.

Module 1, Effective Complaints Handling is for all staff to use and encompasses a number of interactive complaint handling scenarios that encourages engagement of the staff member through the exploration of different e-learning paths. This is very effective for empowering staff to respond to point of contact complaints.



A total of **6067** staff completed this module to date up to December 2022.

Module 2, Effective Complaints Investigation is an interactive learning tool for Complaints Officers, taking them through the entire process of handling a written complaint from when it initially received right through to guiding the user on how to create a final report.

A total of **896** staff have completed this module to date up to December 2022.

Module 3: Your Service Your Say: Complaints Handling Guidance for Clinical Staff gives practical application to the guidance document *YSYS Guidance for Clinical Staff.* Both the guide and module were developed to provide support to the various clinical professionals who may, at some point, be asked to contribute their views as part of a complaints investigation or to write a specific clinical report as part of the complaints investigation.

The module provides clinical staff with a clear understanding of the YSYS complaints process and outlines how individual clinical staff may become involved in the process as well as assisting clinical staff in understanding what is required of them under the YSYS complaints management process.

A total of **2207** staff completed this module to date up to December 2022.

4.4 Audit

4.4.1 Ombudsman Review

At the request of the Office of the Ombudsman, following their investigation of a complaint escalated to his office under Stage 4 of the Your Service Your Say process, NCGLT carried out a review of a service's overall complaint handling processes in March 2022.

The purpose of the review will be to establish the extent to which the service complied with the requirements set out in Part 9 of the Health Act 2004 and the HSE's policy, *Your Service Your Say, the Management of Service User Feedback for Comments, Compliments and Complaints (2017)*. The review also assessed the extent to which the service complied with the recommendations set out in Learning to Get Better with a focus on those falling under *Process* – recommendations 13 to 26.

In addition, the review sought to identify:

- Existing or potential gaps or weaknesses existed within the service's complaints management process.
- Areas for improvement to ensure that the requirements outlined within legislation, policies and best practice are met.
- Areas where practices are to be commended.

The review was conducted in two stages; a general information gathering survey followed by an on-site visit.

Following the review, a draft report was compiled and issued to the service for commentary. The report set out the findings of the review and 23 recommendations in relation to compliance with legislation, the implementation of the HSE Your Service Your Say policy and the Ombudsman's Learning to Get Better recommendations. The service accepted the results of the review and committed to actively progressing the implementation of the recommendations.

In October 2022 NCGLT contacted the service requesting an update on the implementation of the recommendations. Of the 23 recommendations, the service reported 14 as being fully implemented with the remaining nine deemed to be partially implemented and progressing. Of those remaining 9 recommendations, two were scheduled to be completed by end of year 2022, six for the first quarter of 2023 with the remaining recommendation scheduled for Q2 2023.

4.4.2 General Audit

The general audit of services in relation to compliance with the *Your Service Your Say, the Management of Service User Feedback for Comments, Compliments and Complaints 2017 Policy* was deferred until 2023.

4.5 Healthcare Complaints Audit Tool (*HCAT)*

The Healthcare Complaints Audit Tool (HCAT) is an innovative method of classifying complaints developed by the London School of Economics (LSE) after a rigorous analysis of 80,000 NHS complaints. The HCAT tool is a reliable method of coding and systemising healthcare complaints that also supports international comparability of data.

The Healthcare Complaints Analysis Tool (HCAT) treats each complaint as an 'incident', and asks the following:

1. *What is the problem being reported?*
2. *How severe was it?*
3. *Where, in the system, did it happen?*
4. *Who did it involve?*
5. *Was there a consequence?*

The NCGLT in partnership with NUIG analysed a large sample of complaints from across the HSE's services. The purpose of this analysis is to improve the classification system used by the HSE and hence our understanding of the nature and severity of complaints, leading to improvements in healthcare delivery and ensuring high standards of quality and safety.

Classification is an essential part of the processing of each complaint that is received by the Health Services and is a requirement of the HSE's compliance with the Health Act 2004 Section 55.—(2) (b). Under the Act, it is essential the HSE analyse complaints to establish and classify the nature of each complaint received.

This project ran from 2018 to February 2022 and was divided into 2 sections which ran concurrently. The first focused on Acute Services related complaints and the second on Community Services related complaints.

Improved classification systems support the identification of systemic issues and trends within systems and services leading to improvements in healthcare delivery and ensuring high standards of quality and safety.

The broad trends from complaints received by Acute Services pointed to issues with institutional processes, particularly delays in accessing care, and to poor relationships between staff and patients. While no harm was reported in a large number of complaints, complainants nonetheless sought answers to their questions and expressed the desire that other patients have a better experience. Complaints analysed also gave further insight into clinical, management and relationship issues, severity of events or actions, levels of harm, stage of care where the event or action occurred, service users' motivations for complaints and complainant profiles.

