

Acute Services Division Complaints Annual Report 2006/07

1 Executive Summary

It is clear from the expressions of thanks received directly by our staff that patients and their families greatly appreciate the care they receive. However, there will be occasions when things do not go as well as they might or when we fail to meet expectations. In these circumstances, we hope that patients or their relatives will feel able to discuss their issues with staff. If they do wish to make a more formal complaint we have a procedure in place that reflects the guidance to the NHS.

This report reviews performance in managing formal complaints received during 2006/07, comparing this with the experience of previous years. Selected data are also given on informal concerns raised with the hospital complaints officers. Due to changes in management structures in April 2006, it has not been possible to provide comparative data in all cases.

544 formal complaints were received in 2006/07, a fall of 5% on the previous year. This represents a very small fraction of the total number of patient episodes and equates to one formal complaint for every 1200 patient episodes.

As in previous years, the principal issues raised in these formal complaints continued to be around clinical treatment; staff attitude, behaviour or communication; and waiting times. This also reflects national experience. However, although the pattern of issues raised has changed little, complaints are becoming increasingly complex and patient and relative expectations continue to rise. Since we believe that complaints about treatment are closely linked to those about communication, the theme of “good customer care” has continued to feature at induction, in training and awareness sessions available to all staff and at sessions specific to the complaints procedure.

Experience suggests that anxiety and frustration on the part of the complainant rises with the length of time they wait for a response. However, the speed of that response must be balanced with the degree of investigation required and the availability of staff to comment; the more rapid turnover of junior medical staff presents a particular challenge in this regard. The national target for responding to formal complaints is 20 working days. This was achieved in 99% of cases, an improvement on the figure reached in 2005/06. This high level of performance compares extremely favourably with available national comparisons and demonstrates our clear commitment to responding promptly to issues raised with us. Indeed, national statistics for 2005/06, published in November 2006, indicated that the national average for responding within the target time was 62%.

Where an individual is unhappy with the response they receive to a formal complaint, we hope that they will feel able to speak with us so that their remaining concerns can be addressed. However, complainants have the right to take their complaint directly to the Scottish Public Services Ombudsman should they be dissatisfied with the response they receive from NHS

Lanarkshire. During 2006/07 the Ombudsman issued seven reports on complaints raised with her and decided not to investigate a further three complaints. Reports were awaited at the year-end on a further fifteen complaints. The increase in the number of complainants approaching the Ombudsman appears to be largely a reflection of the removal, in April 2005, of the independent review stage of the complaints procedure rather than of poor complaint handling.

Since 1 April 2006 the Acute Services Division has been utilising new software to record and manage concerns and complaints. This is allowing greater flexibility in system interrogation and reporting than the software previously used.

Following the issue of a Health Department Letter in March 2006, an agreement was reached with a consortium of local Citizens Advice Bureaux for the provision of an independent advice and support service for individuals with queries or complaints with effect from 1 September 2006. NHS Lanarkshire was the first Board in Scotland to introduce this service which will also assist clients in sourcing information on health matters and benefits. In order to better understand our respective roles, complaints management staff and the designated caseworkers from the Citizens Advice Bureaux have been shadowing each other.

The positive duties imposed by the various pieces of equality legislation increasingly require NHS Boards to demonstrate that the needs of all individuals are being met. One area in which this should be demonstrated is in the handling of complaints. Since September 2006 NHS Lanarkshire has been participating in a national pilot of complaints equality monitoring.

Following a pilot at Monklands Hospital formal de-briefing sessions have been introduced for nursing staff at which a senior nurse and the complaints officer discuss complaints with the staff concerned. These more formal arrangements should lead to wider discussion of the issues raised in complaints within a structured framework.

During 2006/07, complaints continued to be handled largely on a site basis with appropriate reference to Clinical Directorate teams. A review of these arrangements will be undertaken in 2007/08 to identify any opportunities for improvements in complaints handling.

