CONFIDENTIAL

SOMERSET PARTNERSHIP NHS FOUNDATION TRUST

MONTHLY COMPLAINTS REPORT FOR HEADS OF DIVISION – APRIL 2014

1. PURPOSE

1.1. The purpose of the report is to provide the Heads of Division with a summary of the complaints received during April 2014.

2. NUMBER OF COMPLAINTS

2.1 During the month of April 2014 there were **fourteen** complaints received in total and these are detailed below by division.

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
BRIDGWATER AND NORTH SEDGEMOOR DIVISION						
Bridgwater Community Hospital - Outpatients	Patient	• Several appointments for outpatient clinics at Bridgwater Community Hospital have been cancelled and re-scheduled, but you have not been informed, for example, by letter, of this (and so have arrived for appointments that have been cancelled); • The original appointment has been cancelled and re-scheduled on so many occasions that there has now been a delay of over a year; and • A letter for an appointment in August 2014 did not mention that it would be at the new Bridgwater Hospital or give any information about this.	Upheld	The investigating officer explained that many of the outpatient services based at Bridgwater Community Hospital are provided by Taunton & Somerset NHS Foundation Trust (Musgrove Park Hospital). The Trust therefore contacted the outpatients Directorate Manager at Musgrove Park Hospital who has also undertaken an investigation into the concerns raised. The patient's original outpatient appointment was at Bridgwater Community Hospital for the clinic with Mr X's Registrar on 30 August 2013. Following this consultation a six month follow up appointment was requested and booked with the patient for 21 February 2014 by the Bridgwater staff and a letter was also sent to confirm this. On 13 January 2014 it was noted that unfortunately there was no doctor available to undertake the clinic on 21 February 2014 and the appointment	**Very Low**	Q1-14-01

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				was rescheduled by Bridgwater Community Hospital to 21 March 2014. The records show that a letter was sent to the patient confirming this change, however we sincerely apologise if the patient did not receive this letter. Unfortunately the appointment on 21 March 2014 also had to be rescheduled as again there was no doctor available. This appointment was rescheduled by Musgrove Park Hospital to 16 May 2014. Neither Bridgwater nor Musgrove Park Hospital have any record of a letter being sent to inform the patient of this change and we sincerely apologise for this oversight. However, as the patient was unaware of the cancellation, she attended the appointment on 21 March 2014. Fortunately Mr X was able to see the patient that day and provided the treatment required. The Trust understands that the patient was discharged from the clinic in March 2014 as she was moving before her next planned appointment would have been due. Mr X has noted that he advised the patient to contact her new GP to arrange a further follow up appointment. Unfortunately the outcome from this appointment was not clearly communicated to the Appointments Booking Team at Musgrove Park Hospital and the patient's appointment for 16 May 2014 was still live on the computer system. Mr X had noted in the medical notes that the patient was moving out of the area and needed to be discharged from his clinic but this information was not recorded on the usual outcome slip following an appointment, so the booking clerk did not pick this information up and discharge the patient from		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				the clinic. Unfortunately two further changes were then made to this appointment by Musgrove Park Hospital - one because there was no doctor available and the other the clinic date was changed - but the patient only received one letter in respect of the final change, which rescheduled the appointment for 22 August 2014. The Trust would like to apologise that the letter informing of the appointment in August 2014 did not mention that it is in the new Bridgwater Community Hospital or give any information about this. The computer system that generates letters is only able to give one address for Bridgwater Community Hospital, as some appointments are still at the old hospital and some at the new hospital. A leaflet explaining this and informing the patient of the date of the move should have been put in the envelope with the letter and we sincerely apologise that this did not happen. The Trust is extremely sorry for the confusion and upset that this has caused and would like to thank the patient for bringing these concerns to our attention as there are a number of learning points that have been highlighted within both organisations.		
Minor Injury Unit – Shepton Mallet	Parent	• After attending Shepton Mallet MIU following an accident holding your daughter in the bath, you were told that your daughter had a 'nasty tear' on her vagina and needed stitches at Yeovil District Hospital; upon examination following attendance	Partially Upheld	The investigation noted that the patient was booked into the Minor injury Unit at 6:07pm on 21 March 2014 and was seen by an Emergency Nurse Practitioner at 6:11pm. On examining the patient, the Nurse Practitioner could clearly visualise a wound and she noted in the contemporaneous record that she found a 1.5cm	**Low**	Q1-14-05

