

Learning to Get Better: Progress Report



Ombudsman

A report on the progress made following the Ombudsman's investigation into how public hospitals handle complaints





Ombudsman

2018 Office of the Ombudsman

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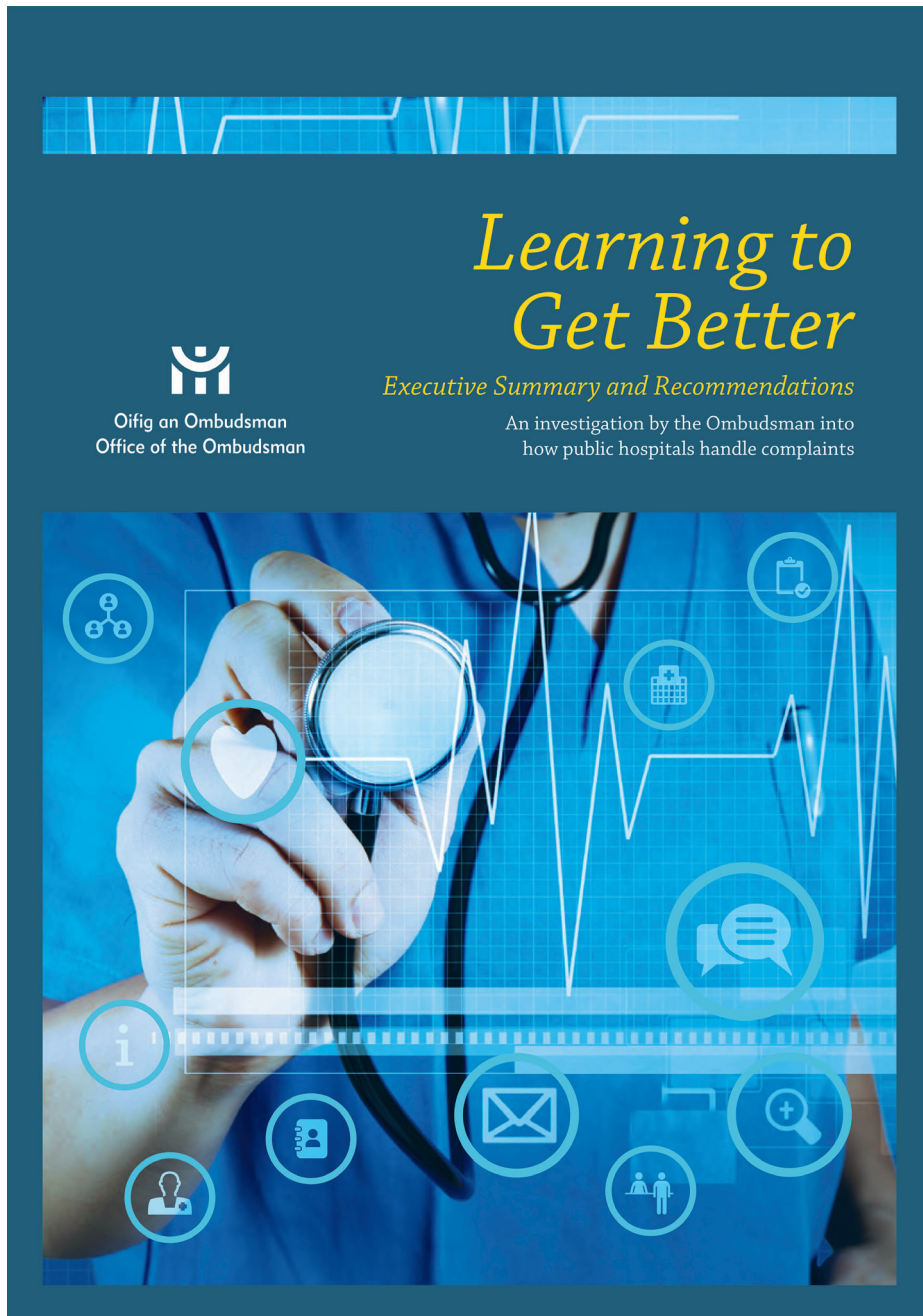


Ombudsman

Learning to Get Better: Progress Report

*A report on the progress made following the Ombudsman's investigation
into how public hospitals handle complaints*

November 2018



Front cover of *Learning to Get Better, Executive Summary and Recommendations*, published by the Ombudsman in 2015.

Foreword

Giving and receiving critical feedback can be difficult for everyone involved. It is, of course, hard to be the person complained about, particularly if you believe that you have done the best you could in the circumstances. However, it can also be difficult to be the person making the complaint when all you may be left with is the fear of repercussions on you and your loved ones. This is particularly true within the health service when the relationship between health service staff and health service users is a very complex and often imbalanced one. In some cases, it may also be life-long.

However, complaints are absolutely integral to improving the quality, safety and accountability of our health services. Listening to service user feedback and learning from what goes wrong is essential if we are to deliver a safe and effective health service. Service users need to feel confident to speak up when things go wrong and to know that their concerns are being taken seriously. Likewise, health service staff need to be able to make service users aware of how to complain, provide reassurance that there is nothing to fear from doing so and make sure that complaints are properly addressed.

In 2015 I published *Learning to Get Better* – an investigation by the Ombudsman into how public hospitals handle complaints. In that report I considered the health complaints systems throughout the process – from how difficult or otherwise it was to make a complaint to the structures in place to share any learning that results. I identified issues within the system that required improvement and made a number of recommendations in order to bring these improvements about. All of these recommendations were accepted by the HSE.

This progress report considers how my recommendations have been implemented in the intervening years. The report focuses on some of the areas that still need attention within the health complaints system. However, this report also highlights the many improvements and initiatives that have taken place since 2015. I would like to commend the HSE and Hospital Groups on the work completed so far and encourage them to continue. I firmly believe that this will ultimately benefit everyone – both health service staff and service users alike.



A handwritten signature in black ink, appearing to read 'Peter Tyndall', written in a cursive style.

Peter Tyndall
Ombudsman
November 2018

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Acronyms used in this Report

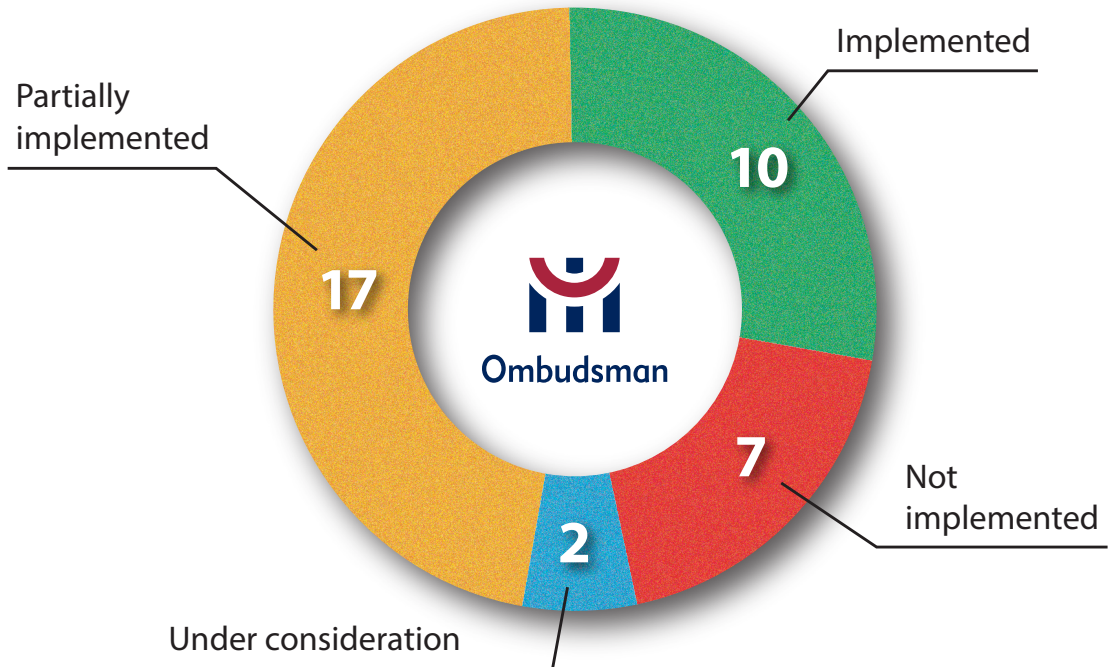
CHO	Community Healthcare Organisation
CMS	Complaints Management System
HSE	Health Service Executive
HIQA	Health Information and Quality Authority
NCGLT	National Complaints Governance and Learning Team
NPSO	National Patient Safety Office

