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 complained to the Trust that a muscle rupture was not diagnosed sooner and that steroid injections received contributed to soft tissue degeneration. Mrs A complained that she was in constant pain, had poor mobility and that her care and treatment had impacted on her quality of life.

Findings
The complaint was investigated by the Parliamentary and Health Service Ombudsman (PHSO) who partly upheld the complaint. The PHSO held that Mrs A's muscle rupture should have been diagnosed and repaired sooner and that this left her in pain for longer than necessary. It was found that the MRI investigations should have identified the injury significantly earlier. However, they found no compelling evidence to suggest that steroid injections caused any soft tissue degeneration or that the delay in diagnosing the tear was the direct cause of the patient's on-going pain and subsequent problems.

Learning and Actions
The Trust fully agreed with the findings of the PHSO and offered sincere apologies to Mrs A. 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 wrote to Mrs A to offer its sincere apologies for the failings identified by the PHSO with regards to not diagnosing her injury following the MRI scan and subsequently not offering surgery at an earlier date which would have reduced the amount of pain, discomfort and depression that she experienced as a result.
- The PHSO asked the Trust to take action to ensure that the failings identified did not occur in the future. The Trust ensured that a formal discussion at the Radiology Errors and Complications Meeting took place in order for group learning to take place. The Matron for Radiology led the case discussion. Both MRI scans were reported and discussed by the Consultants in attendance. It was noted that both scans showed around the greater trochanter and thought to be trochanteric bursitis with surrounding soft tissue swelling. In retrospect, the gluteus medius tendon appeared a little thinner on the right than the left and the muscle itself was showing some atrophy. These signs are like to be due to a partial tear. All agreed that this was quite a difficult diagnosis to make and was more an error of interpretation for the second scan and would be noted for future cases.
- The Trust paid the sum of £1500 to Mrs A in recognition of the distress she experienced as a result of the service failings.

Patient's Story
Mrs B contacted the Trust concerning the care and treatment received by her aunt in 2012. Mrs B was concerned that the Trust had failed to investigate her aunt's mental health problems and to diagnose her dementia. Mrs B also complained about poor communication between medical and nursing staff about her aunt's care, particularly around discharge planning and a failure to find her an appropriate intermediate care bed or to identify an appropriate care home. Mrs B was also unhappy with how the Trust handled her complaint, specifically in that it had taken so long to be resolved.

Findings
Due to the difficulties in getting the complaint resolved Mrs B felt that she had exhausted all other options leaving her only one left and that was to contact the Parliamentary and Health Ombudsman (PHSO). The complaint was sent to be investigated by the PHSO who found that the Trust failed to provide a reasonable level of service with regards to the care the patient received from the Trust in 2012, particularly in relation to:

1. Investigation, diagnosis and treatment of the patient's mental health.
2. Communication from the medical staff with the family and the quality of record keeping.
3. Communication with the family from the nursing staff and poor discharge documentation.
4. Handling of the complaint by the Trust.

The PHSO did not find any failings by medical staff with respect to a diagnosis of dementia or referral for a CT scan or in respect to a decision to maintain intravenous antibiotic administration although they did find there was a lack of communication about this.

Learning and Actions
The Trust fully agreed with the findings of the PHSO and offered its sincere apologies to Mrs B 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:

- There is a Orthogeriatric Consultant led Multidisciplinary Team (MDT) meeting once every week on both Orthopaedic Wards at the Queen Elizabeth the Queen Mother Hospital where there is a holistic assessment of patients and individual patient action plans are made which include plans ~~to~~ for communication with patients and their next of kin

- The Consultant in Trauma and Orthopaedics offered his apologies to Mrs B surrounding communication from the Orthopaedic team. The Consultant now makes a point of talking to relatives during a patient's stay to introduce himself and address any questions or concerns that they may have at this stage.