2 Formal Complaints Received

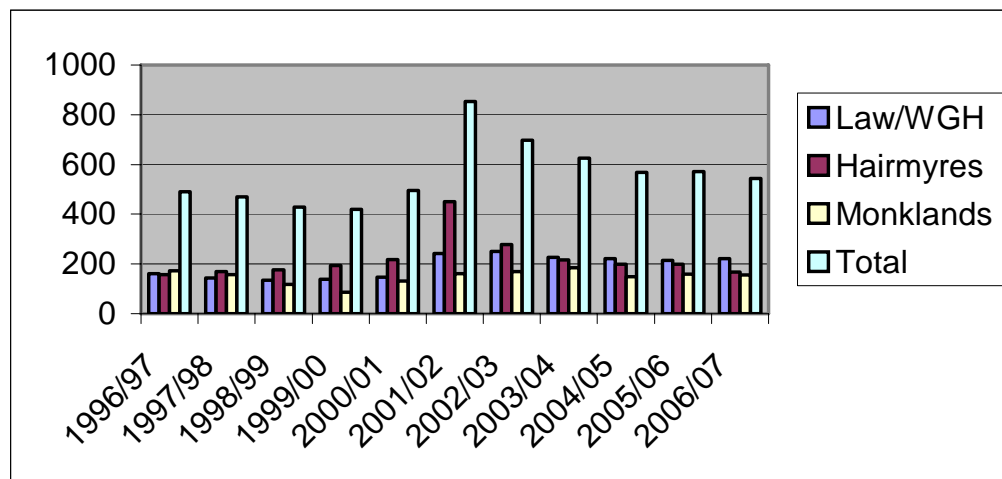
A total of 544 formal complaints were received between 1 April 2006 and 31 March 2007, down 5% on the previous year. All were acknowledged within the national target of 3 working days. Following the change in the management structure in April 2006, complaints are recorded against both the site and the Clinical Division, as illustrated in the table below.

	Emergency & Medical	Surgical & Critical Care	Women's, Cancer & Diagnostic	Other	Total 2006/07	Total 2005/06
Hairmyres	66	72	16	14	168	198
Monklands	68	66	9	12	155	159
Wishaw	79	87	42	13	221	214
Total 06/07	213	225	67	39	544	
Total 05/06						571

Historical data are not available to allow comparisons between Clinical Divisions. However, it is of note that Hairmyres Hospital recorded a 15% fall in the number of formal complaints received, whilst the changes at Monklands Hospital (-3%) and Wishaw General Hospital (+3%) were marginal.

Wishaw General Hospital received the highest number of formal complaints for each of the three main Clinical Divisions, with Obstetrics forming the majority (26) of those relating to the Women's, Cancer and Diagnostics Division.

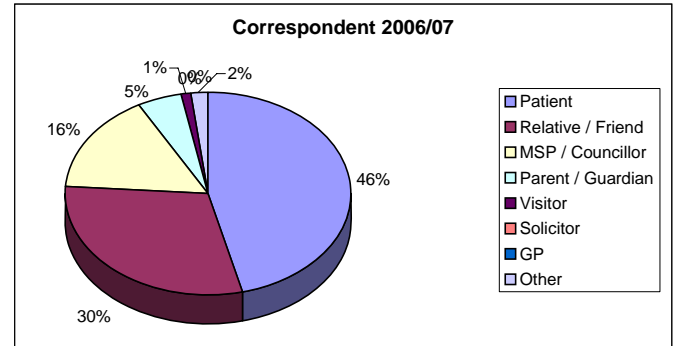
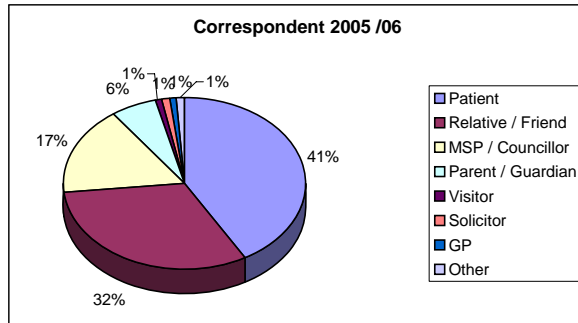
The graph that follows suggests that the overall downward trend since 2001/02, when the new Hairmyres and Wishaw General hospitals opened, continued



Appendix I provides details of the specialties about which the formal complaints were made. A complaint may cover more than one specialty; however, only the principal one is recorded. These revolved around the highest volume specialties: Orthopaedics, Accident & Emergency, General Medicine and General Surgery, with Orthopaedics at Wishaw General hospital being a particular outlier.

3 Correspondent

The graphs below illustrate the source of complaints by correspondent.



In line with previous experience, the majority of formal complaints (54%) were received from someone other than the patient. In these cases, for reasons of confidentiality, consent was sought from the patient or (where the patient had died or was incapable of giving consent) their next of kin before the complaint was investigated.

4 Issues raised in formal complaints

For national statistical purposes, a maximum of three “issues” may be recorded for each complaint received. A more detailed breakdown can be found in Appendix II.

As can be seen, there has been an overall drop in the issues raised in formal complaints. The breakdown in Appendix II illustrates that formal complaints containing issues relating to clinical treatment have been fairly static (226 compared with 224 in 2005/06), with a decrease at Hairmyres Hospital being counter-balanced by an increase at Wishaw General Hospital).

This year again, formal complaints relating to staff attitude/behaviour and written or oral communication featured highly. Whilst overall formal complaints relating to oral communication have increased from 95 to 122, Hairmyres Hospital recorded decreases in each of the communication categories.