Summary

In 2015 I published 'Learning to Get Better', the report of my investigation into how hospitals handle complaints they receive. The report contained 34 recommendations to the HSE and two to the Department of Health. The recommendations were set out under the headings of Access, Process, Response, Leadership and Learning. The HSE and the Department committed to implementing all recommendations.

The following is a summary of the progress made on each of the recommendations divided into those that are 'Implemented', 'Partially Implemented', 'Not Implemented' and 'Under consideration'.

36 recommendations



The number of recommendations implemented, etc., since the Ombudsman's report in 2015.

Status of Recommendations

The following table outlines the status of my recommendations from *Learning to Get Better*.

The following categories are used and each is represented by a different colour:

	The recommendations has been Implemented – the intention behind the recommendation has been fully addressed.
	The recommendation has been Partially implemented – work has been or is being done to implement part of the recommendation.
	The recommendation is Not implemented – no concrete steps have been taken to implement the recommendation.
	The recommendation is Under consideration – implementation of the recommendation is still being considered.

No.	Recommendation	Comment
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.	The review has been conducted, a revised policy has issued and all posters and information have been distributed.
4.	Complaints Officers should be provided with appropriate and accessible facilities within each hospital to meet complainants.	There is now a more obvious presence of Complaints Officers in the public area of hospitals and, in particular, close to reception areas. There are also private meeting rooms available to facilitate meetings with service users.
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 make a complaint.	Independent advocacy services are welcomed at family meetings and to assist patients when making complaints. Advocacy groups are also welcome to join hospital committees to represent the needs of patients and services users.
9.	Each hospital group should develop a process to allow for the consideration of anonymous complaints.	Anonymous complaints are acted upon where they highlight areas of concerns for patient safety or where suggested improvements can add value to the patient or service user experience.
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.	There is increased visibility of the complaint policy in public areas. This policy also appears to be included in induction and training materials.

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No.	Recommendation	Comment
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.	There is a much stronger focus on front line resolution in all areas of the HSE. An e-learning module has also been developed to assist all staff in resolving complaints.
21.	Each hospital group should provide an induction module for all new hospital staff on the hospital complaints process and its underlying statutory framework.	The revised Your Service Your Say policy is included as part of induction training.
25.	Each hospital group should develop an Open Disclosure training programme in line with HSE National Guidelines and make it available to all staff.	The training programme has been rolled out nationally. However, concerns have been raised about the involvement (or otherwise) of clinicians.
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.	Senior management plays an active part in the complaints process and are in receipt of regular reports on complaint trends and outcomes. Senior management also play a key role in highlighting learning from complaints and disseminating compliments to individual staff members.
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.	See comments under no. 32.
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. A fully accessible online version of Your Service Your Say should be developed to allow complainants to make a complaint online.	Comment boxes and information on how to complaint are visible at reception areas. An online form is available on the HSE website but is not explicitly linked to Your Service Your Say. In addition, not every voluntary hospital has a facility to take online complaints.
6.	Each hospital should actively develop and encourage volunteer advocates who can help support patients who wish to express a concern or make a complaint.	Most hospitals welcome volunteers to their hospitals. However, some found it difficult to provide in-house volunteer services due to lack of resources or lack of volunteers.
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.	Some work has been done in this area with evidence of a greater emphasis on one final response issuing to the complainant regardless of how many areas were involved. However, the review of complaints received in this Office showed that, in some cases, complainants still have to make multiple complaints to have all the issues addressed.
10.	Each hospital should appoint an Access Officer (as required under the Disability Act) who should attend all necessary training as provided by the HSE.	There remains some uncertainty about who the Access Officer is in some areas. In some areas, there is no Access Officer in place.

No.	Recommendation	Comment
12.	Each hospital should include a reference to the Ombudsman - 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.	Signposting to my Office is done as a matter of routine in the majority of complaints and correspondence to service users. However, my Office has also seen evidence where signposting is not being done or where incorrect information or contact details have been provided.
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.	The introduction of the CMS should assist the HSE in standardising the categorisation of complaints and reporting requirements. However, this system is not fully embedded in all areas as yet. The HSE will need to evaluate its functionality to ensure that it can deliver these requirements. While standardised training has been provided to Review Officers, similar training has not yet been rolled out for Complaints Officers.
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.	Each CHO Office has appointed Complaints Managers since my last report. However, it is not always clear who has overall responsibility for the complaints process within each Hospital 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.	The HSE has introduced “point of contact” forms to allow standardised recording and documenting of complaints of these complaints. As the forms were circulated in mid-2018, it is not yet possible to assess their effectiveness and value.
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.	It is hoped that this will be achieved by greater use of the CMS (see comments under no. 13).
19.	A standardised information system for the recording of complaints, comments and compliments should be developed across the hospital groups.	See comments under no. 13 and 18). The CMS does not yet allow for the recording of compliments.
20.	Each hospital group should implement mandatory training on complaints handling for all Complaints Officers and other staff involved in the complaints process.	The HSE has developed two e-learning modules for all staff and, while these are not mandatory at present, staff are encouraged to engage with them. While standardised training has been provided to Review Officers, similar training has not yet been rolled out for Complaints Officers.
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.	There is evidence that senior management regularly discuss complaints and outcomes. However, only one Hospital Group has so far conducted a more formal audit of complaints received.

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No.	Recommendation	Comment
23.	Each hospital group should develop a facility to allow for independent (i.e.: outside the HSE) investigation of complaints where the complaint is of sufficient seriousness and where appropriate.	The possibility of independent review is available. However, in some cases it is difficult to source the expertise required. This work is also often conducted in addition to the day to day workload of the clinical experts.
24.	The HSE and hospital groups should take steps to ensure that all complaints are thoroughly, properly and objectively investigated and comprehensively responded to.	There is a stronger emphasis on the proper examination of complaints with comprehensive responses issuing where possible. However, our review of complaints showed that some improvement is still required. Delays also need to be addressed.
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.	The complaints review showed that there remains a reluctance in some cases to detail what changes have been or will be put in place as a result of a complaint. It is also still unclear as to how implementation is monitored after the complaint has been finalised.
29.	Each hospital group should develop 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.	Complaints and compliments remain as an agenda item on monthly management meetings. However, there is no standardised reporting as yet.
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.	As the CMS is populated and becomes fully operational, this information will be provided to the HSE on a monthly basis.
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.	There is still a wide discrepancy in relation to the information available online, both in respect of voluntary hospitals and within the HSE itself. However, the gradual move towards Hospital Group websites is a positive development.
8.	Regulators and the Ombudsman should work 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.	While the development of this site remains on important objective, unfortunately, due to data protection and other concerns, the progress expected has not materialised to date.
28.	Each hospital group should develop a standardised policy on redress.	While the revised Your Service Your Say policy states that it is the policy of the HSE to offer redress, unfortunately, there is little evidence that detailed policies on redress have been developed.