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
		and questioning at Yeovil District Hospital, you were informed she had a small, superficial tear that was nothing to worry about. This experience caused you a great deal of distress.		long wound from the labia towards the anus. There was no bleeding from the wound and, as she had just recently been in the bath, the nurse felt that no further cleaning was necessary at that point. It was the professional opinion of the nurse that the wound probably needed closure and sterile glue or butterfly stitches would not be appropriate and so she decided to take advice from the paediatric team at the acute general hospital. During this conversation, the paediatric team at the acute hospital requested that, due to the nature of the injury, the nurse make a referral to Children's Social Care. The nurse did this and then made arrangements for the patient to be seen at the acute hospital. The nurse reports that she informed both the complainant and her husband of why she had referred the patient to the paediatric team and also to Children's Social Care. She is very sorry if the complainant felt she had not informed them of any of the actions she had taken and is sorry that the delays caused to the complainant and for any added distress. In accordance with the 1989 Children Act, the Trust has a statutory responsibility to report any concerns regarding the welfare of a child. The Trust's Safeguarding Children Policy and Procedure reflects this statutory duty. Referral to Children's Social Care was the correct action in these circumstances. With regard to leaving the department, the nurse has no recollection at any time of stating that the complainant was not allowed to leave the department and she has no memory of the complainant asking if they could		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				leave. The Trust apologises if our communication at this time was unclear and for the distress that this caused. The complainant eventually left the Minor Injury Unit at 19.24pm with an appointment to see the Paediatric team at Yeovil. The Trust fully appreciates that this must have been a very anxious time for the complainant and we are sorry if we increased the levels of distress in any way by the way in which the wound was initially described - however on clinical findings made at the time of the patient's presentation the clinician made the correct decision in relation to the possible need for stitches and in asking for a second opinion.		
Older Adults Community Mental Health Team – Glanville House, Bridgwater	Patient	• At an appointment at Glanville House around March-April 2013, you requested testing for Alzheimer's/memory loss but this has not been done or followed up; • In November 2013 you requested CBT Therapy; you received a telephone call about this in December 2013/January 2014 and an interview at Glanville House around February 2014, followed by a telephone call on 8 April 2014, but have not heard from them since.	Not Upheld	The Trust is sorry that the patient's request for an Alzheimer's/short-term memory loss assessment has not been followed up, and that he has not been kept up to date on the progress that has been made with regards to psychological therapy. The staff who assessed the patient can confirm that they did not find any signs or symptoms of cognitive decline associated with Alzheimer's or other dementia. In the light of this, they did not conduct more specific cognitive function testing. We hope this is reassuring, however, if the patient is not adequately reassured by the initial opinion and would like a specific cognitive test this can be arranged. The Psychological Therapies service had offered an appointment on 20 May 2014 with the member of staff who had previously met the patient at his assessment appointment but we understand he did not attend this appointment	**Very Low**	Q1-14-11

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				and another was sent to him for 9 June 2014. The Trust has tried to contact the patient by phone but have been unsuccessful.		
Older Adults Community Mental Health Team – Glanville House, Bridgwater	Relative - Daughter	• You requested an assessment for your mother to move into a care home on 23 October 2013 but this was not done until 17 January 2014; • A care plan received on 25 November 2013 was inaccurate and did not mention your mother's incontinence, inability to eat meals, anxiety about being locked into her house and her paranoia (about people knocking on her windows); • You have still not received a correct and updated care plan; • Despite reassurance from B and A that forms regarding funding (that had been granted by panel) would be sent on 3 February 2014, you did not receive these until 31 March 2014; • Financial figures given to you on 19 February 2014 were inaccurate and did not mention that your mother had to make a £109.79 Resident Contribution; and • You were told on 19 February 2014 that a financial review would be held	Partially Upheld	The investigation found that the medical notes show there was a delay of six weeks before the Assessment of Needs took place. During the meeting with staff member, she explained that it had been difficult to arrange a date that everyone could meet. This delay was not acceptable and we apologise for the distress that this caused. An alternative Social Worker should have been requested and any significant delays should be brought to management attention as soon as possible. The care plan copied to the relative focused on the new role agreed by the ST&R worker. At interview, the staff member said she had not been made aware that the patient had any issues with incontinence and therefore did not include them in the care plan. The staff member updated the Core Assessments specific to the risks of living alone and anxiety in preparation for placement. It is agreed that Good Practice would require that a Care Plan should be in place to address these issues whilst placement was being sought. We apologise that this was not done and this will be taken as a learning point by the staff involved. We would like to apologise for the delay in the correct paperwork being sent out to you, this falls short of our own expectations and we recognise this added to the general frustration about delays and complicated payment of the placement costs. We would like to acknowledge	**Low**	Q1-14-13