The initial analysis of complaints regarding Community Services was directed towards informing the adaptation of the HCAT into an appropriate model for community care settings. The broad trends from complaints received by Community Services pointed to issues at the "Accessing care" stage, the next most frequent stage of care resulting in a complaint was "During the appointment". Analysis has given insight into domains and categories of complainant profiles, motivations for complaints, severity of events, levels of harm and the stage of care where the event occurred.

4.5.1 National Patient Safety Office Conference (NPSO)

The National Patient Safety Office (NPSO) in the Department of Health hosts an annual conference to showcase work in the area of quality, patient safety and clinical effectiveness. The conference is attended by health professionals, regulators, policy makers, educators, researchers, health service managers and patient representatives.

The NPSO Conference hosts a wide variety of presentations, poster competitions and workshops that provide updates on both the policy and operational work. This is used to promote and embed quality and patient safety across and within the healthcare services; delivering better experiences for patients and their families and supporting staff to deliver high quality care.

For 2022, the annual conference was held in October in the Printworks, Dublin Castle following a 2-year hiatus due to the pandemic. The theme for the conference was "Working Together for Patient Safety" with the aim to highlight how collaboration and people are drivers of patient safety.

The conference featured two poster competitions: a general poster competition and a specialised Antimicrobial Resistance (AMR) & Infection Prevention & Control (IPC) competition, with poster review teams deciding on the most suitable posters for the conference based on the suitability of the submitted abstracts.

NCGLT, together with the National University of Ireland, Galway, submitted a poster under the general poster competition and were delighted to be shortlisted for the competition and have the poster submission on display at the event.

The poster, entitled, '*An Analysis of Complaints about Hospital Care in the Republic of Ireland', sets* out a project that was undertaken by the National University of Ireland Galway and the HSE to apply the London School of Economics' (LSE) Healthcare Complaints Audit Tool (HCAT), an innovative and internationally recognised method of classifying complaints, to patient and service user complaints.

Using HCAT to analyse complaints can identify **hot spots** (where problems occur most frequently or cause major impact) and **blind spots** (where problems occur but cannot be easily observed by healthcare staff) that can help the health service to prioritise the issues to address and better target service improvements.

The project, which was in relation to acute services also demonstrated the value of applying HCAT to complaints as it helps to identify growing problems as well as opportunities for improvements in clinical safety and quality.

Photo of the poster on 'An Analysis of Complaints about Hospital Care in the Republic of Ireland' submitted for the competition.

Pictured Ms Emily O'Dowd, NUIG, Ms Elaine Ahern, NCGLT, Ms Marie Ward, St James' Hospital

4.6 Learning from Individual Complaints: HSE Anonymised Feedback Learning Casebook

Casebooks form part of the HSE's commitment to use complaints as a tool for learning and to share that learning to demonstrate to services users that sharing their experience has made a difference and has led to change. The development and publication of casebooks was also a recommendation by the Ombudsman in his report, *Learning to Get Better* and further progresses the HSE's promise to implement all recommendations from the Ombudsman's report pertaining to the HSE.

The HSE National Your Service Your Say Anonymised Learning Casebook is published on a quarterly basis and available to view on www.hse.ie/yoursay

4.6.1 Casebook Development

National casebooks are generated from the learning notification forms that are completed by Complaints Officers, following a complaint investigation, and Review Officers, following a complaint review and forwarded to Complaints Managers. Complaints Managers review these forms and submit those cases with organisational learning to NCGLT for the inclusion in the national casebook.

4.6.2 2021 Anonymised Feedback Learning Casebook

The four editions of the 2022 casebooks presented 82 cases covering both complaints and compliments received by Hospitals, Community Healthcare Organisations and National Services.

The casebooks contained 56 complaints that were investigated and/or reviewed along with their outcomes and featured 26 compliments that highlighted the learning to be gained from positive feedback.

The following services contributed to the 2022 Casebook:

Community Healthcare Organisations	Hospital Groups
CHO 1	Children's Health Ireland
Community Healthcare West	Ireland East Hospital Group
Cork Kerry Community Healthcare	Saolta University Health Care Group
HSE Community Healthcare East	University of Limerick Hospital Group
Dublin South, Kildare and West Wicklow Community Healthcare	Dublin Midlands Hospital Group
CHO Dublin North City and County	
National Services	
National Mental Health	
National Screening Services	

The following services **did not** contribute to the casebook during 2022

Community Healthcare Organisations	Hospital Groups
Community Healthcare Mid West	RCSI Hospital group
South East Community Healthcare	South South West Hospital group
National Services	
National Ambulance Service	
Primary Care Reimbursement Service	

The top categories for both complaints and compliments for the 2022 casebook relate to *communication and information, safe and effective care* and *access*

The cases presented across the four editions of the casebook for 2022 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.

Current and past casebooks can be accessed from:
https://www.hse.ie/eng/about/who/complaints/hse-complaints-casebook/

Your Service Your Say

5.0 The National Complaints Governance and Learning Team: Operational Services

The National Complaints Governance and Learning Team (NCGLT) operates two national frontline complaints services that are co-located between Naas and Limerick.