A particular theme was complaints, both formal and informal, regarding the provision of spinal surgery within NHS Lanarkshire.

5 Informal Complaints Received

Individuals may have concerns but do not wish to pursue them through the formal complaints procedure. The majority of these are resolved with ward staff. However, in order to gain a broader picture of patient opinion, concerns raised with and resolved through the hospital complaints officers outwith the formal complaints procedure are also recorded. As has been the case in previous years, Monklands Hospital addressed substantially more concerns through this mechanism than the other two sites.

	Emergency & Medical	Surgical & Critical Care	Women's, Cancer & Diagnostic	Other	Total 2006/07	Total 2005/06
Hairmyres	25	50	9	4	88	79
Monklands	69	64	13	31	177	180
Wishaw	19	21	20	3	63	67
Total 06/07	113	135	42	38	328	
Total 05/06						326

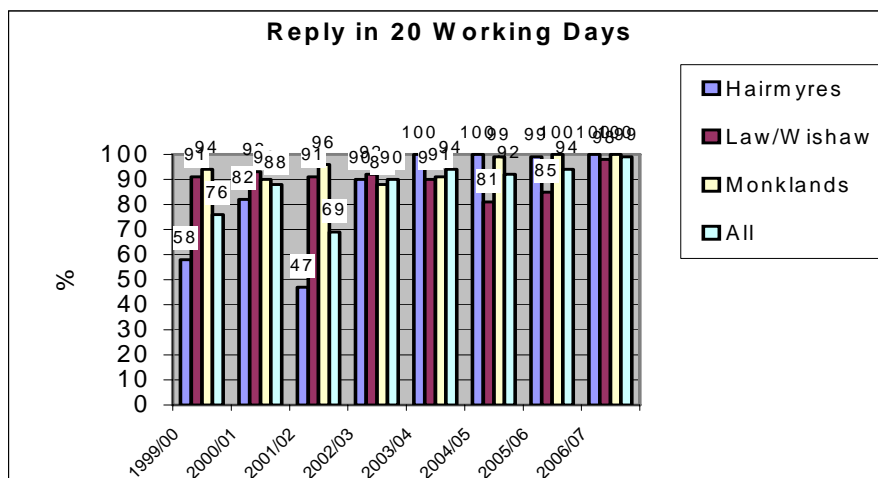
Appendix III provides details of the specialties to which informal complaints related.

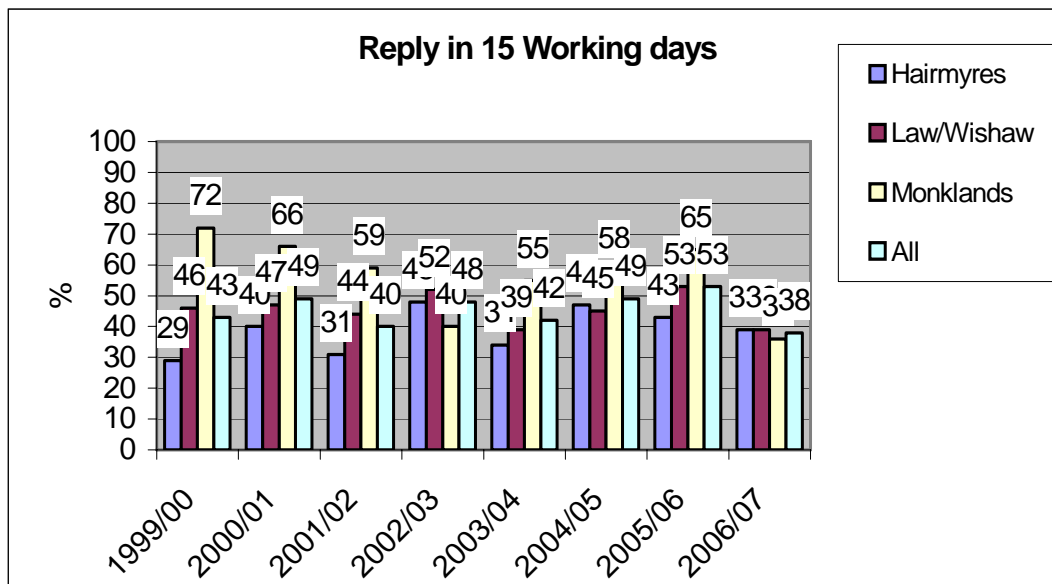
6 Issues raised in informal complaints

Using the ISD categories, Appendix IV provides a breakdown of issues raised in informal complaints. Although there is a significant variation between sites in the number of informal complaints raised with the complaints officers, the issues that are raised are broadly in the same categories and largely reflect experience in formal complaints.