Regarding poor communication on the ward, the following actions have been taken:

- The nurse in charge of the patient and the ward based discharge co-ordinator now meet with the Physiotherapist and Occupational Therapist based on the ward daily in order to discuss patient progress and discharge plans.
- The need for ICT beds, placement or enablement packages is now discussed at the daily meeting and following those decisions the therapy team complete the Discharge Referral. Nursing staff complete the supplementary information needed for this. This is updated daily in the handover sheet so that all nursing staff have access to updated information.
- The Ward now has a privacy room to facilitate meetings and discussion with family members.
- There are notices around the ward and at the entrance inviting patients' next of kin to book a meeting to discuss progress and discharge planning with members of the team. These meetings are available four days per week between 2pm and 3pm.
- Apologies have been offered for substantial failures in the complaints handling. Since the completion of this complaint there have been significant changes to the Patient Experience Team (PET) and the manner in which complaints are handled. Particular members of PET are allocated to particular Divisions to ensure constant communication and weekly reports are created to identify which cases are not on target and need extra input. When a complaint is made to the Trust there is now a rigorous triaging process and training is now supplied to staff members regarding how to handle initial concerns and also how to create written responses.
- The Trust paid the sum of £1000 to Mrs B in recognition of the distress she and her immediate family and her aunt experienced as a result of the service failings.

Patient's Story

Miss C complained about the care and treatment she received from 2003 to 2012 and in particular that the Trust failed to diagnose her multiple sclerosis (MS). Miss C complained that she had presented with symptoms such as optic neuritis and saddle anesthesia over the years and this should have led to an earlier diagnosis of MS and that the Trust did not follow NICE Guidelines. Miss C stated that if she had been diagnosed earlier she would have acted differently and pursued other employment opportunities and not taken out a loan.

Findings

The complaint was investigated by the Parliamentary and Health Service Ombudsman (PHSO) who partly upheld the complaint. The PHSO found that the Trust failed to provide a reasonable level of service with regards to the care the patient received, particularly in relation to:

- Not discussing Miss C's diagnosis of optic neuritis with her and referring her to a neurologist in 2005 as required under NICE Guidelines
- Not answering Miss C's specific question regarding NICE Guidelines or any acknowledgement that the guidelines had been followed
- Further tests were warranted but not carried out in 2009 and it is likely that had Miss C seen a neurologist at that time, the diagnosis of MS is likely to have been made sooner

The PHSO did not find any evidence of service failure with regards to orthopedic attendances; Miss C had complained that she had attended the orthopedic department in 2006 with symptoms of temporary saddle anesthesia and right foot drop and that these symptoms should have added to her clinical picture and given an earlier diagnosis of MS. The PHSO held that Miss C's odd neurological symptoms were part of inflammation of the central nervous system and he would not have expected further investigations to be carried out by the orthopedic team.

The PHSO agreed that there was no clear evidence that the disease modifying treatment for relapsing remitted MS would delay the onset of secondary progressive MS or that any earlier treatment would have made any difference to Miss C's outcome or symptoms. However, the PHSO held that Miss C lost opportunities to make informed choices with regards to financial planning and employment.

Learning and Actions

The Trust fully agreed with the findings of the PHSO. 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 sent a formal letter of apology to Miss C for the failings identified by the Ombudsman with regards to missed opportunities to diagnose her MS earlier and for the distress caused to Miss C as a result of this. The Trust also apologised that the Trust's previous responses to Miss C's concerns failed to answer her specific questions regarding NICE guidance and for the frustration that this caused Miss C
- The PHSO recommended that the Trust explained how it will ensure that patients with optic neuritis will be appropriately informed of their diagnosis and referred to a neurologist. As such, Miss C's case history and findings by the PHSO were presented in the Ophthalmology Audit Meeting by one of the Surgical Division Governance, Patient Safety and Quality Managers on 17 July 2015. This is a meeting which is attended by the Ophthalmic Medical and Nursing staff. During the presentation, the NICE guidance and adherence to this was discussed and the presentation containing the guidance circulated to the medical staff. All staff were also reminded of the importance of discussing a patients diagnosis with them and ensuring that a referral is made to a neurologist where required.
- The Trust paid the sum of £1500 to Miss C in recognition of the distress she experienced as a result of the service failings.