1. The **National Your Service Your Say office** provides a dedicated national contact point for Service Users, or an individual acting on behalf of a Service User, to provide feedback (comments, compliments and complaints) on their experience with our health services or to seek assistance with providing feedback. During 2022 the office engaged in 25,262 client interactions.

   During 2022 the demand for a separate **COVID-19 Vaccination Client Services (VCS)** team, which had been established in April 2021 to support the national HSE vaccination, declined. In total just 1,268 vaccine related queries were dealt with in 2022. COVID-19 vaccine related queries have now been absorbed into the National Your Service Your Say operational function.

2. **Assessment of Need Disability Complaints service**
   NCGLT also offers a specialised service for those wishing to make a complaint under the Disability Act 2005 where they are unhappy with their child's assessment of need or Service Statement. In 2022, the **Assessment of Need Disability Complaints Service** received 892 disability complaints relating to Assessment of Need (AoN). This was up 76% from 2021 figures.

5.1 The National Your Service Your Say Office

The HSE is committed to encouraging and enabling those who use our services to share their experience with us so that we learn from this and improve the safety and quality of those services.

The National Your Service Your Say office comes under the remit of the National Complaints Governance & Learning Team (NCGLT). The Your Service Your Say Team responds to queries, provides advice and information as needed and ensures that any feedback given is directed to the appropriate local service for their examination and direct response to the person raising the concern.

The Team also supports the office of the HSE Chief Executive Officer and the Department of Health. The Team ensure that Service Users who have been in contact with these offices have their issues routed to the appropriate service for examination and response within the Your Service Your Say process, as appropriate, to provide them access to review mechanisms both internally and externally, if required.

5.1.1 The National Your Service Your Say Office Activity

Activity for the National Your Service Your Say office is based on the interactions generated by calls, emails, online forms and post received into the National Your Service Your Say office, either directly from Service Users, or from individuals acting on behalf of a Service User, or through the Office of the Chief Executive Officer or the Department of Health.

For 2022, the National Your Service Your Say Office recorded **25,262** interactions. This was a 22% decrease on 2021. Part of this decrease may be attributed to a reduction in COVID-19 related activity for the National Your Service Your Say office in 2022 compared to the previous year.

Email continued to be the preferred method of contact with the National Your Service Your Say office accounting for 42% of office activity with online forms were the next preferred method of contact accounting for 21%.

5.1.2 *Activity Overview*

Your Service Your Say Office

In 2022 there were 14,102 comments, compliments, complaints and queries logged under Your Service Your Say, compared to 18,362 in 2021. Of this, 11,638 were complaints, 1,270 were compliments, 311 related to comments, while 872 queries were received. Eleven complaint review requests were received.

The feedback can be broken down between services as follows:

CHO	Acutes	National Service	Nursing Home	Voluntary Agency	Voluntary Hospital	Out Of Hours GP	Covid Vaccination Clinics (CVC)	VCS	FOI
3546	3416	3317	3	33	777	196	211	825	1

Table 45: Breakdown of YSYS feedback by service for 2022

The top two categories of complaints in 2022 were *Access,* accounting for 37% and *Communication & Information,* accounting for 25%. As in 2021, *Accessibility & Resources* emerged as the key sub category within Access. *Information* emerged as the key sub category within the category of *Communication & Information* for 2022.

Full breakdown of the issue categories logged are below:

Access	Accountability	Improving Health	Communication & Information	Dignity & Respect	Privacy	Safe & Effective Care	Participation
37%	3%	0.30%	25%	18%	0.51%	16%	0.54%

Table 46: Breakdown of issue categories for YSYS feedback for 2022

Office of the HSE Chief Executive Officer
In 2022 there were 194 items of feedback received from the CEO's office; which represents a decrease when compared with 233 items received in 2021.

Department of Health
In 2022 there was a total of 1,435 items of feedback received from the Department of Health via email.

COVID-19 Vaccination Client Services (VCS)
In 2022, the demand for the VCS team declined as COVID-19 vaccine related queries were absorbed into operational functions. As such, the reduced VCS team dealt with 1,268 vaccine related queries in 2022.

Summary of Your Service Your Say National Office Activity for 2022
Issues relating to *Access* along with *Communication and Information, Dignity and Respect,* and *Safe & Effective Care* were the four main categories of feedback received from Service Users into the National Your Service Your Say Office, either directly or through the CEO's office or the Department of Health.

Overall, *Access* accounted for 5,742 (39%) of categories recorded, *Communication and Information* accounted for 3,465 (23%), *Dignity & Respect* accounted for 2,507 (17%) and *Safe & Effective Care* accounted for 2,401 (16%) of the categories recorded.