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
		within 28 days to which you would be invited; you have heard nothing more.		the delay in completing the Placement Review and apologise for any distress this has caused. The outcome of this investigation concludes that the six week delay from 6 December 2013 when the patient had finally decided to seek permanent placement, and assessment of needs taking place on 17 January 2014, was unacceptable. The staff member has been advised that any significant delays in completing assessment should be raised with her line manager to avoid this happening in the future. There was key information missing on the Care Plan sent to the relative regarding risks at home. Whilst we acknowledge that the staff member had updated the Care Assessment, this information should have formed part of the Care Plan whilst the patient remained at home. The delay in correct financial paperwork being sent out also falls short of the Local Authority's expectations to assist people into Permanent Care. The placement process has been identified as an area for her further professional development for the staff member concerned. The Trust would like to thank the complainant for taking the time to put her concerns in writing and we would like to assure them that the outcome of this investigation will be used in our staff's development so that another person does not have the same experience.		
TAUNTON AND WEST SOMERSET DIVISION						

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
Pyrland Ward, Taunton	Relative - Daughter	• Following admission to Pyrland Ward under the Mental Health Act (from 24 February – 20 March 2014), you were concerned that robust tests and investigations were not carried out; • You felt your mother was discharged from Pyrland Ward without an appropriate care package in place; • You believe your mother was not well enough to be discharged from Pyrland Ward; and • You have not received proper support in your role as a carer for your mother.	Partially Upheld	The investigation has found by reviewing the patient's records that there is evidence that a variety of tests and investigations were carried out to ascertain the cause of the patient's deterioration in mental health and also to support nursing staff in the care given to the patient. There are also records of regular observations made by staff of the patient's behaviour, compliance and the levels of support she needed to maintain independence and regain good health. As the patient made a recovery from the way that she was behaving when she originally was admitted, further investigations were not felt to be required at the time. A package of care was arranged following the patient's discharge review by the Care Co-ordinator. This package of care consisted of home care visits four times a day to provide assistance and monitoring in relation to diet, hygiene, medication and laundry and this package was explained to the complainant at the discharge meeting. After reviewing the patient notes and discussing with staff involved in the discharge review meeting, it was evident that the patient had made a considerable recovery since admission to the point where she no longer required care in an acute mental health ward. By the time the patient was discharged, she had become independent in her care needs, compliant with medication and was much less acutely confused. Whilst it was acknowledged that the patient had some memory problems, it was considered that the main contributing factor to her recent deterioration had been a urinary tract	**Very Low**	Q1-14-07

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				infection that had occurred prior to admission and was treated by her GP. Subsequent tests showed no further evidence of infection. Following admission to the ward, all carers and relatives are invited to a family liaison meeting within seven days of admission to discuss concerns, expectations and possible support required. The Trust understands that, unfortunately, it was not possible for the complainant to attend the liaison meeting arranged on 3 March 2014. As a Trust, we do try to involve and support carers and family members wherever we can we are sorry that the complainant did not feel properly supported and involved with her mother's care. The Trust is sorry that the complainant's experience of our services has not met her expectations. We are aware that navigating through NHS Services can sometimes be difficult and we fully appreciate the concerns raised and take every opportunity to learn from patients' experience to ensure that we improve the services that we offer to our patients.		
Clinical Psychology	Patient	• You are concerned that you were discharged without any input from you, which you believe is contrary to what's advised in the NICE guidelines; and • You are concerned that only short-term therapy has been offered, which you believed is contrary to what is suggested in the NICE guidelines.	Partially Upheld	With regard to the concerns raised that the patient was discharged from the service without any input from them, the investigation found that during a formal review of the patient's care and treatment on 3 February 2014 it was planned that her need for psychotherapy would be reviewed following the Nursing & Midwifery Council hearing set to take place on 25 February 2014. However, in a telephone call with Dr C (19 February 2014) and email to Dr D (22 February 2014) the patient indicated her decision to see Dr E instead for	**Very Low**	Q1-14-08

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				therapy. Dr D sent a letter on 24 February 2014 stating that as the patient had chosen to seek counselling from another service and no longer required any further sessions she would be discharged from the Clinical Psychology Service. At this stage there was evidence that the patient was working collaboratively with the staff involved in her care towards discharge. In respect of the concern that the patient had only been offered short-term therapy and that this contradicted NICE Guidelines for Borderline Personality Disorder (BPD), the investigation found that there appeared to be common agreement between the patient and the staff involved in her care and treatment that she did not meet the specific diagnostic criteria for Emotionally Unstable Personality Disorder - Borderline Type but that there were some underlying significant traits, and she did not wish to pursue a specific NICE guideline recommended treatment for BPD. During her assessment sessions with Dr F between May 2013 and June 2013, various treatment options were explored including their respective benefits and limitations. The patient's preference was to pursue an integrative approach, which commenced in September 2013 with Dr D. Eight sessions were completed until a break in therapy was agreed on 3 December 2013. The focus of these sessions was to identify goals which appeared to periodically change and this seemed to be a response to the patient's uncertainty about therapy and changing needs. The Trust understands this has been a difficult		