No.	Recommendation	Comment
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).	An annual commentary has not yet been published.
34.	Each hospital 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.	There is little evidence of how implementation of actions or improvements resulting from complaints are monitored.
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.	In one geographical area, a network of Complaints Officers has been established on an informal basis. However, there are no formal structured arrangements in place which would facilitate shared learning throughout the health service as a whole.
36.	Each hospital group should publicise (via the development of a casebook) complaints received and dealt with within that hospital group. The 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.	To date no casebook has been published. However, the HSE has developed a template for a casebook and it is intended that these will be compiled on a quarterly basis.
15.	Consideration should be given on a wider front to amending the statutory complaints process (and the remit of the Ombudsman) to allow for inclusion of clinical judgement as a subject about which a complaint can be made.	While a review of the statutory complaints process is under consideration by the Department of Health, it is likely that any such review will not take place until 2019 at the earliest.
26.	The Department of Health should undertake a full review of the Health Act 2004 (Complaints) Regulations 2006.	See comments under no. 15.



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Introduction

What this report is about

In May 2015 I published *Learning to Get Better – an investigation into how public hospitals handle complaints*. As with other Ombudsman investigations, this report contained a number of recommendations (36 in all), the majority of which were directed towards the Health Service Executive (HSE). The HSE accepted my recommendations at the time the report was published and began work on implementation shortly afterwards. It also decided to extend implementation of the recommendations to the community health sector (now known as Community Healthcare Organisations or CHOs). I welcomed this extension. This follow-up report looks at the progress made since then in implementing my recommendations.

How my Office approached it

When *Learning to Get Better* was published, I signalled my intention to conduct a follow-up investigation once the HSE had an opportunity to implement my recommendations. Earlier this year, and as part of this follow-up investigation, my Office conducted site visits to eight hospitals (some of which had been visited as part of the original investigation) and three CHOs. The purpose of these visits was to learn about what progress had been made in handling complaints since 2015. My Office also conducted an audit of hospital and HSE websites and reviewed 15 randomly selected complaints received by my Office in each of the years 2016, 2017 and 2018 in order to determine whether the reality of complaint-handling matched what we had been told by the HSE and hospitals. My Office also looked for examples of good practice in this regard.

The recommendations contained in *Learning to Get Better* were grouped under the following headings – **Access, Process, Response, Leadership** and **Learning**. As this report considers the progress (or otherwise) made in relation to these recommendations, the chapters in this report correspond to these headings.

In this report, I have focussed on the main issues which have seen improvement since 2015 as well as the areas which still require attention. I have also included a table which details each of my recommendations and I consider, in respect of each recommendation, whether it has been implemented, partially implemented or otherwise.

Overview of the public health system

In *Learning to Get Better*, I outlined plans to organise the country's public hospitals into seven Hospital Groups. This work has now been completed.

A list of the hospitals in each group can be found at Appendix 1 to this report.

Each Hospital Group has its own management structure with a focus on working together as a single entity to provide acute care within that Group's geographical area.

The CHOs are an even more recent development within the Irish health service. They are responsible for the broad range of services provided outside of the acute hospital system, including primary care, social care and mental health services. As with the Hospital Groups, the CHOs are arranged by geographical area and are as follows –

- CHO Area 1 – Donegal, Sligo, Leitrim, Cavan, Monaghan
- CHO Area 2 – Galway, Roscommon, Mayo
- CHO Area 3 – Clare, Limerick, North Tipperary
- CHO Area 4 – Kerry, Cork
- CHO Area 5 – South Tipperary, Carlow, Kilkenny, Waterford, Wexford
- CHO Area 6 – Wicklow, Dún Laoghaire, Dublin South-East
- CHO Area 7 – Kildare, West Wicklow, Dublin West, Dublin South City, Dublin South West
- CHO Area 8 – Laois, Offaly, Longford, Westmeath, Louth, Meath
- CHO Area 9 – Dublin North, Dublin North Central, Dublin North West

Each of these CHOs has a number of Complaint Officers. Every CHO also has a Complaints Manager. The role of the Complaints Manager is to champion the feedback process and ensure that it is fully implemented.

Chapter One: Access

For complaints to make a difference within the health service, service users must find it easy to make a complaint when they are not satisfied. The complaints process must therefore be open, easily understood and accessible to everyone. In 2015 I therefore made 12 recommendations in relation to accessing the complaints system. These recommendations were intended to address how a service user finds out about how to make a complaint and the level of assistance provided when doing so. They were also intended to highlight the importance of signposting this Office when communicating with complainants.

Your Service Your Say

Part 9 of the Health Act 2004 established the current statutory complaints system for public health services. The Health Act 2004 (Complaints) Regulations 2006 provided for the establishment of a statutory complaints process – a process and policy now known as Your Service Your Say.

Your Service Your Say outlines how users of a public health service can make a complaint about the service they receive. In 2015, I recommended that the HSE 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. I also recommended that a fully accessible online version of Your Service Your Say be developed to allow service users to make complaints online.

In the months following the publication of *Learning to Get Better*, the HSE established a Steering Committee to review and revise Your Service Your Say (within the confines of the current governing legislation). This Steering Committee included representatives from the HSE, the Hospital Groups, agencies funded under section 39 of the Health Act 2004 (that is agencies providing services ancillary to the HSE), the Department of Health and patient advocacy groups. My Office was also represented on this Committee.

In November 2017, a revised Your Service Your Say policy was launched with a focus on supporting service users to give feedback and staff to receive and handle this feedback. This policy sets out and defines the roles, responsibilities and lines of authority for all involved in the complaints process.



As part of this policy, the HSE has embraced five guiding principles

- To **enable** service users to provide feedback
- To **respond** to feedback promptly
- To **support** service users and staff through the process
- To commit to **learning** from feedback and use it to improve services and make them **accountable**

As part of the revised policy the HSE also introduced a Complaints Management Pathway. This pathway (which is included as an appendix to this report) sets out three internal stages – point of contact resolution (Stage 1), the formal investigation process (Stage 2) and the internal complaint review (Stage 3). The pathway also, for the first time, outlines how complaints that include elements of clinical judgement can be examined and responded to and provides for the active participation of clinicians.

A new feedback leaflet was also produced in conjunction with the revised policy. This form includes full contact details for giving feedback (be it a complaint or compliment) and allows the service user to provide feedback on the form itself. The feedback form is currently available in nine languages and is downloadable from the HSE website. It is also now possible to provide feedback online and through the HSE website.

In addition, and in line with my recommendation that multiple methods of making a complaint should be available, most, though not all, of the hospitals visited now have comment boxes available in the hospital reception. In a small number of hospitals, comment boxes are also available in clinical areas while at least one hospital has a mobile “feedback station”. The email address yoursay@hse.ie is still operational for all complaints made under Your Service Your Say while all voluntary hospitals (and some HSE-run hospitals) also have their own dedicated email address to accept complaints.

(((Bright Spot)))

Complaints Officer in visible and accessible location – Tallaght Hospital

Recommendation 4: Complaints Officers should be provided with appropriate and accessible facilities within each hospital to meet complainants.