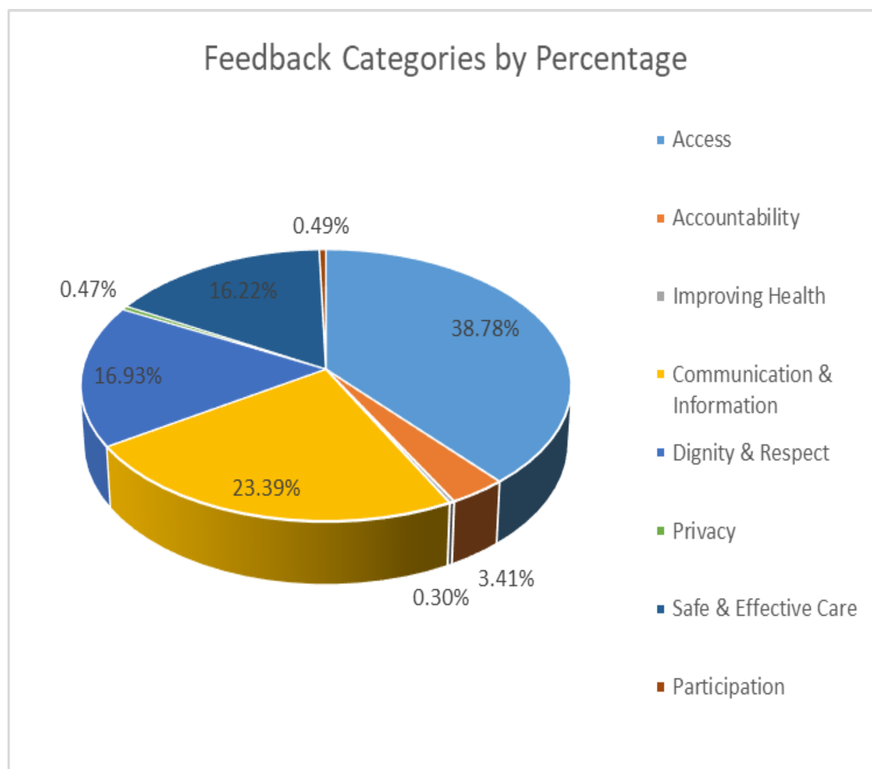


Figure 9: Feedback categories by percentage

5.2 Assessment of Need (AoN) Complaints - 2022

The Disability Act 2005 provides for a special complaints and appeals procedure for service users if they are unhappy with their child's assessment of need or Service Statement.

Under the Act a parent/guardian can make a complaint in relation to one or more of the following:

(a) a determination by the assessment officer concerned that he or she does not have a disability;
(b) the assessment under section 9 was not commenced within the time specified in section 9(5) or was not completed without undue delay;
(c) the assessment under section 9 was not conducted in a manner that conforms to the standards determined by a body referred to in section 10;
(d) the contents of the service statement provided;
(e) the Executive or the education service provider, as the case may be, failed to provide or to fully provide a service specified in the service statement.

In 2022, 892 complaints were received by the AoN Complaints Office. 9% of completed investigations were dealt with by an AoN Complaints Officer within 30 days.

Variance from 2021

Summary Table of Variance	2022	2021	% change
HSE Assessment of Need	892	508	+76%

Breakdown of Recorded 2022 Complaints (Excluding Voluntary Hospitals and Agencies)

HSE: Excluding Voluntary Hospitals and Agencies	Total
Complaints received under Part 2 of the Disabilities Act 2005 (Assessment of Need)	892

Complaints received and resolved by the AoN Complaints Office (Disabilities) (across all CHOs) under the Disability Act.

AoN Nationally (across all CHOs)	Complaints received 2020	Complaints that do not fall under Part 2 of the Disability Act 2005	Withdrawn	Anonymous	Resolved informally	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	% Resolved ≤30 working days
Total	892	26	7	0	0	37	372	9%

- The number of applications for Assessment of Need (AoN) in 2022 was 6755; a 14% increase on the previous year.
- The number of complaints received by the AoN Complaints Office in 2022 was 892; a 76% increase in complaints received in 2021.
- The proportional increase in complaints received (+76%) has outpaced the proportional increase in AoN applications (+14%).
- The average number of complaints received per 100 AoN applications increased from 8 in 2021 to 12 in 2022.
- The average number of days taken by AoN Complaint Officer to close out a complaint increased from 47 days in 2021 to 87 days in 2022.
- Of the complaints investigated the primary ground for complaint was Ground B, accounting for 74% of those investigated thus far, which is up 9% from last year.
- Single issue complaints make up the vast majority (76%) of complaints investigated thus far, however they are down on the previous year due to the rise in multi-issue complaints which are up 4%.
- Of the multiple issue complaints investigated, 40% relate to the Service Statement, down from 80% in 2021 due to the rise in complaints regarding the assessment process itself.

Assessment of Need Nationally (Disabilities) (across all CHOs)

	Complaints received 2022	Withdrawn, Anonymous, Excluded	Less Withdrawn, Anonymous, Excluded	Resolved through formal investigation ≤30 working days	Resolved through formal investigation >30 working days	Complaints not yet resolved	% Resolved ≤30 working days
Across all CHOs	892	33	859	37	372	446	9%

There is currently a backlog of complaints regarding Assessment of Need services to be addressed. NCGLT recruited an additional Disability Complaints Officer and administrative support post during 2020. This expanded the team to 4 staff, three of which are Disability Complaints Officers and one administrator. However, due to the increasing complexity of the investigative process, resourcing is now proving insufficient to meet the demand on the service.