7 Responses Sent to Formal Complaints

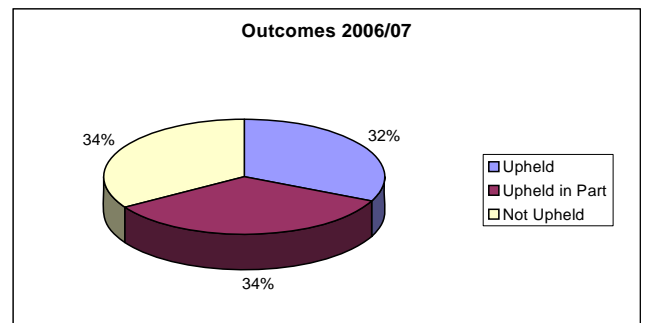
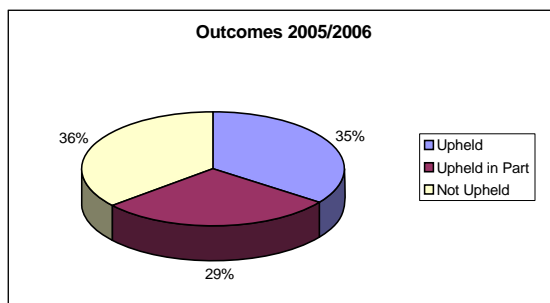
The national target of responding to complaints in 20 working days was achieved in 99% of cases in 2006/07, up from 94% in 2005/06. This demonstrates the firm commitment of all staff to responding promptly and compares extremely favourably with national figures. Slightly disappointingly, the local target of responding within 15 working days was achieved in 38% compared with 53% of cases in 2005/06. This may in part be explained by the growing complexity of complaints relating to clinical care.





8 Outcomes

National arrangements require that a judgement be taken as to whether or not a complaint was justified. This is clearly a subjective decision but is one that is taken as objectively as possible. In order to monitor consistency, an audit of outcomes assigned is undertaken twice-yearly.



An indication of actions taken in light of complaints can be found in Appendix V.

9 Scottish Public Services Ombudsman

Changes made in April 2005 to the NHS complaints procedure and changes within the Scottish Public Services Ombudsman's office make it likely that more complaints will be put to the Ombudsman than in previous years.

During 2006/07 the Ombudsman's office issued seven reports. Brief details of the findings in relation to these complaints were as follows. In each case an action plan was developed to address any recommendations made and to ensure learning across the system.

- Nursing staff failed to maintain the patient’s dignity (upheld); nursing staff failed to ensure the patient’s nutritional needs were met (upheld); nursing staff responded poorly to family concerns (upheld); and the Board’s response to the complaint was inadequate (upheld).
- A student nurse made unacceptable remarks to a patient (unable to reach a conclusion); and the handling of the complaint was poor (not upheld).
- A failure to diagnose cancer (not upheld); nursing care was inadequate (not upheld); and the patient’s diagnosis was communicated in an inappropriate manner and in contravention of previously expressed wishes (upheld).
- The care provided by an A&E doctor was inadequate (upheld); care provided by an out-of-hours doctor was inadequate (not upheld); pain relief in hospital was inadequate (upheld); communication between staff and the family was inadequate (not upheld); and procedures for arranging the post-mortem were inadequate (upheld).
- The giving of sedatives was inappropriate (not upheld); the timing of diagnosis of stroke (not upheld); lack of nursing observations (not upheld); and poor standard of clinical records (not upheld).
- The failure of out-of-hours GP to call ambulance (upheld); patient not taken to nearest hospital or transferred there subsequently (not upheld); care in A&E was not as outlined in the response to the complaint (not upheld); cleanliness of hospital (not upheld); not assisted with feeding at mealtimes (not upheld); regular medication was not administered correctly (not upheld); appropriate action was not taken following diagnosis of Staph. aureus (partially upheld); and the response to complaint was not adequate (not upheld)
- Nursing staff’s communication with the complainant and the family about the patient’s health was inadequate (upheld to the extend that no apology was given); erroneous information was given to the complainant and the family about the cause of the patient’s death and, additionally, that the wrong cause of death was recorded on the death certificate (upheld); nursing care and conduct were inadequate (upheld to the extend that no apology was given); nursing staff failed to adequately manage the patient’s diabetes (upheld to the extend that no apology was given); nursing staff’s communication with the Hospital Emergency Care Team (HECT) did not convey the urgency of the patient’s situation (upheld); and information was missing from medical records (upheld)

The Ombudsman also decided not to investigate a further three complaints. Reports were awaited at the year-end on fifteen complaints.