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				time for the patient and it has been hard for her to identify and decide on the treatment she wanted and needed. The people involved in her care have promoted choice and been flexible in trying to meet her needs, and her involvement has generally been collaborative. The investigation showed that there was good communication between the patient and services. The reasons for discharge from the Clinical Psychology Service seem appropriate. The Trust is however sorry to find that the patient did not feel fully included in the process. We strive to work collaboratively towards discharge from services and transition between services, and we hope this has not caused too much distress or disruption in the patient's recovery. We always remind all appropriate staff of the importance of being as collaborative as possible in the planning and implementation of discharge and transitions between services.		
Williton Community Hospital	Partner	• That, while a patient at Williton Hospital at the end of January 2014, the patient began showing signs of a rash and was in a great deal of discomfort and distress for several weeks, but was not diagnosed with scabies until a GP appointment on 7 April 2014, which, by that time, had also passed to his partner; and • That the patient suffered from a urine infection while in Williton	Upheld	A full review of the medical and nursing notes has been undertaken in relation to the concerns raised. It is clear from all the documentation examined during this investigation that on this occasion scabies was not considered further and we can only sincerely apologise for this and for any anxiety and distress that this unfortunate incident has caused. On investigation we have been able to identify that scabies has an incubation period of up to eight weeks so it is highly likely that the patient had already been in contact with this prior to admission, however, the	**Low**	Q1-14-14

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
		Hospital, but no urine sample was taken to confirm the source of infection: it was not until a GP analysis of a specimen that it was found that the bacteria was resistant to the antibiotics that were prescribed.		obvious delay in confirming a diagnosis has clearly caused distress and for that we are very sorry. With regards to the urinary infections, the patient was regularly tested by the ward staff when symptoms presented indicating a possible urinary infection. On receipt of the results from the Path Lab the appropriate antibiotic course was commenced. All relevant documentation relating to the tests carried out was filed within the patient's medical records. Again we can only sincerely apologise to the patient if he felt that we were not addressing his urinary infections, however, we can provide assurance that his nursing notes indicate that everything was done to assess, diagnose and treat him. We appreciate that continence issues can be very upsetting for patients and management plans can take some time to take effect and this issue continues to be an ongoing problem. We acknowledge that ward staff could have explained this better to the patient which may have helped him to have a better understanding of his condition. The Trust would like to reassure the patient that a thorough examination of his notes from all the therapists involved in his care do not reflect a delay in the patient's rehabilitation process and actually identify that he made good progress overall throughout his inpatient stay. Once again the Trust would like to apologise for any distress caused and would like offer assurance that this event will be discussed with staff at the next team meeting to examine the learning from the incident.		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
SOUTH SOMERSET DIVISION						
Community District Nursing	Relative – Daughter	• Your father was not given sufficient pain relief during the final few weeks of his life; • The District Nurse, on discovering that the wrong sized bed had been ordered, advised the family to call Medequip, but did not think to tell Medequip that the patient was in the bed (so it was not possible to adjust); • There was no single point of contact for end-of-life care; • There was no careful or systematic monitoring of your father's symptoms of levels of pain in his final weeks; • The District Nurses came rarely and different nurses came each time; • The District Nurses did not read the notes written by the daily carers; • End-of-life equipment was not provided by the services, so the family had to learn and assist in getting this equipment (e.g. Kylie sheets, incontinence pads, Proshield cream, Thick and Easy, mouth sponges, Fentanyl patches, syringe drivers, catheterisation	Upheld	The complainant was concerned that her father was not given sufficient pain relief during the final few weeks of his life. The healthcare records indicate that the patient's symptoms were monitored at each visit. In particular he was asked questions about any pain he may be experiencing and appropriate actions were taken to relieve his symptoms. Medications were prescribed for the patient which could be used to manage symptom control if required and the records indicate that the registered nurses administered these when symptoms indicated. We apologise if this pain relief did not seem to relieve the patient's symptoms sufficiently at this difficult time. The records also show that the nursing staff communicated regularly with the GP and discussed his pain control. They made suggestions about how symptoms could be managed, including suggesting the use of a modified release analgesic patch, which was prescribed. The GP has to make the clinical decision as to when the time is right for a syringe driver to be commenced. We apologise if the arrangements for the patient's pain management was not clearly communicated. The records indicate that the District Nurse telephoned the end of life coordination centre to ask them to order an extension to the patient's bed, which is the normal process. The nurse cannot recall (and the records do not indicate) that the family were asked to arrange this, however, if this was the case, we	**Moderate**	Q1-14-02

