

Quarter 3 2017 / 2018 complaint summaries					
Case Summary Number	Date complaint closed	Outcome	What happened?	What we found	Putting it right
17	20 October 2017	Partially upheld	Concerned that student sonographer kept getting details wrong. The sonographer was not able to complete each scan they tried. Alleges that this has caused undue stress to 2 first time parents.	Although the complainant had consented to the scans by a student, the reassurance that was given by a trained sonographer was not as effective as it could have been and information may not have been clearly communicated/	All future scans undertaken by trained sonographer. Full response given and answers to individual questions provided. Apology provided for miscommunication. Actions taken to ensure that all patients know that a student will complete scan, and if they are not happy to flag this to the trained staff. Advised of actions being taken to improve the experience for parents, including overhead monitors so that parents can watch from the beginning of the scan.
18	24 October 2017	Partially upheld	Raised concern that only half the boxes of medication ordered from Pharmacy arrived. Believed the pharmacist took away their asthma inhaler and it took 3 days for heart medication to arrive.	Normal medication regime was altered in hospital, and over the weekend of admission due to capacity there was a delay in the Pharmacy team checking medications and there was a delay in discussing the medication prescription with the doctor. There was an oversight in prescribing two medications causing a delay. Whilst the Pharmacy team did their best to ensure medications were prescribed it was recognised there was a delay.	Full explanation of Trust processes given. Apology for the delay, and lack of explanation provided at the time. Complaint shared with staff to ensure that they are careful when prescribing medication. Ward to review the routine medication stock list to ensure important medication is held as stock.
19	1 November 2017	Partially upheld	Complainant came in to have blood taken,	During the investigation the Trust found that the	Meeting held with Head of Nursing and Quality, and had of service and phlebotomy supervisor. Experience will be

			<p>explained to the Phlebotomist they were on warfarin. The Haematologist carried on trying to take blood causing the complainant pain and leaving them badly bruised.</p>	<p>phlebotomist who took the blood was not aware of the pain being caused, and that her 'light hearted' comment was unprofessional and ill judged. No other issues had been raised regarding the staff's practice before.</p>	<p>discussed staff member to ensure lessons are learnt, review of practice and further training provided. Full apology given and recognition that the extent of bruising was larger than usual.</p>
20	10 November 2017	Partially upheld	<p>A number of concerns were raised about the care and treatment under the Gynaecology service for a patient with Cancer, including lack of support, poor communication and attitude of consultant.</p>	<p>The investigation identified that due to the rare cancer the patient had, the clinical pathway and tests required were complex and the patient deteriorated quicker than anticipated. It was recognised that improvements could have been made in communication, breaking bad news and providing MacMillan Support.</p>	<p>A full explanation was given and apology for the failings, Advised that recruitment has taken place to improve the support for patients with cancer. The training in advanced counselling courses for senior staff has been reviewed to ensure that staff are provided with appropriate training. A meeting with the Chief Executive to discuss further was offered.</p>
21	10 November 2017	Partially upheld	<p>Concerns raised that patient was discharged following operation with no equipment to help them manage at home and that further tests should have been carried out as inpatient. Concerned that another patient was racially abusing nurses and</p>	<p>It was found that the referral to the Occupational Therapy Team was not received. Other patient was on appropriate ward for clinical need. Identified that some medication was not given but that the rationale for this was not provided to patient.</p>	<p>Explanation and apology given for equipment not being available at time of discharge and for the distress caused. Acknowledged the distress caused by 'confused' patient, and assurance given that staff were trained and supported to manage the patients. Apology given for lack of communication around the medication issues.</p>

			being disruptive.		
22	4 December 2017	Partially upheld	Multiple concerns raised about care and treatment under the care of the surgical team, resulting in a poor discharge experience	The investigation found that the Trust did fail to discharge the patient safely, and recognised that communication could have been improved with the patient and family.	A full and open response was provided to the complainant and actions have been put in place to ensure lessons are learnt including reminding all medical staff of the need to introduce themselves to patients and abide by the Duty of Candour principles.
23	4 December 2017	Partially upheld	Issues raised regarding the cleanliness of the ward and main car park toilets. Claims that infection control principles were not adhered to during inpatient stay.	The investigation found that the cleanliness assistant had cleaned the room on the date in question. The main car park toilets are cleaned daily, and a sign off sheet for this has been checked to confirm it has been done. It was recognised that the toilets do see a high volume of traffic and are subject to vandalism at times.	Full explanation provided, and an apology if the cleanliness was not up to our expected standard. Full discussion has taken place with cleanliness assistant and the supervisor has spent to reiterating the correct procedures to be followed. Regular audits will continue to be undertaken and monitored on a monthly basis.