Area	Applications for AoN	Complaints received under Part 2 of the Disability Act 2005 (AoN)	Complaints received per 100 applications
CHO 1	455	16	4
CHO 2	197	9	5
CHO 3	395	17	4
CHO 4	683	77	11
CHO 5	341	98	29
CHO 6	495	75	15
CHO 7	1745	221	13
CHO 8	916	78	9
CHO 9	1528	301	20

Table: Assessment of Need complaints in the context of the no. of Applications received, 2022

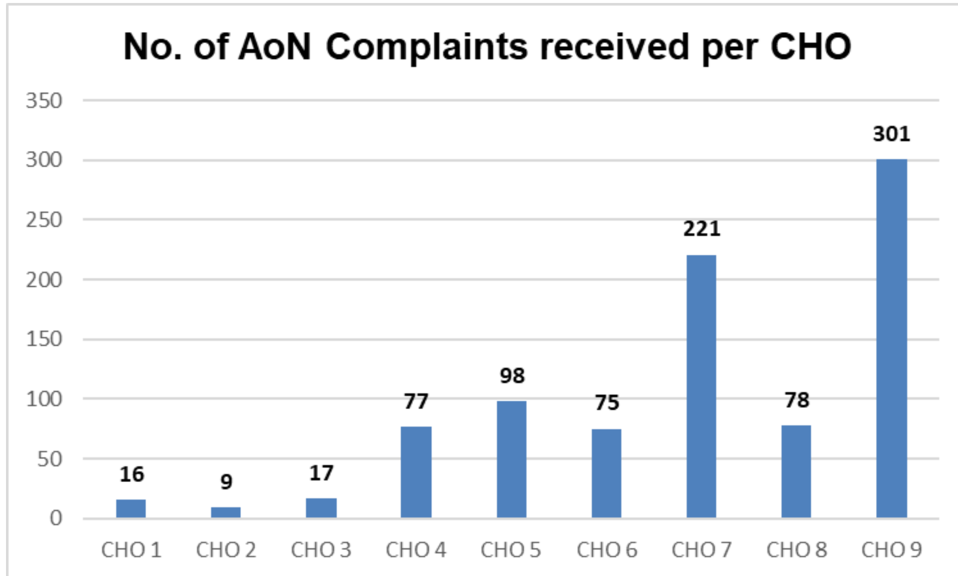


Figure: No of AoN complaints received per CHO

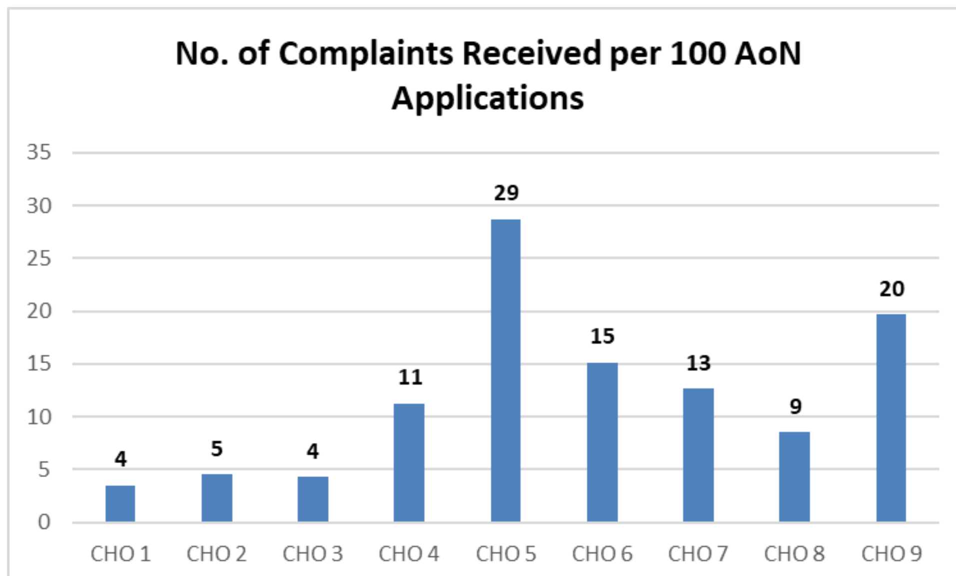


Figure: No. of AoN complaints received per CHO per 100 Applications

Assessment of Need Nationally (across all CHOs)

Assessment of Need Nationally (across all CHOs)	Access (ground B, D, E)	Dignity and Respect	Safe and Effective Care (ground C)	Communication and information	Participation	Privacy	Improving Health	Accountability	
AoN	382	0	76	0	0	0	0	0	
Assessment of Need Nationally (across all CHOs)	Clinical Judgement (ground A)	Vexatious Complaints	Nursing homes / residential care age >65	Nursing homes and residential care age ≤64	Pre-school inspection services	Trust in Care	Children First	Safeguarding Vulnerable Persons	Yet to be determined via investigation
AoN	31	0	0	0	0	0	0	0	476

Table: AoN Complaints Categories 2022

Note: A complaint may contain multiple grounds for complaint. For the purposes of the table above one complaint may be counted in more than one category, hence the total of the above figures surpasses the total no. of complaints received.