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
		equipment); • Pharmacies were often not aware of the end-of-life equipment needed or did not have it in stock; • The District Nurse hub often had trouble getting hold of a District Nurse. We also requested responses from the following organisations: • Yeovil District Hospital: • The Out-of-hours service: • The Hospice: • Preston Grove Surgery:		apologise. This would not be the accepted process and should not have been left to the family to do at such a difficult time. It is apparent that there was some confusion around the model of the bed and if the bed was actually able to be extended. An extension was ordered to be delivered but the records indicate that the bed was not able to be extended whilst the patient was in it. We would like to apologise for the difficulties and distress caused as a result. The investigation found that it was not clearly identified to the family who had overall responsibility for the patient's care and that there was a lack of clear communication in some instances. We are disappointed to learn this was the case and wish to apologise for the lack of leadership shown in some aspects of the patient's care. The District Nursing Service aims to provide continuity of care wherever possible. The nurses who visited the patient were part of the same district nursing team. They were fully informed of his nursing needs, had access to his electronic patient record and had regular handovers of information regarding his care. We are sorry if the family feel that continuity of care was not provided and apologise for any concern caused as a result. The records indicate that the community nurses did regularly check the carers' notes as they were monitoring the patient's bowel function and were also able to check if the carers had any concerns from these notes. We are sorry if it did not appear that the nurses were reading the notes written by the daily carers and that this		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				was not properly conveyed to the family. Although there is some evidence that the nursing staff did speak with the family about where they could obtain the necessary equipment, the family have noted in their letter that there was difficulty knowing where to obtain certain supplies. It is documented in the patient's electronic patient records that the nurses obtained some of the items for the patient. We apologise if communication was not adequate and for the difficulties you experienced as a result. We are sorry that that the family experienced difficulties obtaining the items needed from pharmacies. Pharmacies are aware of the medications prescribed for end-of-life care but unfortunately we do not have any influence on their stockholding. It is clear from our investigation that aspects of the care provided to the patient and those caring for him fell below the standards we would aim to provide and would have the right to expect. We apologise for the shortcomings in the service and the failings in communications that this investigation has identified. The learning from these experiences will be discussed with the District Nursing team in their team meetings, in particular the Senior District Nurse will ensure the teams reflect on the importance of clear communication with family members and we will review our processes for identifying a named nurse for patients. The District Nursing Service is currently reviewing shift patterns and I hope that this will enable us to provide better continuity.		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
Crewkerne Community Hospital	Patient	• You found the rehabilitation at Crewkerne Community Hospital to be poorly resourced, sparse and insufficient for proper rehabilitation following your early discharge from Musgrove Park Hospital following hip surgery; • The extent of the physiotherapy provision that was available in the community hospital was not as extensive as described by Musgrove Park Hospital; • Call bells were not answered promptly at Crewkerne Community Hospital, resulting in you soiling your bed on one occasion which caused you embarrassment and loss of dignity; • HCA's appeared to lack training in moving patients, and did not use slides when this would have been appropriate and helpful; • HCA's did not always clean temperature equipment between patients; • You were given oral morphine in preparation for a physiotherapy session, but did not receive the physiotherapy session.	Partially Upheld	The Matron has discussed the concerns raised with the lead of the countywide Independent Living Teams service. The service is able to provide rehabilitation care with a personalised care plan that should be discussed and agreed with the patient within 48 hours of admission. This discussion and assessment should communicate how much rehabilitation the patient would be expecting with specific goals agreed and worked towards. At the time of the patient's admission there were Independent Living Teams' staffing and resource challenges within the team that the patient was assigned to, however, we are pleased that recruitment across the service is improving and the staffing resources within the teams have been significantly increased in response to anticipated level of service activity. The Trust is working very closely with acute hospital provider to ensure they are communicating and offering a realistic rehabilitation plan for patients who require "intensive" therapy within community hospitals and ensuring the definition of intensive is explored prior to transfer and agreed. Unfortunately on occasions acute providers give patients unrealistic expectations of the quantity of rehabilitation service time that they will receive when they are transferred to a community hospital. We apologise that the patient was given unrealistic expectations on this occasion. Our investigation showed that it was anticipated that the patient was to receive rehabilitation, and oral morphine was prescribed prior to this therapy to improve pain relief and function during the	**Low**	Q1-14-03