It is very important that patients and their families know who to go to with questions or concerns about their care and treatment. While in many cases this can and should be a member of staff on the ward, the Complaints Officer should also be clearly visible and accessible to everyone in the hospital.

Since 2015, the Complaints Officers (otherwise known as Patient Advocacy) in Tallaght Hospital have relocated their office to the main reception area. This office is now clearly visible to all those entering and leaving the hospital. There is also space to meet with patients and their families to discuss their concerns in a welcoming environment and without having to travel through the hospital building.

“No wrong door” policy

In 2015, I recommended that a “no wrong door” be developed so that, regardless of where a complaint is raised, it is the responsibility of the health service and not the complainant to route it to the appropriate person to get it resolved. The revised Your Service Your Say policy also stresses that the feedback process be accessible, flexible and responsive to the needs of service users through a “no wrong door” approach.

As part of the review of complaints received in this Office since *Learning to Get Better* was published, I have seen some good examples of this approach in action. For example, in one complaint involving a community health service, the letter of complaint was sent to a clinician working within the service. The clinician acknowledged receipt of the letter and assured the complainant that, while she would not be examining the complaint, she would make sure that it got to the person who would be looking after it.

However, unfortunately, my Office has also seen incidences which would suggest that this policy has not yet been adopted across the service as a whole. In one case, a man made a number of complaints about the HSE (directed at both acute hospital and community services). Upon receipt of the complaint, however, the matter was forwarded on to the hospital for response on the issues relevant to it. While the complainant was provided with contact details in order to pursue the other aspects of the complaint, the HSE should instead have ensured that each aspect was properly responded to without the complainant having to take any further action

Websites

Increasingly in this digital age, people are turning to the internet and websites for information on how to access or do something. All public voluntary hospitals have their own website. For the HSE hospitals and CHOs, an online presence usually means a page on the HSE website (although this is no longer exclusively the case – a small number of HSE hospitals now have their own website). The CHOs do not have their own webpage.

In *Learning to Get Better*, I made a number of recommendations in relation to this area. In particular, I recommended that a standard approach should be adopted in relation to the information available to the public.

As part of this follow-up investigation, my Office conducted another website audit. In conducting this audit, we looked at whether the information on websites in relation to the complaints process is standard across the hospitals. We also considered a number of questions such as how easy (or otherwise) it is to find information on how to make a complaint, whether all the contact details for the Complaints Officer are available and whether it is possible to make a complaint online.

This audit found that, unfortunately, a standard approach has not yet been achieved in terms of how information about the complaints process is presented online. For example, on the relevant pages on the HSE website, there is a marked disparity as to whether the information on how to make a complaint was readily available or not – while a number of HSE hospitals (21 in all) have a clear link to guidance on how to make a complaint or give feedback (under the standard heading Feedback and Complaints), other HSE hospitals do not have this link. The relevant information is often almost hidden away and listed under other more ambiguous headings such as Make a Comment. On one HSE hospital webpage, while there is an apparent link to Feedback, this link does not work and there is no other information available on how to make a complaint.

In respect of the public voluntary hospitals, the online information is usually more detailed and clear. Complaint and feedback policy details are provided in most cases as well as contact details (email, telephone, number, etc.). In some cases, directions as to how to find them within the hospital is also provided along with office hours. In addition, a small number of hospitals include a positive statement about welcoming complaints and, in two cases, include a link to my Office.

However, most of the voluntary hospitals do not have information about how to make a complaint on their homepage. It is often necessary to search and click through a number of links for the relevant information. In addition, and as with some of the HSE hospitals, information on how to make a complaint was almost hidden under more vague headings such as Further Patient Information or under the About Us heading. In an age where an organisation's website is often the first port of call to get information, this is regrettable and needs to be addressed.

In terms of being able to make a complaint online, the majority of HSE hospitals include a link to the online complaint form. However, in the case of eleven of the voluntary hospitals it is not possible to make a complaint online.

Advocacy

The use of advocacy services can help service users and their families not only find their voice but be heard in relation to their concerns. In particular, an advocacy service can help a service user access and understand information about how to make a complaint and to explore their options when doing so. In 2015 I found that only one hospital had a volunteer advocacy programme in place to assist with this. Since then an increasing number of hospitals are working with volunteer advocates. However, there is still no consistent level of service available across the health service.

In December 2016, the Department established the National Patient Safety Office (NPSO) to oversee a number of patient safety reforms aimed at improving patient and service user experiences of the public healthcare system. Since then, NPSO has worked on a number of initiatives including the development of a Patient Safety Complaints and Advocacy Policy.

As part of this, NPSO commenced a review of international health complaints advocacy models and a consultation process involving key stakeholders (including my Office). A report on the consultation process was published recently and it is intended that this will be a key element in the development of the new policy. It is also intended that a competency framework for independent advocates will be developed and training provided.

As a result of these initiatives, the Department plans to create a National Patient Safety Advocacy Service. It is intended that this service will be independent of the Department and HSE and will operate in line with international best practice. A request for tender to operate this service issued in October 2018.

Access Officers

The Disability Act 2005 places obligations on public bodies (including hospitals and CHOs) to make their buildings and services accessible to people with disabilities. The appointment of an Access Officer is also a legal obligation under the 2005 Act. In 2015, I found that a number of hospitals did not have a designated Access Officer in place.

Since then, the HSE has implemented a nationwide training programme and has ensured that Access Officers have been appointed across the health service. In addition, a significant number of HSE hospitals provide contact details for the Access Officer on their webpage. However, my Office has also found that a small number of hospitals and CHOs do not currently have an Access Officer in place – either because none has been appointed or, more commonly, the previous Access Officer has left their post and has not been replaced.

Signposting to my Office

Anyone who complains about a public hospital or health service (or indeed about any public service provider) should be made aware that they have a right to make a complaint to the Ombudsman if they are not happy with the outcome of their complaint to the service provider. This duty (which is a statutory duty under section 4A of the Ombudsman Act 1980, as amended) applies regardless of the service provider's view as to whether the complaint is within the remit of my Office or not.

In *Learning to Get Better*, I found that a significant number of hospitals did not advise complainants of the right to go to my Office. Since then, however, I have noticed that there has been a noticeable improvement in signposting to my Office, with the vast majority of complainants advised of their right to contact my Office at any stage in the process. The revised Your Service Your Say policy also clearly highlights the correct process to be followed in this regard.

Contact details for my Office (and the Ombudsman for Children) are also invariably provided. However, I have noticed that at least one Hospital Group and CHO, while referring to the right to refer the complaint to my Office, provides the contact and address details for the Ombudsman for Children instead. I have also noticed that the contact details for my Office are out of date on some parts of the HSE website such as referring to old email and website addresses.

In addition, on a small number of HSE hospital webpages and complaint policies, misleading information is provided as to when my Office can get involved in a complaint. For example, on a number of HSE hospital webpages, it is stated that a complainant can contact my Office only after completing the review stage of Your Service Your Say. This is incorrect – while a complainant is expected to take reasonable steps to seek redress from the service provider before contacting my Office, I can nevertheless accept a complaint at any stage in the process and, in particular, after Stage 2 of the process. In addition, a complaints policy from one of the voluntary hospitals states a complainant must refer a complaint to this Office within 30 days of the hospital's response - again this is incorrect. Unfortunately, one voluntary hospital does not make any reference to my Office at all but instead allows for an internal review to the hospital's Chief Executive.



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Chapter Two: Process

All complainants have a right to have their complaints fully and properly considered. Learning to Get Better contained 14 recommendations around the process of examining and recording complaints in order to ensure that complaints are dealt with fairly, objectively and in a timely manner.