Complaints by Divisions: CHOs

Community Health Organisation (CHO)	Complaints received under Part 2 of the Disability Act 2005 (AoN)
CHO1	16
CHO2	9
CHO3	17
CHO4	77
CHO5	98
CHO6	75
CHO7	221
CHO8	78
CHO9	301
Total	**892**

Table: AoN Complaints by Divisions: CHOs, 2022

Complaints Reported by Service

Assessment of Need Nationally (across all CHOs) 2022

Complaints received - Assessment of Need - Nationally (across all CHOs)	Social Care	Primary Care	Mental Health	Health and Wellbeing
AoN	892	0	0	0

Table: AoN Complaints by Service, 2022

HSE

Your Service Your Say

Appendices

Appendix 1: Complaint Categories

Incident /Category	Sub Category Type	Sub Category Please Specify
Access	Accessibility / resources	Equipment
		Medication
		Personnel
		Services
		Treatment
	Appointment - delays	Appointment - cancelled and not rearranged
		Appointment - delay in issuing appointment
		Appointment - postponed
		Surgery / therapies / diagnostics - delayed or postponed
		Operation and opening times of clinics
	Appointment - other	No / lost referral letter
		Appointment - request for earlier appointment
		Unavailability of service
	Admission - delays	Delayed - elective bed
		Delayed - emergency bed
		Admission - delay in admission process
		Admission - postponed
	Admission - other	Admission - refused admission by hospital
	Hospital facilities	Crèche
		Lack of adequate seating
		Lack of baby changing facilities
		Lack of / minimal breastfeeding facilities
		Lack of toilet and washroom facilities (general)
		Lack of toilet and washroom facilities (special needs)
		Lack of wheelchair access
		No treatment area / space for consultation / trolley facilities
		Shop
		Signage (internal and external)
	Hospital room facilities (access to)	Bed location
		Disability facilities
		Isolation / single room facilities
		Overcrowding
		Public
		Semi-private / private
	Parking	Access to disabled spaces
		Access to spaces
		Car parking charges
		Clamping / Declamping of car
		Condition or maintenance of car parks

Access contd.	Parking contd.	Damaged cars
		Location of pay machine
	Transfer issues	External transfer
		Internal transfer
	Transport	External transportation
		Internal transportation
	Visiting times	Lack of visiting policy enforcement
		Special visiting times not accommodated
Dignity and Respect	Alleged inappropriate behaviour	Patient
		Staff
		Visitor
	Delivery of care	Lack of respect shown to patient during examination / consultation
		No concern for patient as a person
		Patient's dignity not respected
	Discrimination	Age
		Civil status
		Disability
		Family status
		Gender
		Membership of traveller community
		Race
		Religion
		Sexual orientation
		Socio-economic
	End-of-Life Care	Breaking bad news
		Breaking bad news - private area unavailable
		Death cert - delay in issuing death cert
		Death cert - incorrect / returned death cert
		Delay in release and condition of body
		Inattention to patient discomfort
		Mortuary facilities
		Organ retention
		Palliative care
		Poor communication
	End-of-Life Care (contd.)	Single room for patient unavailable
		Treatment of deceased not respected
	Ethnicity	Insensitivity to cultural beliefs and values
		Requests not respected
		Special food requests unavailable
Safe & Effective Care	Human Resources	Competency
		Complement
		Skill mix
	Diagnosis	Diagnosis - misdiagnosis
		Diagnosis - delayed diagnosis
		Diagnosis - contradictory diagnosis

Safe & Effective Care contd.	Test	Delay / failure to report test results
		Incorrect tests ordered
		No tests ordered
		Mislabelled test result/sample
		Mislaid sample
		Performed on wrong patient
		Repeat test required
		Result not available
		Delay in transport/collection of sample
	Continuity of care (internal)	Poor clinical handover
		Lack of approved home care packages
		Lack of community supports
		Lack of medical devices / faulty equipment
		Lack of support services post discharge
		Unsuitable home environment
	Discharge	Adherence to discharge policy
		Delayed discharge
		Discharge against medical advice
		No discharge letter
		Patient / family refuse discharge
		Premature discharge
	Health and Safety issues	Building not secure
		Central heating
		Equipment (lack of / failure of / wrong equipment used)
		Failure to provide a safe environment
		Fixtures and fittings
		Furnishing
		Lights
		Manual handling
		Noise levels
		Overcrowding
		Pest control
		Slips / trips and falls
		Temperature regulation
		Waste Management
	Health Care Records	Admission / registration process error
		Inaccurate information on healthcare record / hospital systems
		Missing chart
		Missing films/scans
		Patient impersonation (identify theft)
		Poor quality control of chart
		Poor recording of information
		Wrong records applied to patient