	Hairmyres	Monklands	Wishaw	Total
Carried forward from 2005/06	4	4	1	9
New requests for papers	3	6	7	16
No further action			3	3
Decisions to investigate	3	5	2	10
Investigation reports issued	3	3	1	7
Decisions pending at year-end		1	2	3
Reports pending at year-end	4	7	4	15

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Head of Patient Affairs
28 06 07; Updated 27 07 07

Formal Complaints by Clinical Division and Specialty

EMS	Hairmyres					Monklands					Wishaw					06/07	05/06
	OP	DC	IP	Other	2006/07	OP	DC	IP	Other	2006/07	OP	DC	IP	Other	2006/07		
A&E	20		3		23	15				15	29		5		34	72	
Cardiology	1		1		2	5		3		8	1		1		2	12	
Care of Elderly			7		7			10		10			4		4	21	
Dermatology	5				5	1		1		2	2				2	9	
Diabetes	4				4						2				2	6	
Emergency Care								9		9			5	2	7	16	
Gastroenterology						3				3	1		1		2	5	
General Medicine	8		14	1	23			17		17	3		20		23	63	
ID						1				1						1	
Neurology	2				2						2				2	4	
Renal								2		2						2	
Rheumatology	1				1	1				1	1				1	3	
SCC																	
Anaesthetics							1			1	1				1	2	
Breast						1				1	4				4	5	
Colorectal												3			3	3	
ENT	6				6	3		3		6	1		1		2	14	
General Surgery	14	1	10	1	26	5		11		16	7	2	8		17	59	
Ophthalmology	4	4			8	1				1	4		1		5	14	
Oral/Max	2				2	1	1	1		3	1				1	6	
Orthopaedics	8		9		17	7		12		19	19	1	22	1	43	79	
Plastics		1			1						2				2	3	
Thoracic	1		3		4											4	
Urology	6	1	1		8	4		15		19	3	1			4	31	
Vascular											3		2		5	5	
WCD																	
Gynaecology	7		2		9	3		1		4		1	1		2	15	
Laboratories	1				1						2		2		4	5	
Infertility						1				1						1	
Obstetrics											8	1	17		26	26	
Oncology	3				3			1		1	3				3	7	
Pharmacy													1		1	1	
Radiology	2				2	2		1		3	4		2		6	11	
Other																	
PSSD	2		5	6	13	2		4	4	10	3		1	2	6	29	
Medical Records						2				2	3				3	5	
AHPs	1				1						1		3		4	5	
Total	98	7	55	8	168	58	2	91	4	155	110	9	97	5	221	544	

APPENDIX II

Issues Raised in Formal Complaints

Category	Hairmyres						Monklands						Wishaw									
	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	06/07	05/06		
Staffing																						
Attitude/ Behaviour	10	12	1	2	25	30	11	6	1		18	32	7	9	7	1	24	41	67	103		
Complaint Handling												1						1			2	
Comms - written	4	5	3		12	23	5	4		1	10	19	3	2	2	1	8	6	30	48		
Comms – oral	8	8	2	2	20	33	26	32	3		61	42	14	17	10		41	20	122	95		
Shortage/ Availability	2	1			3	2	1	1			2	3	2	1	1		4	2	9	7		
Competence							2				2	7	1		1		2	1	4	8		
Waiting Times for																						
Date for admission/ attendance	7	11	1		19	11		16			16	13	3	20		1	24	24	59	48		
Date for appointment	5	6	1		12	36	6	5	2		13	18	7	18	4		29	24	54	78		
Result of tests	1	3			4	10	4	2			6	4	2	2	2		6	4	16	18		
Delays in/at																						
Admission/ transfer/ discharge	4	1			5	11	5	3			8	8	15	6	5		26	17	39	36		
Outpatient and other clinics	3	1	1		5	15	3	3	1		7	7	2	4	4		10	4	22	26		
Environment/ Domestic																						
Premises (inc access)			2	5	7	9		1	1	4	6	8			1	1	2		15	17		
Aids, appliances, equipment		1			1							1						1	1	2		
Catering	1	1		5	7	10		1		3	4	2				2	2		13	12		
Cleanliness/ laundry	3			3	6	7	2			3	5	14		1	1	2	4	2	15	23		
Patient privacy/ dignity						6	3				3	3	2				2	3	5	12		

Category	Hairmyres						Monklands						Wishaw							
	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	06/07	05/06
Patient property/ expenses	1				1		2				2	2	2				2	4	5	6
Patient status/ discrimination						1														1
Personal records		2	1		3	4	1	4		1	6					2	2		11	4
Shortage of beds	2	1			3	4		3			3							6	6	10
Mixed accommodation																				
Hospital acquired infection (MRSA)						1	2	1			3	9		1			1	1	4	11
<u>Procedural issues</u>																				
Failure to follow agreed procedure						1	1				1								1	1
Policy & commercial decisions	1	1			2		1	1			1	1	1	2	2		5		8	1
NHS Board purchasing																				
Mortuary/ post mortem arrangements												2								2
<u>Treatment</u>																				
Clinical treatment	30	28	7		65	84	39	35	5		79	84	36	26	17	3	82	56	226	224
Consent to treatment	1				1		1	3			4	2							5	2
<u>Transport arrangements</u>	2	3			5	4						4	1				1	3	6	11
<u>Other</u>									1	1	10		1	1		1	3	13	4	23
TOTAL	85	85	19	17	206	302	115	120	13	13	261	296	99	110	57	14	280	233	747	831