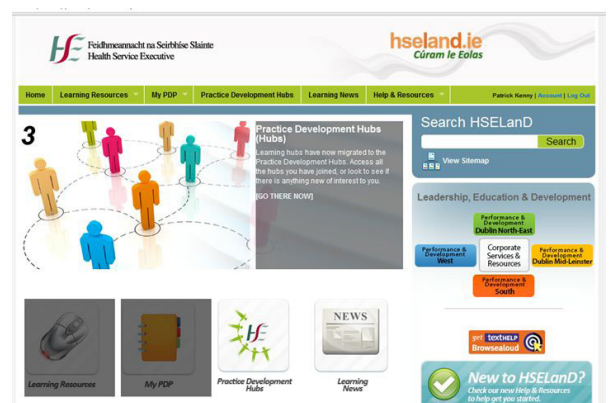
Early resolution of complaints

Addressing complaints at the earliest possible stage in the process should be a priority for each hospital and CHO. After all, most people making a complaint want a simple and quick resolution of the issue. In *Learning to Get Better* I therefore recommended that all staff should be provided with the appropriate training to allow them to deal with issues as they arise. I also recommended that these complaints should be recorded and documented.

Early resolution (or, as the HSE refers to it, Point of Contact Resolution) is now a key part of the Complaints Management Pathway (Appendix 2) and is referred to as Stage 1 of the process. As part of this, there is an emphasis on resolving a complaint (and, in particular a verbal complaint) at point of contact, if possible - whether directly by the frontline staff member to whom the complaint is made or through escalation to the line manager. Under the Complaints Management Pathway, a complaint received at this stage should not be referred to the formal complaints process (known as Stage 2) unless the complaint cannot be resolved within 2 working days or the complainant wishes to go down the formal route.

As a service user may make a complaint to any staff member, it is important that all staff receive some training on the complaints process. It would appear that a number of hospitals still provide training at induction stage to all staff on the process which is to be welcomed. In addition, the HSE has also invested resources in developing training modules in order to give frontline staff members the confidence to address a complaint at point of contact. In particular, the HSE has recently developed (in conjunction with my Office) an interactive e-learning module on early resolution which can be accessed on the HSE training website HSELand. While I am aware of at least one hospital that has made completion of this module mandatory for all administrative staff, this is not yet the case across the health service or grades.

Having systems in place to properly record these complaints can ensure that trends and learning can be identified and shared. When my Office visited selected hospitals as part of the original investigation, only two hospitals recorded these interactions. However, the HSE has now developed a Point of Contact Complaint Resolution Form which allows the frontline staff member to detail what the complaint was about and the actions they took to resolve it.



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Early resolution of complaints – St. John's Community Hospital (CHO1)

Recommendation 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.

In 2015 I found that more could be done to make the complaints process more open and collaborative, both from the complainants' perspective and health service staff. St. John's Community Hospital in Sligo encourages residents to raise concerns at any stage during their stay. This is facilitated by the Director of Nursing meeting with each resident as soon as possible after admission and by holding weekly residents' meetings.

The hospital also adopts a reflective practice model with staff after a concern or complaint is made in order to encourage and minimise the risk of recurrence.

Recording complaints (and compliments)

In *Learning to Get Better*, and in order to facilitate a more meaningful analysis of complaints, I recommended that a standardised information system for the recording of complaints, comments and compliments should be developed across the Hospital Groups. In response, the HSE has developed a web-based complaints management system (known as the CMS). The CMS is an end-to-end complaint management tool that allows the HSE (and HSE-funded services including voluntary hospitals) to manage complaints throughout the lifecycle of a complaint and identify emerging trends. It is envisaged that the CMS will, in the future, also be able to record and report on early resolution complaints and recommendations made. Awareness and training sessions in relation to the CMS are ongoing while refresher training and an online toolkit is also available.

However, at this time, many of the Hospital Groups and CHOs have expressed concerns to my Office about the functionality of the CMS and, in some cases, are continuing to use other systems in tandem with the CMS. This apparent disconnect is unfortunate as a proper functioning case management system would not only allow for data and information to be collected and reported on in a consistent manner across the health service but also allow for the HSE and hospitals to monitor trends and particular areas of concern. Instead, at this point, there is a continuing danger that issues will be overlooked and/or ignored.

Patient satisfaction (as opposed to dissatisfaction) is also a key measure of the patient experience. It is after all just as important to learn from and share what is working well. In 2015, I found that a significant number of hospitals did not have a process in place for recording compliments. Since then, however, it appears that a more robust approach to recording and sharing compliments has been developed – for example, in a number of hospitals visited as part of this investigation, the CEO includes details of compliments received as part of their regular updates to staff. It is also intended that the CMS will, in the future, be able to record compliments as well as complaints.

Open Disclosure

Open disclosure promotes an open, consistent approach to communicating with service users when things go wrong. This includes speaking openly and honestly to the service user as soon as possible after an adverse event has occurred, expressing regret for what has happened and outlining the steps taken to prevent a recurrence. Since 2015, a national training programme on open disclosure has been rolled out by the HSE.

At the end of 2017, the Civil Liability (Amendment) Act 2017 placed the open disclosure process on a statutory footing. As a result, there is now legal protection in respect of information provided or any apology given during an open disclosure meeting – in other words they cannot be used in any later legal proceedings as an admission of fault or liability.

Currently, and despite these statutory provisions, the open disclosure process remains entirely voluntary. However, in the wake of serious incidents such as the CervicalCheck audit, there are proposals to bring forward new patient safety legislation which will make open disclosure of serious incidents mandatory (the proposed Patient Safety Bill). It is also proposed that clinicians and hospitals will be required to inform the relevant safety and oversight agencies of incidents (for example, the Health Information and Quality Authority (HIQA)).

This is a welcome development. According to the Final Report of the Scoping Inquiry into the CervicalCheck Screening Programme (otherwise known as the Scally Report), the evidence suggests that currently a relatively small number of medical staff are taking part in open disclosure training. It also appears that no specific evaluation of the open disclosure programme and training in acute hospitals has yet been carried out.

Complaints Officers

When *Learning to Get Better* was published in 2015, there were over 900 Complaints Officers working within the HSE. It is estimated that this number has now been reduced to approximately 500. Under the revised Your Service Your Say policy, the Complaints Officer has a number of functions including investigating complaints and making recommendations in relation to those complaints which may also support organisational learning. The Complaints Officer is also responsible for ensuring that user-friendly information on how to offer feedback and, in particular, on how to make a complaint is widely available.

It is the responsibility of the HSE, and in particular Consumer Affairs, to provide training to Complaints Officers on all aspects of complaint-handling. In 2015, I recommended that mandatory training for all Complaints Officers should be implemented. However, while some Hospital Groups have begun to develop their own training programmes with a focus on investigation skills and report writing, unfortunately it would appear that many Complaints Officers have not received training (or refresher training) for a number of years. In one hospital, staff last received training 10 years ago. It is vital that all staff who are managing complaints are appropriately trained to do so.

In May 2018, the HSE (in collaboration with my Office) launched Module 2 of the e-learning training programme. This module is aimed specifically at Complaints Officers and, using an interactive hypothetical scenario, takes them through the process of investigating a complaint from beginning to end. However, as with Module 1, this training is not yet mandatory for Complaints Officers.