Safe & Effective Care contd.	Hygiene	Cleanliness of area
		Hand Hygiene / Gel Dispensers
		Linen (beds and Curtains)
		Spills on floors
		Waste management
	Infection prevention and control	Communication deficit - infection status
		Health Care Associated Infection
		Non-compliance with Infection and Control policies and protocols
		Personal hygiene of staff
	Patient property	Clothes
		Dentures
		Glasses
		Hearing Aid
		Jewellery
		Lack of secure space
		Money
		Personal equipment
		Toys
	Medication	Administering error
		Dispensing
		Prescribing
	Tissue Bank	Bone marrow
		Cord blood
		Cornea implant
		Cryogenics
		Fertility issues
		Heart valves
		Samples/test results
		Skin
		Stem cell
	Treatment and Care	Failure / delay in treatment / delivery of care
		Failure / delay to diagnose
		Failure to act on abnormal diagnostic results
		Inconsistent delivery of care
		Insufficient time for delivery of care
		Lack of follow-up care
		Lack of knowledge in staff
		Lack of monitoring of pain control
		Lack of patient supervision
		Practitioners not working together / cooperating
		Prolonged fasting
		Unsatisfactory treatment or care
		Unsuccessful treatment or care

Communication & Information	Communication skills	Patient felt their opinion was dismissed / discounted
		Disagreement about expectations
		Inadequate listening and response
		Inappropriate comments from staff member
		Lack of support
		Language barrier between patients/relatives and staff
		No opportunity to ask questions
		Non-verbal tone / body language
		Open disclosure (lack of)
		Patient dissatisfied with questions
		Patient felt rushed
		Staff not introducing themselves and letting patients know their role
		Staff unsympathetic
		Tone of voice
		Untimely delivery of information
	Delay and failure to communicate	Breakdown in communication between staff or areas
		Failure / delay to communicate with outside agency/organisation
		Failure / delay in communicating with patient
		Advising patient of treating consultant
		Failure / delay in communicating with relatives
		Failure / delay in notifying consultant (external)
		Failure / delay to communicate with GP / referral source
		Lack of information provided about medication side effects (KPI)
	Diverse Needs	Interpretation service (e.g. Braille services)
		Special needs
		Translation service
	Information	Conflicting information
		Confusing information
		Insufficient and inadequate information
		Misinformation
	Telephone calls	Telephone call not returned
		Telephone call unanswered
Participation	Consent	Consent not obtained
		Lack of informed consent
		Patient felt coerced
	Parental Access and Consent	Consent, guardianship and information issues related to lesbian, gay parental relationships
		Correct procedure not consented for
		Guardianship consent not explained
		Mother or father unable to access information
		Mother/Father/Guardian not informed

Your Service Your Say

Participation contd.	Patients/ Family/ Relatives	Excluded from decision making process - family / relatives / advocate / next of kin
		Excluded from decision making process - patient
		Opinion discounted - family / relatives / advocate / next of kin
		Opinion discounted - patient
		Parent not allowed accompany child in recovery room
		Parent not allowed accompany child to theatre
		Second opinion
Privacy	Confidentiality	Breach of another patient's confidentiality
		Breach of patient confidentiality
		Security of files and records
	Hospital Facilities (Privacy)	Lack of privacy during consultation/discussing condition
		Lack of privacy during examination/ treatment
		Privacy - No single room
		Privacy - Overcrowding
Improving Health	Empowerment	Independence and self care not supported
		Lack / provision of patient / carer education
		Patient / family preference discounted / disrespected
	Holistic Care	Lack of information / support on how to prevent further illness / disease
		Lack of understanding as to what is important to the patient
	Catering	Dietary requirements not met
		Food quality
	Smoking Policy	Non-compliance (visitor, patient, staff smoking)
Accountability	Patient feedback	Feedback not provided to patients on improvements made as result of their feedback
		Information about the complaints / patient feedback process not available
		Patient concerns not dealt with promptly
		Quality of response to the complaint made
		Where to go to ask questions in relation to services and giving feedback (visibility of customer services)
	Finance	Bill dispute
		Bill sent to deceased patient
		Cost of products
		Insurance cover
		Invoice error
		Unhappy with income collection process