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				therapy. Unfortunately, the rehabilitation then did not take place due to unforeseen events on the day. We apologise that the patient was given oral morphine in preparation for a physiotherapy session that did not occur. We acknowledge that the patient felt they had not had a full physiotherapy assessment prior to leaving hospital and had not completed a stair assessment until they were at home. The physiotherapy lead has explained that that the rationale for all stairs assessments is that the patient is required to be assessed on their own steps or stairs and not stairs in the hospital that may be entirely different to the patient's own. This reduces any false expectations and achievements if when reaching home the patient cannot achieve their own steps or stairs. The patient's experience of moving and handling at the community hospital should have been person-centred and assessed according to the personal requirements, in order to ensure safety, dignity and respect. Due to very rigorous Health and Safety regulations the nurses and Allied Health Professionals are no longer able to "lift" patients. We are sorry that it appeared that the Healthcare Assistants on the ward appeared to lack training in moving patients the Matron has provided assurance that all of her staff are trained and regularly updated in the manual handling of patients. The Trust is sorry for the patient's experience when requiring the toilet and that the call bell was not answered swiftly. All call bells are answered as soon as possible which is anticipated to be within a very short time however		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				during busy episodes when more patients wish to have a nurse's attention at the same time this can result in a longer than usual time frames. Matron has discussed this issue with her team and has given direction that the prompt answering of call bells is always a priority on the ward. It is not acceptable that the patient's dignity was compromised at this time and we offer our sincere apologies for the embarrassment and distress this must have caused.		
Adult Community Mental Health Team, Holly Court	Patient	• When you moved your flat was cleared of your possessions without your permission. You believe that the person responsible for this was Mr G, a social worker from Holly Court. You would like an investigation into this.	Not Upheld	The investigation officer found that the patient went to new accommodation for one month's trial on 18 May 2010. On 17 June 2010 his care co-ordinator visited him at the accommodation and the patient had decided he would like to move there permanently. The patient and his care co-ordinator discussed what items he would like to keep from his flat which included a desk, a bed, bedding and some clothes. The investigation found that these items were collected and delivered to the new accommodation on 24 June 2010. Giving notice on the patient's previous property was also discussed at the same time. The care co-ordinator e-mailed the patient's appointed trustee to discuss giving up the tenancy and the trustee was informed that the patient had requested the rest of his belongings be sold. The investigation found that the care co-ordinator explained that due to the condition of the items, they were not able to be sold with the exception of a cooker which might have been able to be sold. The care co co-ordinator informed the trustee that	**Low**	Q1-14-04

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				the flat would need to be cleared and cleaned before handing over to the Council or there may be a charge. The trustee and care co-ordinator agreed funding to pay for this. The Trust is sorry if this was not explained fully to at the time and apologise for any confusion this may have caused. The investigation found that on 15 July 2010, the care co-ordinator met a housing officer at the home who checked for faults prior to the patient giving up his tenancy. The patient telephoned his care co-ordinator the same day and informed him that he thought that he was going to get lots of money for the items in his flat. The care co-ordinator again tried to explain to the patient that he did not think the items were worth any money. The investigation found that the care co-ordinator contacted a company who may wish to purchase the items in the flat and he arranged to meet them at the property in order for them to see the items the patient wished to sell. However, they did not turn up to view the items. On 26 July 2010 it was agreed with the trustee the Housing Association would clear the remaining items from the flat and that they would clean and do the agreed repairs to the property. The trustee was informed there would be a cost and they agreed to pay the bill that was incurred. The Trust apologises if this was not fully explained to the patient and for any distress caused as a result. The Trust appreciates that the patient felt that the items in his flat were worth a lot of money and he was disappointed that he was unable to sell them. The investigation found		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				evidence that the items in the flat were of little financial value and would probably not have sold. The care co-ordinator tried to explain this to the patient on a number of occasions. He also consulted the trustee who agreed that the items could be removed by Housing Association and disposed. The investigation believes that the care co-ordinator worked with the trustee in the patient's best interest as he would have had to continue to pay full rent on the flat as long as his belongings remained there. The investigation found that the care co-ordinator tried to sell the items as instructed but the company did not attend an agreed appointment at the property. There would have come a time when the Housing Association would have requested the keys were returned and the remaining items in the flat would have been disposed. It was felt that the financial costs of the rent would have been far greater than any financial payment the patient would have received from the sale of the items. The Trust is sorry to inform the patient that as a result the Trust is not therefore able to offer any compensation for the loss of the items.		
ADULT MENTAL HEALTH INPATIENT & ASSESSMENT TEAM DIVISION						
Assertive Outreach Team, Foundation House, Taunton	Advocate on behalf of patient	• That patient had been discharged from the Trust's services; • That patient's previous support service, provided by the Trust, was withdrawn;	Not Upheld	The investigation which included a review of the healthcare records as recorded that the patient was seen extensively by the Brief Intervention Team (BIT) and Support Time and Recovery (STR) from June 2010 until October 2013 to do 'graded exposure' to help him leave the house	**Low**	Q1-14-09