Alongside training, it is just as important that Complaints Officers have sufficient resources and opportunity to perform their role. This includes having the time to properly investigate and respond to a complaint. When visiting the selected hospitals and CHOs my Office found that not all Complaints Officers worked solely on complaints but instead combined this role with others such as responding to parliamentary questions and Freedom of Information requests. While I accept that it may not always be feasible within an organisation for one person's time to be devoted solely to handling complaints, nevertheless consideration must be given to the primacy and importance of the complaints-handling role when allocating tasks and responsibilities.

Legislation

Two of my recommendations in respect of the complaints process were directed towards the Department of Health as follows –

- Consideration should be given to amending the statutory complaints process (and the remit of the Ombudsman) to allow for the inclusion of clinical judgement
- A full review of the Health Act 2004 (Complaints) Regulations 2006 should be undertaken

As part of the development and review of policy in this area, the Department (through NPSO) is undertaking a review of the Health Act 2004 (Complaints) Regulations 2006 with a view to enhancing the statutory provisions for the management of complaints. This includes a review of relevant national and international legislation and consultation with service users, organisations and health service staff to help inform policy in this area. It also includes consideration of the clinical judgement exclusion.

In May 2017 (and repeated again in May 2018), NPSO launched the first National Patient Experience Survey in collaboration with HIQA and the HSE. This was a nationwide survey which asked patients to tell public hospitals about their experiences while in hospital. The survey was issued to all adult patients discharged during the month of May and the responses are confidential. It is an important tool to allow hospitals to monitor their performance and to plan and implement changes where necessary.

Some changes that have been or are being implemented as a result of the survey include:

- Clearer information for patients who are to be admitted to hospital or are discharged home from hospital
- Monitoring of the quality and nutritional value of the food at meal times
- Provision of more substantial snacks on the night time tea round
- Provision of a leaflet on aftercare for wounds following discharge

Chapter Three: Response

In Learning to Get Better, I made two recommendations in relation to responding to a complaint. The objective of these recommendations was to ensure that complainants were provided with full and proper responses to their complaint.

Responding to the complainant

It is a key part of any complaints process that the outcome of any examination of a complaint must be conveyed to the complainant in clear and understandable language. Every issue raised in the complaint should be fully addressed in the response. The complainant should also be told of any proposed changes to be made to practices and procedures as a result of the complaint. These key principles were reflected in my recommendations.

In the majority of the hospitals and CHOs visited as part of this follow-up investigation, I am pleased to note that the focus appears to be on issuing one response, even if the complaint was about a number of areas (or concerned some clinical matters). This approach allows for a comprehensive and co-ordinated reply to the complainants and ensures that every element of the complaint is addressed at the same time.

In addition, and as part of the revised training for Complaints and Review Officers, the HSE has developed guidance outlining the key elements that a response to a complaint should contain. These elements include a summary of the complaint, the complaint examination process, findings and recommendations.

As mentioned previously, my Office conducted a review of complaints received since 2015. This review showed that many of the responses to complaints were well-drafted, empathetic and, in some cases (and in line with the revised guidance) clearly outlined the steps taken as part of the examination of the complaint. However, unfortunately the review also showed that there is still a tendency on the part of the health services to adopt a defensive attitude and shy away from providing a proper explanation for what went wrong – in one case more details were provided to the complainant’s private insurer provider as to what happened than to the complainant.

Unfortunately, the review also showed a tendency on the part of the Complaints Officer to simply reiterate the treating clinician’s point of view. While I would of course expect the Complaints Officer to get an account of events from the person involved, the Complaints Officer’s response should not rely solely on this account. This is of particular importance when a Complaints Officer is presented with conflicting evidence and does not have an objective basis to favour one version of events over another.

In addition, while the review highlighted one case where the Complaints Officer offered to share the quality and improvement plan with the complainant, overall the review showed that there is still a reluctance to detail any learning or follow-up as a result of the complaint. Instead there remains a reliance on broad assurances that learning will be shared or vague statements such as “actions have been implemented”. In view of the fact that (as found in *Learning to Get Better*) one of the main reasons people are reluctant to complain in the first place is because it is seen as a waste of time with nothing

changing as a result, this is unfortunate. Complainants should receive more than bland assurances that changes have been or will be made. Instead, they should, where possible, be informed of what those changes are.

My Office's review of our complaints also showed that, in some cases, the responses which issued from the hospital or CHO did not always address all the issues raised and even, in some cases, were confusing. For example, in one case, the complainant received two different responses from two different Complaints Officers on the same issue – only in one of these responses was the agreed HSE template used. In another case, the complainant received a letter from the treating clinician who attempted to address her complaint and apologise. However, this letter was not on headed paper and arrived without warning and without any indication of the involvement of the Complaints Officer.

I think it is important to also note that, while this was not the subject of a specific Ombudsman recommendation, unfortunately, delay in responding to the complainant remains a marked feature of the complaint-handling process within the health service. Under Your Service Your Say, there are clear timelines for acknowledging and responding to a complaint – the examination of a complaint should be concluded within 30 working days and, if that is not possible, the complainant should be provided with an update every 20 working days. Likewise, if a complaint is referred for review, this should be completed within 20 working days.

While I completely accept that it is not always possible to complete the examination of a complaint within these timescales (and particularly having regard to the complexity of some health service complaints), nevertheless the review revealed that some complainants have to wait months if not years for a response. In one complaint examined by my Office, the complainant waited nearly 3 years for a response while, in another, receipt of the complaint was acknowledged by the HSE almost immediately but the examination did not begin for a further 9 months with the complainant receiving no update in the meantime. Another complainant to this Office waited over 14 months for her complaint about a catering issue to be responded to.

In yet another case, the complaint was passed to three different people (none of them being a designated Complaints Officer) before it was examined. The response to the complaint was then not issued by the hospital for another few months as the person dealing with the complaint had “no time to respond” in the meantime.

None of these examples point to an acceptable practice in responding to complaints. It is imperative that the process and timelines for responding to complaints, as set out in Your Service Your Say is followed as closely as possible and that, if a response is delayed, the complainant is provided with regular updates about this.

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Auditing complaints – RCSI Hospital Group

Recommendation 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.

How a hospital or health service handles and responds to a complaint is a key indicator as to how seriously the hospital has taken the complaint in the first place. It is therefore vital that the complaints process is monitored and audited on a regular basis.

The Quality and Safety Directorate of the RCSI Hospital Group has completed an audit of 10% of patient complaints across the hospital group. This audit considered issues such as whether the complaint had been acknowledged and responded to in a timely manner, whether the response issued in plain English and without unnecessary medical jargon, whether the response addressed all of the issues raised by the complainant and whether any appropriate learning was identified.

Redress

Any redress offered must be realistic, achievable and, where possible, should seek to ensure that the problem is addressed. The revised Your Service Your Say policy provides that it is the policy of the HSE to offer redress as part of the management of feedback. In this regard, the HSE views redress as a commitment to acknowledge, apologise and explain when things go wrong and to put things right quickly and effectively.

However, in 2015, I recommended that each Hospital Group (and by extension CHO) should develop a standardised policy on redress. To date, and while some hospitals now have policies in place regarding issues such as reimbursement for lost property items, I have seen little evidence that detailed policies on wider redress have been developed.

That said, since 2015, and, in particular since the roll-out of nationwide open disclosure training, the HSE has developed clear guidelines and tips on how to make a meaningful apology when warranted. Guidance on how to deliver an apology is now available on the HSE website and this guidance also refers to the Ombudsman's Guide to a Meaningful Apology. It is also noticeable (from my Office's review of complaints) that good apologies are now a feature of a high number of responses to complaints. In many of these complaints, face to face meetings with the relevant clinicians and nursing staff were also freely offered (with some hospitals even providing specific training to staff as to how to approach such meetings). If approached in an open and honest way, these meetings can be an effective way to resolve complaints to the satisfaction of everyone involved.