APPENDIX III

Informal Complaints by Clinical Division and Specialty

	Hairmyres					Monklands					Wishaw					YTD	05/06
	OP	DC	IP	Other	2006/07	OP	DC	IP	Other	2006/07	OP	DC	IP	Other	2006/07	Total	Total
EMS																	
A&E	4				4	9			1	10	7		1		8	22	
Cardiology	1		1		2	6		1		7						9	
Care of Elderly			4		4			8	1	9						13	
Dermatology	2				2	6		1		7						9	
Diabetes	2				2	3				3						5	
Emergency Care								8		8			1		1	9	
Gastroenterology						3				3						3	
General Medicine	2		8		10	1		12		13	3		3		6	29	
ID/BBV						1		2		3						3	
Neurology						2				2	4				4	6	
Renal						1				1						1	
Respiratory	1				1				1	1						2	
Rheumatology						1				1						1	
SCC																	
Breast											1				1	1	
Endoscopy																	
ENT	3				3	1		4		5						8	
General Surgery	7	4	6		17	6		11	1	18	2		2		4	39	
Ophthalmology	7	1			8	3		1		4						12	
Oral/Max	1				1	1		1		2						3	
Orthopaedics	5		2		7	10		8		18	13	1	1		15	40	
Plastics	1				1	1				1						2	
Urology	13				13	7		9		16	1				1	30	
WCD																	
Gynaecology	7				7			1		1		1	4		5	13	
Laboratories						1		2		3						3	
Infertility																	
Obstetrics												1	8		9	9	
Oncology	1				1								1		1	2	
Pharmacy						1				1						1	
Radiology	1				1	5		3		8	5				5	14	
Other																	
PSSD	1		2	1	4	7		5	10	22				3	3	29	
Medical Records						7		1	1	9						9	
AHPs								1		1						1	
Total	59	5	23	1	88	83		79	15	177	36	3	21	3	63	328	

APPENDIX IV

Issues Raised in Informal Complaints

Category	Hairmyres						Monklands						Wishaw							
	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	06/07	05/06
Staffing																				
Attitude/ Behaviour	1	4			5	12	8	9	1	6	24	26	3	1			4	16	33	54
Complaint Handling	1				1														1	
Comms - written		6			6	11	6	9	1	2	18	12		1	2		3	4	27	27
Comms – oral	5	8	2		15	17	24	31	2	3	60	64	5	3	7		15	19	90	100
Shortage/ Availability		1			1							4							1	4
Competence							2				2	1	1				1	1	3	2
Waiting Times for																				
Date for admission/ attendance		3			3	4	2	9			11	10		6			6	2	20	16
Date for appointment	3	5			8	12	16	11	7		34	36	1	2	4		7	6	49	54
Result of tests	3	9	2		14		3	2	1		6	14	6	3			9	5	29	19
Delays in/at																				
Admission/ transfer/ discharge	1	3			4	3	4	6			10	8	2	1	2		5	4	19	15
Outpatient and other clinics		4			4	5	1	2			3	6						3	7	14
Environment/ Domestic																				
Premises (inc access)				2	2	4				14	14	15				3	3	1	19	20
Aids, appliances, equipment	1				1				1	1	2	1							3	1
Catering				2	2	2	3		1	1	5	4							7	6
Cleanliness/ laundry	1				1	2	3		1	1	5	4							6	6
Patient privacy/ dignity						2							1				1	1	1	3

Category	Hairmyres						Monklands						Wishaw							
	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	EMS	SCC	WCD	Other	06/07	05/06	06/07	05/06
Patient property/ expenses	2				2		3				3	2							5	2
Patient status/ discrimination	1				1														1	
Personal records	1	1			2			1	1	2	4	5							6	5
Shortage of beds						2						1			1		1	2	1	5
Mixed accommodation																				
Hospital acquired infection (MRSA)							1	2			3	1							3	1
<u>Procedural issues</u>																				
Failure to follow agreed procedure																				
Policy & commercial decisions												1		6			6		6	1
NHS Board purchasing																				
Mortuary/ post mortem arrangements						1						1								2
<u>Treatment</u>																				
Clinical treatment	7	4	1		12	15	13	14	1		28	33	6	2	12		20	16	60	64
Consent to treatment																				
<u>Transport arrangements</u>		2	1		3	1	1	1			2	3						1	5	5
<u>Other</u>				1	1		1				1	10	1	2			3	5	5	15
<u>TOTAL</u>	27	50	6	5	88	93	91	97	17	30	235	262	26	27	28	3	84	86	407	441