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
		• That patient does not have a mental health diagnosis, and he believes he should have one; • That patient has not had sufficiently robust psychological assessment.		and overcome his anxiety. The graded exposure work is a usual approach to working with people who have anxiety and who are housebound. The patient appeared at times to benefit from it but at other times felt overwhelmed and often asked to defer his work when things felt too much. He sometimes stated that he would like to do the work himself as he prefers this to formal work with a health care worker, and some of the episodes of care were stopped where he agreed to proceed alone as this works "better for him". The patient was offered Cognitive Analytical Therapy (CAT) at Foundation House in 2009 but declined this as he felt unable to work with his 'underlying issues' at that time. He then requested CAT again but was advised against due to other issues which would make engagement with therapy difficult at that time. The patient was not offered a psychological assessment by one of the Clinical psychologists because his anxiety was being addressed well using graded exposure through the BIT staff with support from STR, and because it would be standard practice for the team to try and support patients to get out of their homes to attend appointments for formal therapy or psychological assessment. Although there is currently no open referral to the team, a Psychologist and Team Member will make contact with the patient to offer him a reassessment. He could be seen at home for this, which may involve one or two sessions to provide an assessment and advice about the way forward.		

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
Holford Ward, Taunton	Advocate on behalf of patient	• That on or around November 2013 the patient was taken from Kingston police station to the Holford Ward, where he was injected against his will. He says that drugs were 'forced down his throat' and that Nurse H 'tried to break his arm'. There were a number of nurses present but the only names that he remembers are Kieran and Jan. He says that he has been assaulted by this nurse before.	Partially Upheld	The investigation has shown that the patient was admitted to the ward from 7 October 2013 until the end of November 2013. There are no records of any similar incident on the ward during this period; however, the patient was initially admitted to the PICU Ward from Kingston Police Station on 17 September 2013, where he was placed in the extra care area immediately on arrival. During the admission process, due to his presentation and being mindful of the need to maintain the safety of the patient, fellow patients and staff members, he was escorted to the extra care suite by the ward team and Rapid and Secure staff in precautionary holds. Once on the ward, the patient continued to present in an aggressive and resistive manner which necessitated moving to the seclusion area with support from additional staff from the other Ward. The patient was offered oral medication which he initially refused, but then accepted this with some food and drink. At this point all staff present left the seclusion room and the records do not record that any injection was given during the admission process. It seems likely that this is the incident the patient describes in his complaint letter and we hope the information above is helpful, but as there are inconsistencies between our records and the patient concern, it would be helpful if he could confirm the date and provide us with any additional information so that a more comprehensive investigation can be undertaken. The Trust understands that during this admission to PICU Ward the patient raised several concerns with his IMHA, who addressed these in turn with	**Low**	Q1-14-10

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				the Ward Manager. The Trust also understands that during his previous admission to the ward that he had some similar concerns, which were responded to at the time.		
Ash Ward, Bridgwater	Advocate on behalf of patient	• That the patient claims he was threatened that, if he misbehaved on Ash Ward, he would be sent out of county and this would mean that his parents would not be able to visit him; • That the patient wants to know why his ward round schedule was changed while Consultant Psychiatrist was on leave and why he was not informed of the times he could go; • That the patient feels unable to raise complaints on the ward.	Partially Upheld	The investigation has shown that the patient's care pathways were discussed with him and he was advised that if things did not go well and his behaviour was so severe that it could not be managed on the ward, then in all likeliness he would have to go to a care provider out of area. He accepted that, when discussing his care pathway, staff are trying to be transparent and let him know what the outcomes of his current admission may be. The patient has clarified that he has never been threatened by anyone in relation to his care pathway. He acknowledged that his awareness that there are no local alternatives to higher levels of security or specialist inpatient services that would meet his needs is a perceived threat and not an actual threat. He understands that the transfer of his care to an out of area provider is not an option that is being explored at the current time, as staff are working with him to find a local care provider that can meet his needs when he is ready to move. During the discussion with the ward manager the patient accepted that the he has reassured him in the past that he is happy to deal with his complaints when he is available and discussed examples of issues which had been resolved together. The patient has also accepted that at times when he wants to make a complaint,	**Low**	Q1-14-12