Appendix 2: Learning to Get Better: Recommendations

Access

1. Multiple methods of making a complaint should be available and easily understood, both during and after treatment. These should include comment boxes within hospital wards (if not already in place). A fully accessible online version of Your Service Your Say should be developed to allow complainants to make a complaint online.
2. The HSE should undertake a review of Your Service Your Say with a view to making sure that service users have greater clarity, guidance and information on how the complaints system works.
3. A standard approach should be adopted by all hospitals in relation to the information available to the public when viewing their website, particularly those hospitals availing of the HSE website – hospital details on this site should all contain the same information and the same links for ease of reference.
4. Complaints Officers should be provided with appropriate and accessible facilities within each hospital to meet complainants.
5. Independent advocacy services should be sufficiently supported and signposted within each hospital so patients and their families know where to get support if they want to raise a concern or issue.
6. Each hospital should actively develop and encourage volunteer advocates with the hospital who can help support patients who wish to express a concern or make a complaint.
7. A no "wrong door" policy should be developed so that wherever a complaint is raised, it is the system and not the complainant that is responsible for routing it to the appropriate place to get it resolved.
8. Regulators and the Ombudsman should work more closely together to co-ordinate access for patients to the complaints system. In this regard, the online platform healthcomplaints.ie should be extended to provide a better publicised point of information and access for complainants.
9. Each hospital group should develop a process to allow for the consideration of anonymous complaints.
10. Each hospital should appoint an Access Officer (as statutorily required under the Disability Act 2005) who should attend all necessary training as provided by the HSE.
11. A detailed complaints policy statement should be displayed in public areas within all hospitals, on the hospital website, and in, or near, the Complaints Officer's office. Induction and other training for staff should include a reference to the policy. Staff should also be periodically reminded of the provisions of the policy.
12. Each hospital that has not yet done so, should include a reference to this Office:
    - In any letter or correspondence notifying the patient/family of the outcome of the complaint to the hospital;
    - On websites, booklets and information leaflets where the hospital refers to their complaints system;
    - Verbally if explaining how to make a complaint to a patient or their family.

Process

13. The HSE should introduce a standard approach to implementing Your Service Your Say across the public health service. This should include standard forms, standard guidance for patients and staff, standard categorisation of complaints and standard reporting to give certainty to complainants and to allow for comparison on complaint handling, subjects and outcomes between hospitals and hospital groups.
14. Addressing concerns at ward level should be a main focus for each hospital. All hospital staff should be provided with the appropriate training to allow them to deal with issues as they arise.
15. Consideration should be given on a wider front to amending the statutory complaints process (and the remit of the Ombudsman) to allow for the inclusion of clinical judgement as a subject about which a complaint can be made.
16. Each hospital group should have a Complaints Officer to take overall responsibility for the complaints process and co-ordinate the work of complaints staff in each hospital in the group.
17. A standardised process and template for recording and documenting complaints at ward level should be embedded via a standardised system across the hospital groups.
18. A standardised structure and template for collecting and documenting a complaint should be developed across the hospital groups outlining the nature of the complaint, preferred method of communication and desired outcomes.
19. A standardised information system for the recording of complaints, comments and compliments should be developed across the hospital groups.
20. Each hospital group should implement mandatory training on complaints handling for all Complaints Officers and other staff involved in the complaints process.
21. Each hospital group should provide an induction module for all new hospital staff on the hospital complaints process and its underlying statutory framework.
22. Each hospital group should implement a bi-monthly audit of the complaints dealt with within the group in order to assess the quality of the process, including the response.
23. Each hospital group should develop a facility to allow for independent (i.e. outside the HSE) investigation of complaints where the complaint received is of sufficient seriousness and where appropriate.
24. The HSE and the hospital groups should take steps to ensure that all complaints are thoroughly, properly and objectively investigated and comprehensively responded to.
25. Each hospital group should develop an Open Disclosure training programme in line with the HSE National Guidelines and make it available to all staff.
26. The Department of Health should undertake a full review of the Health Act 2004 (Complaints) Regulations 2006. This Office looks forward to working with the Department in this regard.

Response

27. The outcome of any investigation of a complaint together with details of any proposed changes to be made to hospital practices and procedures arising from the investigation should be conveyed in writing to the complainant with each issue in the complaint responded to.
28. Each hospital group should develop a standardised policy on redress.

Leadership

29. Each hospital group should redevelop standardised reporting on complaints with greater attention paid to the narrative contained within complaints data so that senior management can identify recurring themes / issues and take action where appropriate.
30. Each hospital group should provide a six monthly report to the HSE on the operation of the complaints system detailing the numbers received, issues giving rise to complaints, the steps taken to resolve them and the outcomes.
31. The HSE should publish an annual commentary on these six monthly reports alongside detailed statistical data (using the reports published in the United Kingdom by the HSCIC as a model).
32. Each hospital group should appoint a senior member of staff to assume an active and visible leadership role in the complaints process with key involvement in education, training and reporting arrangements.
33. Senior managers in each hospital should foster and encourage positive attitudes towards complaints to ensure that each hospital is open to feedback and is responsive to complaints.

Learning

34. Each hospital group should develop a standardised learning implementation plan arising from any recommendations from a complaint which should set out the action required, the person(s) responsible for implementing the action and the timescale required.
35. Each hospital group should put in place arrangements (both within and across the hospital groups) for sharing good practice on complaint handling. This should include a formal network of Complaints Officers to ensure that learning and best practice is shared throughout the public hospital sector.
36. Each hospital group should publicise (via the development of a casebook) complaints received and dealt with within that hospital group. This casebook should contain brief summaries of the complaint received and how it was concluded/resolved (including examples of resulting service improvements) and should be made available to all medical, nursing and administrative staff as well as senior management. This could usefully form part of a larger digest incorporating all information on adverse incidents whether arising from complaints, whistle blowing or litigation to ensure that there is a comprehensive approach to learning from mistakes.