ACTIONS TAKEN IN LIGHT OF COMPLAINTS

April – June 2006

Issue	Action Taken	Information shared with other sites
Patient waiting too long in Accident and Emergency Department. Other patients who came in at a later stage were seen before them. (H)	Trial patient flow co-ordinator to follow patient's journey through the hospital. Also extended "see and treat" area.	To be picked up under Unscheduled Care Collaborative arrangements.
Appointment received after date of appointment. (H)	Patient Focus Booking Team Leader to review protocol	Results to be shared.
Nurse rude to patient. (H)	Undertaking further education part of which will focus on communication skills.	No: local operational issue.
Patient transferred to Udston, family not informed. (H)	Discussed at ward meeting to highlight error to staff.	No: local operational issue.
Patient fell from trolley in Accident and Emergency Department. (H)	Review undertaken by Senior Nurse on patient safety issues within the department.	No: local operational issue.
Patient using bin in Accident and Emergency for paper towels that were covered in blood. (H)	Review undertaken by Infection Control. Clinical waste bins ordered for area.	No: local operational issue.
Patient given wrong medication, when wearing red wrist band. (H)	Discussed at postgraduate meeting with junior doctors.	To be reinforced to new intake of medical staff.
Results from Monklands Hospital not available at the clinic. (H)	Administrative Co-ordinator to review current protocol.	Results to be shared.
Delay in biopsy results. (H)	Clinical Director to review current procedures.	Results to be shared.
Delay in patient being seen in A&E by the on-call Orthopaedic doctor due to the volume of patients who required his/her attention. (M)	The delay in the patient being seen by the Orthopaedic specialist was unacceptable and this is currently under review with the team in an effort to make improvements in the short term.	Results to be shared.
Delay in paediatric patient being seen in A&E. (M)	Following this complaint A&E consultants and the Nurse Manager met to discuss the problems that the patient and his/her parents encountered on that evening. They will be reinforcing to all of the staff the importance of expeditiously treating children where possible and affording them a higher priority than their clinical condition merits, while also being careful not to prejudice the treatment of others that may be more seriously injured.	No: local operational issue.

Information regarding patient's condition was not passed on to Anaesthetist prior to procedure. (M)	It was acknowledged that in this case there was a breakdown in the normally robust communication channels within the ENT pre-assessment service. Information on the patient's condition should have been passed on when the anaesthetist was assigned to the list. Pre-assessment staff have amended their procedures to ensure written referrals are now provided to all members of the team at the time of pre-assessment. This process will highlight any specific information likely to impact on surgery at an early stage.	Yes, as part of the review of entire Pre-assessment Services across NHS Lanarkshire.
Wrong patient attended for diagnostic tests. (M)	Steps have been put in place for staff to check patient details against the original referral received by the Department so that a similar mistake can be avoided in the future.	To be shared.
Patient's MRSA status was not communicated by A&E to receiving ward. (M)	Clinical Nurse Manager, A&E to remind staff of the importance of communicating patient specific information on transfer.	No: local operational issue.
On admission there were delays before the patient was given an inpatient bed. (M)	Senior Nurse, Surgical and Critical Care Division, has developed a protocol for supporting patients whilst awaiting an inpatient bed. This is designed to ensure that the admitting specialty completes all the appropriate documentation and supports the patient's needs whilst waiting for admission.	To be shared across surgical & Critical Care Division.
Urine infection identified at Pre-assessment. Patient attended for procedure but was cancelled as the urine infection was still present and had not been dealt with appropriately. (M)	As part of the development of pre-assessment services the management of laboratory results is being redesigned. Results are currently forwarded to the intended ward of admission, however they will now be returned to pre-assessment to ensure patients and their GPs are able to act on any abnormal findings.	Yes, as part of the review of entire Pre-assessment Services across NHS Lanarkshire.
Patient contacted Booking Office to cancel appointment; received letter stating she had failed to make contact and was being removed from waiting list. (W)	All Booking Office staff reminded of importance of following through on any arrangements made with patients.	Yes.
Baby within neonatal unit given drug in error. (W)	Clinical incident form completed and Supervisor of Midwives contacted.	No.
Patient assessed by minor injury nurse (MINTS): failure to detect fracture. (W)	MINTS nurses will check the accuracy of their diagnosis with a middle grade doctor. Further teaching will be provided to the nurse in question. Consultant to investigate how x-ray fell through checking loop within Radiology.	Results to be shared.
Patient's relatives were advised she had been discharged from hospital when she had been transferred to another ward. (W)	Senior Nurse has spoken to the ward manager and a clinical incident form has been completed.	No.