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
				it is not always the best time as it is fuelled by emotions and often anger. He accepted that often in these situations he does not want to complain once he has calmed down and reflected on the issues. The patient acknowledged that the ward has posters informing patients how to make a complaint if they wish and opportunities for this are also raised in community meetings. However he stated that he gets frustrated when his complaints are not always immediately responded to with an instant resolution, which may happen on occasion, for example in the evenings. The patient has agreed that it may be helpful for his key worker to ask him weekly if he has any concerns that need addressing in the hope that they can be resolved. If not, the patient knows he can raise complaints with the Ward Manager, his advocate or PALs. He has agreed with the principle of trying to address things informally in the first instant.		
GOVERNANCE DIRECTORATE						
Trust Headquarters Mallard Court	Patient	• Appropriate processes are not in place for the retention and disposal of medical records; • Appropriate processes for the retention and disposal of medical records have not been followed; • On 2 January 2013 when you requested your medical records from Children's Unit, you believe	Not Upheld	The Trust is very sorry that we have been unable to retrieve the patient's records. We appreciate that this is very difficult for the patient and has caused them considerable distress. The Trust apologises that its communication about these matters has not always been as clear as it could have been. This investigation has identified that the patient's file was catalogued and reviewed. This review concluded that the file had met its retention date which is in line with the Records	**Low**	Q1-14-06

Service:	Source:	Complaint:	Outcome:	Response and learning:	Risk	ID
		that your records were available and should have been released to you at that time (you have now been advised that they are now unobtainable and marked for disposal). • You have asked the following questions, which we will endeavour to fully address in our investigation: 1. What is our retention/disposal policy? 2. What is our Place of Deposit for archiving? 3. What are our safeguards against the accidental loss of disclosure of the records? 4. Can we please provide a record of the destruction of your records with the reference, description and date of destruction (the record of the destruction of your record)?		Management NHS Code of Practice Part 2 (2nd Edition) and put forward for destruction. Approval for this destruction has been confirmed by the Caldicott and Information Governance Group. The Trust accepts that there has been a delay in this destruction process; unfortunately the Trust cannot re-call a file which is in the process of being destroyed. The Trust is sorry that aspects of the communication regarding the status and availability of the records have been confusing but is satisfied that the Trust has followed correct processes in the storage, handling and processes for destruction of the records and that every effort has been made to try to locate them following receipt of the patient's request.		

4. TRENDS

4.1 The table below illustrates the number of complaints received regarding subject during the month of April 2014.

Subject	Number of complaints
All Aspects of Clinical Treatment	10
Appointments, delay/cancellation (outpatient)	2
Patients property and expenses	1
Personal records (including medical and/or complaints)	1

4.2 The table below illustrates the number of complaints received regarding professions during the month of April 2014.

Profession	Number of complaints
Nursing	10
Professions supplementary to medicine *	2
Trust Administrative Staff / Members	2

** 1 = social worker and 1 = psychological therapist*

5. PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO) OPEN CASES

5.1 There are currently **two** cases with the PHSO for independent review.

5.2 Mr and Mrs X, the parents of a joint CAMHS and Sirona Healthcare male patient feel that the organisations have failed to undertake an accurate assessment for autism spectrum disorder and they are also concerned about the way in which their complaint was handled. All the appropriate documentation has been provided to the PHSO and they advised in writing on 19 February 2014 that they intend to investigate the concerns further. We await further correspondence.

5.3 Miss Y, the daughter of elderly deceased male patient under the care of the District Nurse Service on End of Life Care plan complained to the PHSO about the failure of the DN service and the delay in treating the patient on the night he died. She feels that had the family known that the nurse would not be coming they would have contacted the hospice where they feel he would have received the relevant care. All the appropriate documentation has been provided to the PHSO on 7 May 2014 and we await further correspondence.

6. RISK RATING

6.1 To assist with monitoring our governance arrangements within all activities of the Trust each complaint is given a risk rating using the 5x5 matrix as used for the Trust Risk Register.

Colour	Risk Grading	Number of complaints
	= very low risk	**8**
	= low risk	**5**
	= moderate risk	**1**
	= high risk	**0**
	TOTAL	**14**

7. RECOMMENDATIONS

7.1 The Group is asked to note the content of this report.

LUCY NICHOLLS
Patient Experience Manager

DAWN GODFREY
FOI and Complaints Officer