LEARNING TO GET BETTER: PROGRESS REPORT
A report on the progress made following the Ombudsman's investigation into how public hospitals handle complaints

Chapter Four: Leadership and Learning

Eight of my recommendations in Learning to Get Better addressed leadership and learning within the complaints process. These recommendations sought to ensure that a positive culture towards receiving feedback is embedded within the organisation and, where system improvements are identified, that these will be implemented.

Role of Senior Management

Senior management within the health service play a key role in the implementation of an effective complaints process. My Office's visits to selected hospitals and CHOs found that, in line with my recommendations, senior management received reports on complaints (and, in particular the narrative within complaints) on a regular basis. More value is also being attached to complaints as a useful source of information about the quality of the service as a whole. As a result, my Office has found that complaints (including any follow-up required) are increasingly a standing item on management meetings with time allocated to listening to patient stories (both good and bad) and to discussing quality and safety issues. In addition, within some Hospital Groups, anonymised complaints are shared at senior management level. However, in saying that, it remains unclear as to how senior management satisfy themselves that measures have been put in place to ensure that the same issues and failings do not arise again.

In *Learning to Get Better*, I also emphasised the importance of senior members of staff assuming an active and visible leadership role in the complaints process and made a recommendation to that effect. Over the past few months, my Office has met with a number of senior staff (including hospital Chief Executives and Directors of Nursing) from across the Hospital Groups and CHOs who do indeed play an active role within the complaints process – for example by meeting with the Complaints Officers on a regular basis, providing additional resources when needed and helping to resolve more complex complaints (including getting timely responses from staff involved in a complaint). In addition, in at least one hospital visited as part of this investigation, the Complaints Officer reports directly to the Director of Nursing. These are all welcome developments – credible support from management can only help to promote a positive culture for welcoming all feedback.

I also recommended that senior managers should foster and encourage positive attitudes towards welcoming complaints. As documented in *Learning to Get Better*, the fear of a negative impact on care or even retribution has stopped people from complaining in the past. Senior managers therefore have an important leadership role in ensuring that this does not happen and instead should help complainants to believe that it is safe to communicate their concerns. The involvement of management in the complaints process (and in sharing both the positive and negative experiences) is not only an

encouraging step in this regard but also in promoting a cultural shift where learning from complaints can drive (and are seen to drive) improvements.

Within the HSE itself, the National Complaints Governance and Learning Team (NCGLT) has been established. The NCGLT's role is to support and provide governance and assurance on the delivery of the HSE's commitment to improve its feedback processes. Some of the projects which the NCGLT has been involved in include the development of the revised Your Service Your Say policy and a guidance document for clinical staff involved in the investigation of a complaint. It has also developed Complaints Officer and Review Officer training and is actively engaged in research with academic partners (and in collaboration with the Health Research Board) on how to improve the complaints process.

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Taking feedback seriously – the Mater Hospital

Recommendation 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.

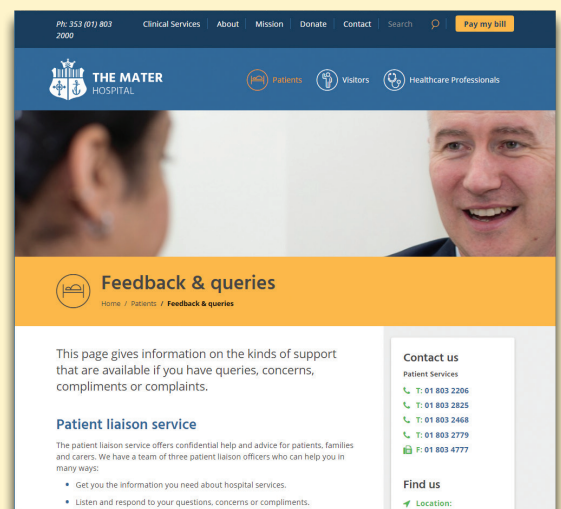
Perhaps one of the most striking findings in Learning to Get Better concerned the reasons why people don't want to complain about the health service. Fear of repercussions for themselves or their relatives was highlighted as a major concern.

It is vital that patients and their families should be made to feel confident and safe about making a complaint. Unfortunately, in 2015 I found that few hospitals had made concerted efforts to reassure them of the importance of their feedback.

On its website, the Mater Hospital now provides detailed information on how to make a complaint. However, just as importantly, it also includes a clear statement on the value of making a complaint and addresses the, for some, very real fear of what might happen when a complaint is made:

“Will raising a concern affect your (or your relative’s) care:

Some people can be worried about raising a concern or complaint about their care or the care of someone else close to them. Please don't be. We want to provide the safest, highest quality of care. Your feedback will help us to keep improving.”



Learning from Complaints

Many who complain do so not to punish but rather to try and ensure that others will not have the same experience they had. This is particularly true for the health service where a significant number of complainants want the system and the people working within it to learn and benefit from their experiences. Learning from complaints is therefore just as important as any other part of the process. It was in this context that I made a recommendation that a standardised learning implementation plan be developed in respect of each complaint where recommendations are made. This action plan should set out the action required, the person(s) responsible for implementing the action and the timescale.

From my Office's visits to hospitals and CHOs, it is clear that there is now a greater focus on learning from complaints. A number of hospitals visited publicise learning notices (examples of learning from complaints) within the hospital and all were able to refer to examples of changes made as a result of complaints. For example, one hospital referred to the introduction of notice boards on the wards which gives information to patients and families about meal times, medication times, colours of staff uniforms for identification purposes, etc. This was brought about as a result of patient complaints and feedback. The increased focus on learning is a positive development and a move away from seeing each complaint as an isolated incident. Related to this is a more open attitude and an increased focus on listening to patients and, in some cases, even including patients in changes being made or implemented as a result of feedback.

However, unfortunately, the development of learning implementation plans is still at a fairly early stage in many areas. Many of the hospitals and CHOs visited reported that it was still quite difficult to track recommendations arising from a complaint in order to ensure that they are implemented as intended. As a result, there is still a very clear danger (and as evidenced in my Office's review of complaints) that once the response to the complainant has issued, any follow-up (and therefore learning) tends to be forgotten about. This is not only often frustrating for the complainant who may never know whether their complaint led to service improvements but also for the service itself which misses the opportunity to fully learn from complaints but instead risks repeating the same mistakes.

Sharing the learning

In *Learning to Get Better*, I found that the health service provided few opportunities to share the learning. As a result, I recommended that a formal network of Complaints Officers should be established to ensure that best practice and learning is shared.

Since then, the HSE has established a National Complaints Managers Governance and Learning Forum which includes representatives from all the Hospital Groups and the CHOs. This Forum meets on a quarterly basis. It also appears that, as anticipated in 2015, the new structures and, in particular, the establishment of the Hospital Groups have provided some new opportunities for communication and sharing. For example, most if not all of the Hospital Groups and CHOs have a Director of Quality and Safety as well as Quality and Safety Committees which monitor developments and initiatives across the Group as a whole and allow for the sharing of anonymised patient stories. A number of Hospital Groups are also in the process of setting up complaints management networks within the Group.

However, that being said, there does not appear to be any similar established arrangement or mechanism across the Hospital Groups to share the learning – in other words one Group sharing learning with another. In most cases, the hospitals and CHOs reported that there is no such formal network although my Office has learnt about an informal network involving Complaints Officers from the larger Dublin hospitals. This was apparently established on the initiative of a Complaints Officer working in one of the hospitals.

