East Kent Hospitals University NHS
NHS Foundation Trust

Our Trust Values and Complaints

We will be regularly publishing case studies showing how our complaints procedure works and how issues and concerns raised by patients and their families have been resolved.

Putting patients first

Patient's Story
Mrs. A contacted the Trust concerning the care and treatment received by her late mother. Mrs. A was concerned that her mother had not received adequate nursing care towards the end of her life and that there was a lack of communication with her family at that time. Mrs. A felt that as a result of the Trust's actions her mother died alone and without the family being able to say goodbye.

Findings
The complaint was investigated by the Parliamentary and Health Service Ombudsman (PHSO) who found that the nurse looking after Mrs. A's mother had not carried out the required observations resulting in deterioration of the patient not being properly monitored. The PHSO also found that the Trust did not have a clear management plan in place resulting in a missed opportunity to treat Mrs. A's mother and subsequently a missed opportunity to alert Mrs. A and her family to her mother's deteriorating health.

Mrs A. and her family would like the attached statement to be included in the patient story:

'As a result of our mother not being given the care and attention she deserved by staff in Margate Hospital she died alone and without any of her seven children she struggled to bring up, a lot of the time on her own or any of her grandchildren being present to hold the hand of our beloved mother and tell her how much we loved her. The pain of how she must have been feeling at the time she passed alone will haunt all of us for the rest of our lives and we are all suffering considerable stress and upset because of this.

Hospital staff need to remember when dealing with elderly patients in their care that everybody is important to somebody and to remember that this could have been one of their loved ones'.

Learning and Actions

The Trust fully agreed with the findings of the PHSO and offered its sincere apologies to Mrs. A and her family.

The Trust took the complaint very seriously and put in place a number of actions to ensure that similar incidents did not occur in the future. These were:

- The Trust has a robust electronic system called VitalPac that provides patient observations electronically so that doctors and senior nurses are immediately informed of the deteriorating patient. Improvements to the system were undertaken which allows medical staff to request that a doctor attends a patient and after a five minute lapse then the staff member are prompted to bleep the doctor.
- All staff were reminded that they must adhere to the VitalPac observation regime and must not deviate unless the rationale is recorded in the clinical notes.
- Further training and support was provided to the nurse involved to ensure the nurse's clinical competencies and decision making were updated.
- The nurse in question has worked alongside the ITU outreach sister to look specifically at escalation and to go through scenarios similar to the patient.
- All staff were reminded of the importance of communication with families as to their relative's condition.

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Patient's Story

Miss. B contacted the Trust concerning the care and treatment received by her late grandmother while admitted to the Emergency Department.

Miss B's grandmother had been previously diagnosed by her GP with both bladder and chest infections and was suffering with back and stomach pain when admitted to hospital.

Miss. B complained that her grandmother was not properly assessed by the junior doctor and did not receive appropriate care and treatment.

Miss B's grandmother was discharged from hospital and died at home.

Findings

The complaint was investigated by the Parliamentary and Health Service Ombudsman (PHSO) who found that the junior doctor did not adequately assess Miss B's grandmother as he failed to carry out an examination of the patient's abdomen.

In addition, the nurses did not calculate an early warning score or put in place an appropriate management plan.

Learning and Actions

The Trust fully agreed with the findings of the PHSO and offered sincere apologies to Miss B.

The Trust took the complaint very seriously and put in place a number of actions to ensure that similar incidents did not occur in the future. These were:

- Action taken in discussion with junior doctor concerned in care.
- Development and training undertaken with nursing team to calculate early warning scores.
- The electronic system was updated to require an early warning score prior to printing the Casualty Card.
- A minimum standard of hourly observations for all patients in majors area, regardless of early warning score, was implemented in the Emergency Department.
- An improved observation chart incorporating scoring system was developed and implemented in the Emergency Department.
- The Induction pack and training for junior doctors was updated to highlight the importance of abdominal examinations for all patients aged 50 years and over presenting with back pain.
- Paid the sum of £500 to Miss B in recognition of the distress she experienced as a result of the service failings.

People feel **safe**, reassured and involved

Putting patients first

Patient's Story

Mr C's mother was admitted to hospital following a fall at home and it was clearly documented that his mother suffered from diabetes.

Mr C contacted the Trust concerning the Trust's failure to make adequate discharge arrangements for his mother including the necessary arrangements to ensure that his mother would be provided with insulin following her discharge.

Findings

The complaint was investigated by the Parliamentary and Health Service Ombudsman (PHSO) who found that Trust failed to treat the patients' blood sugar levels when found to be high and did not establish how she was given her insulin.

The Trust failed to refer to the patient's diabetes care plan while admitted to hospital or to put in place arrangements for the patient to be given insulin after she was discharged.

Learning and Actions

The Trust fully agreed with the findings of the PHSO and offered its sincere apologies to Mr C. The Trust took the complaint very seriously and put in place a number of actions to ensure that similar incidents did not occur in the future. These were:

- A more robust care pathway/referral system between primary and secondary care and a comprehensive handover sheet was implemented.
- A nurse consultant for the emergency floor was appointed who works with the medical and nursing teams to ensure pathways and protocols are fit for purpose.
- A permanent Diabetic Liaison Nurse has been employed at the hospital.
- A new protocol was introduced whereby all diabetics to have their blood sugar recorded within four hours prior to discharge.
- On-line training for blood glucose monitoring introduced within the Trust.
- Specific training for all grades of staff on CDU in addition to the on line training introduced and further "Think Glucose" training sessions provided.
- VitalPAc system (handheld computers) introduced which alert senior nurses/medical staff to abnormal results.
- Paid the sum of £2500 to Mr C in recognition of the injustice experienced by his mother as a result of the service failings.