Quarter 2 2017 / 2018 complaint summaries					
Case Summary Number	**Date complaint closed**	**Outcome**	**What happened?**	**What we found**	**Putting it right**
8	6 July 2017	Partially upheld	Patient not happy that they were not advised of a significant diagnosis in 2013; requesting second opinion and review of this and their more recent test results.	Following consultant review, it was noted that the diagnosis was present, and that patient should have been informed at time.	Meeting was held with Consultant, and full review undertaken. Copies of scans and reports provided as requested. Apology given for miscommunication and distress caused, offer of further clinical consultations offered, and patient chose to be referred to a mainland provider for ongoing care and treatment.
9	6 July 2017	Upheld / Well founded	Concerns raised that when patient saw Doctor in Fracture Clinic and requested an MRI scan Doctor said this was not necessary as the symptoms were simply that of osteoarthritis. Patient had a private MRI which showed they had a torn meniscal cartilage.	Found that whilst the tear was not diagnosed at the time, as it was not clinically evident, it was not excluded. Plan was to follow up if symptoms persisted with further imaging.	Explanations provided. Assurance given that MRI was not withheld due to financial reasons, and was based on clinical decisions. Apology given that the patient had suffered a tear to the meniscal cartilage which was identified on private imaging.
10	7 July 2017	Partially upheld	Concern raised regarding surgical procedure and feels they were discharged too soon. Felt there was a lack up of follow post-surgery, over reliance on patient / family to chase tests and results.	Trust identified that the surgery was the correct choice for patient symptoms and that that they were safe to be discharged. Appropriate tests were carried out in line with the patients presenting symptoms. There was a failure to	All questions posed were answered, and apologies and condolences were given on the loss of patient. Further meetings have been held with the family, and following further investigations it was recognised that there may have been some failings in communications between the Trust and Specialists MDT. Further investigations under the Serious Incident Process requested. Family made aware.

			No referral to Oncology	communicate the results in a timely way.	
11	7 July 2017	Partially upheld	Consultant was unfriendly, and rude. Consultant had a poor attitude and made patient feel as they were a liar and wasting the doctor's time.	There was misunderstanding regarding the appropriateness of the referral to the Consultant, and that the Consultant appeared to have not reviewed x-ray results.	A full apology was provided by the Consultant and that they did not intend to come across in this manner. Explanation regarding the referral and review of results was provided. The Chief Executive advised that the Consultant will continue to be monitored via the Consultant Appraisal Programme.
12	28 July 2017	Partially upheld	Patient concerned that an injection was not undertaken as scheduled and following the administration of pre-procedure drops they were left waiting and forgotten.	Patient was not due an injection, and the drops were to enable a clearer scan to be undertaken. It was identified the patient was incorrectly sent to the waiting room, when they should have been allowed home from clinic.	Full explanation of the treatment plan given, and of the error that occurred on the day in question. Apology given for the unnecessary waiting. Assurance given that the appointment was necessary for the condition suffered, and that ongoing treatment will continue. Contact given for senior nurse to support ongoing pathway plan. Doctor reminded not to send patients to waiting room once consultation has ended.
13	8 August 2016	Upheld / well founded	Patient attended the Emergency Department with a cut hand. Patient's wound was dressed and patient sent home. On seeing Consultant 4/5 weeks later, patient was told they had severed the tendon.	Diagnosis was missed. Patient should have been offered a follow up appointment and told to come back if no improvement within 5 days	Local resolution meeting held. Apology and explanation given regarding the missed diagnosis. Advised that junior doctors have been informed of the management of hand injuries during their rotation in ED.
14	9 August 2017	Upheld / well founded	Attended ED after falling from scaffold. X-rayed and sent home with a sprained ankle.	Fracture was missed.	Meeting held with Emergency Department Consultant and Sister to discuss the complaint and address all issues. The service advised that they do monitor missed fractures and work with staff to ensure that they keep

			Came back to ED as still in pain to find out ankle was broken.		such incidents to a minimum. ENP involved is being monitored and their practice is being observed. Complainant was thankful for honesty and being given the opportunity to meet.
14	18 August 2017	Partially upheld	Issues raised regarding inappropriate referral to police and social services following attendance at ED with patient, and the subsequent length of admission.	It was identified that the appropriate protocols were not followed in ED which had they have been would have resulted in less distress. The Trust acknowledged that there was miscommunication regarding length of stay and that the family should have been fully informed.	Apology provided for the miscommunication and delays in following processes and undertaking the x-rays. Explanation of processes provided. Assurance given regarding the clinical presentation. Offer of meeting extended to discuss further if required.
15	21 August 2017	Partially upheld	Critical of management of patient with dementia on surgical ward.	It was found that the clinical decision regarding the surgical management of patient's clinical condition was in patient's best interests. It was recognised that there was a failure to administer medication and liaise with Dementia services to ensure that patient has continuity of care and treatment.	Explanations were given regarding surgical management, and an apology that this was not communicated clearly. Advised all action was taken in patients best interests. Actions have been taken to maintain continuity of patients dementia care during hospital stay, and staff have been reminded and provided further training to ensure this happens. Complaint shared with the Dementia Nurses to ensure lessons are learnt.
16	17 August 2017	Partially upheld	Patient not happy with the lack of care and monitoring provided. Felt there was a lack of support and information by the	It was recognised during the investigation that there were lessons to be learnt around the provision of information, second opinion options, and communication that could	A full and thorough investigation was undertaken, and whilst it was felt the management was appropriate there were lessons to be learnt around second opinions, and the communication / provision of information. There were also aftercare issues that needed to be improved. A productive meeting has been held with service, and

			consultant and failures to deal with the situation sensitively.	have been improved during the care and treatment.	links made with voluntary sector to help the Trust improve care in this area going forward. Complainant is fully engaged in this work for which the Trust is extremely grateful.