I also recommended that complaints received and dealt with should be publicised via the development of a casebook. This would be a very useful way of outlining recent complaints and, more importantly, the learning that resulted from them. A template for these casebooks has been developed by the HSE and it is intended that these will be compiled (by Complaints Officers) on a quarterly basis and then published. However, so far, no Hospital Group or CHO has published a casebook.

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Sharing the learning from complaints – University Hospital Limerick

Recommendation 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.

An important hallmark of a good and effective complaints process is that there is capacity to bring about service improvement and learning as a result. It is also important that this learning is shared.

Unfortunately, the HSE and Hospital Groups have not yet produced a casebook as recommended in Learning to Get Better. However, in University Hospital Limerick, learning notices are produced and shared amongst staff on a regular basis. These notices outline any learning and improvements that have taken place as a result of a complaint. They can be found on staff notice boards throughout the hospital and in other visible areas such as the canteen.

In addition, the hospital has developed a practice of presenting three positive and three negative “patient stories” at each hospital board meeting.

Appendix One

The seven Hospital Groups are:

Ireland East Hospital Group

- The Mater Misericordiae University Hospital Dublin
- St Vincent's University Hospital Dublin
- Midland Regional Hospital Mullingar
- St Luke's General Hospital, Kilkenny
- Wexford General Hospital
- Our Lady's Hospital, Navan
- St Columcille's Hospital Loughlinstown Dublin
- St Michael's Hospital, Dun Laoghaire
- Cappagh National Orthopaedic Hospital Dublin
- Royal Victoria Eye and Ear Hospital Dublin
- National Maternity Hospital Dublin

Academic Partner is University College Dublin (UCD)

RCSI Hospitals Group

- Beaumont Hospital Dublin
- Connolly Hospital Dublin
- Our Lady of Lourdes Hospital Drogheda
- Louth County Hospital Dundalk
- Cavan General Hospital
- Monaghan Hospital
- Rotunda Hospital Dublin

Academic Partner is the Royal College of Surgeons (RCSI) Dublin

Dublin Midlands Hospital Group

- St James' Hospital Dublin
- St Lukes Radiation Oncology Network
- The Adelaide & Meath Hospital (Tallaght Hospital) Dublin
- Midlands Regional Hospital Tullamore
- Naas General Hospital
- Midlands Regional Hospital Portlaoise
- The Coombe Women & Infant University Hospital Dublin

Academic Partner is Trinity College Dublin (TCD)

University Limerick Hospitals Group

- University Hospital Limerick
- University Maternity Hospital Limerick,
- Ennis Hospital,
- Nenagh Hospital,
- Croom Hospital

Academic partner is University of Limerick

South/South West Hospital Group

- Cork University Hospital/Cork University Maternity Hospital;
- University Hospital Waterford
- University Hospital Kerry
- Mercy University Hospital
- South Tipperary General Hospital
- South Infirmery Victoria University Hospital
- Bantry General Hospital
- Mallow General Hospital
- Lourdes Orthopaedic Hospital Kilcreene

Academic Partner is University College Cork (UCC)

Saolta Hospital Group

- University Hospital Galway and Merlin Park University Hospital
- Sligo Regional Hospital
- Letterkenny University Hospital
- Mayo General Hospital
- Portiuncula Hospital
- Roscommon County Hospital

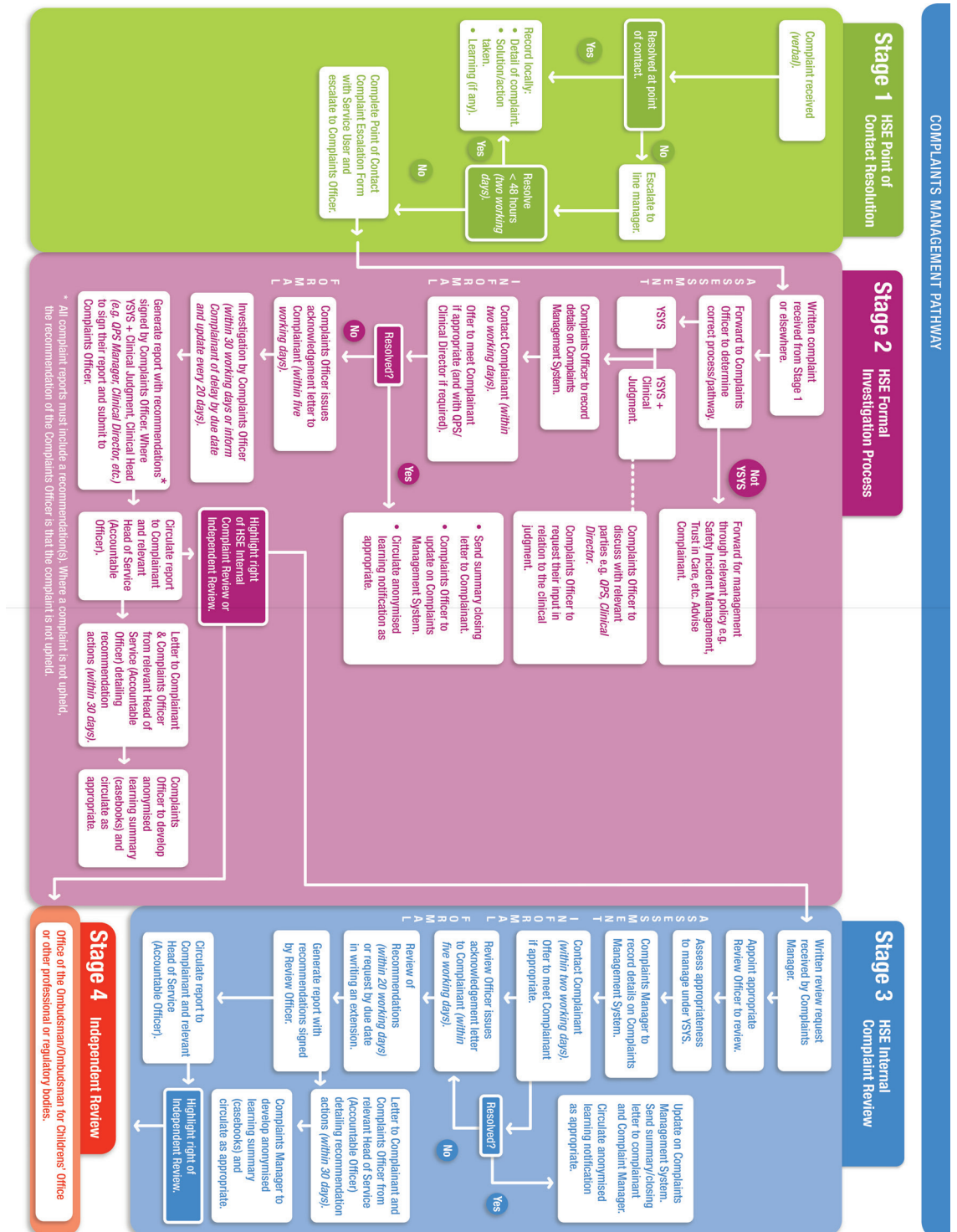
Academic partner is National University of Ireland Galway (NUIG)

Children's Hospital Group

- Our Lady's Children's Hospital, Crumlin
- Temple Street Children's University Hospital
- National Children's Hospital Tallaght

Appendix Two

HSE 'Your Service Your Say' – Complaints Management Pathway





Ombudsman

2018 Office of the Ombudsman

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