July – September 2006

Issue	Action Taken	Information shared with other sites
Patient kept waiting in ENT because only one piece of equipment available and had to be sterilized. (H)	New sterilizer bought which will speed up the process.	No.
Windows in Ward 18 draughty. (H)	3 windows replaced.	No
Ward 18 interior looking worn and shabby. (H)	Internal decoration programme commenced September 2006.	No
Dermatology Day Unit dirty when patient attended. (H)	Staff reminded of responsibility for identifying additional cleaning requirements to Help Desk.	No
Patient unhappy with food. (H)	Patient Opinion Survey being carried out.	Yes
Reverend unhappy about not being allowed to visit patient during ward round. (H)	Staff reminded about policy on visitors during the Consultant ward round.	No
Patient was transferred from ERU to ward and family were not notified. (M)	There was a breakdown in communication regarding the updating of the Patient Management System. The Deputy Charge Nurse has spoken to all staff with regards to accurate record keeping and staff are currently undergoing a programme of training on the Patient Management System.	No
Patient was given a clinic appointment that fell on a public holiday which was applicable to medical staff only. (M)	To avoid a recurrence of this problem clinics falling on public holidays applicable to medical staff only will be closed off on the system and only reinstated at the request of medical staff	Yes
Family were unhappy that they were not allowed to leave personal belongings for patient due to strict visiting hours. (M)	Lead Nurse and Deputy Charge Nurse to review current arrangements with a view to becoming more flexible in exceptional cases.	No
Information regarding wound and wound dressings was omitted from Discharge Summary.	Staff reminded of the importance of ensuring the correct information is included in the Discharge Summary.	No
Patient was inappropriately dressed on discharge from the ward. (M)	Ward Manager has spoken to staff regarding patient's attire on discharge.	No
Misdiagnosis of fracture at A&E. (W)	Lead consultant has spoken to doctor responsible to ensure a similar incident does not happen again.	No
Relatives not contacted about a patient's discharge. (W)	Senior Nurse and Ward Manager have spoken to the staff and reminded them of the importance of communication.	No
Patient unhappy with consultation provided by Staff Grade Surgeon in ENT. (W)	Consultation arranged with Consultant ENT Surgeon.	No

Patient booked for sterilisation at same time as admission for caesarean section – consultant omitted to carry our sterilisation – hospital only discovered error 3 months later. (W)	Investigation carried out by Service Manager/Clinical Director and measures put in place to ensure a similar incident does not occur again.	No
Possible misdiagnosis of breast cancer. (W)	Formal investigation carried out within laboratories and measures put in place to ensure a similar incident does not occur again. Breast clinic process reviewed to ensure that no changes are required.	Yes.
Patient unhappy about waiting times for chemotherapy to be administered at Medical Day Bed Unit. #1 (W)	General manager had discussion with pharmacy department regarding cancer service – ongoing discussions are taking place re cancer service across NHS Lanarkshire. Clinic appointments at WGH were reviewed.	Yes.
Patient unhappy about waiting times for chemotherapy to be administered at Medical Day Bed Unit. #2 (W)	General manager had discussion with pharmacy department regarding cancer service – ongoing discussions are taking place re cancer service across NHS Lanarkshire. Clinic appointments at WGH were reviewed.	Yes.
Patient unhappy about waiting times for chemotherapy to be administered at Medical Day Bed Unit. #3 (W)	General manager had discussion with pharmacy department regarding cancer service – ongoing discussions are taking place re cancer service across NHS Lanarkshire. Clinic appointments at WGH were reviewed.	Yes
Patient received appointment to attend Hairmyres for colonoscopy as part of a waiting list initiative – Day Surgery at Hairmyres not advised of patient’s details. (W)	Secretary at WGH who co-ordinated the list was spoken to regarding this error – she had omitted to send the paperwork to HM.	No.

October – December 2006

Issue	Action Taken	Information shared with other sites
Poor communication between staff (H)	Specialty Clinical Director to ensure communication more effective between ward staff and AHPs	No - local operational issue.
Patient transport not booked (H)	Discussed with staff, reminded of importance of ensuring appropriate transport ordered	No - local operational issue.
Draught in ward due to old windows	Windows resealed and temperature monitored	No - local operational issue.
Failed to attend letter in patient’s notes when appointment had been cancelled (H)	Letter amended an apology given	No - local operational issue.
Junior doctor in A&E reported to be rude to patient’s relative (H)	Consultant on duty spoke to SHO to ensure this does not happen again	No.

Patient given overdose of medication (H)	Incident discussed at Clinical Risk Group	No.
Complainant felt that Clinical Support Worker spoke inappropriately to patient (M)	The Ward Manager has spoken to the Clinical Support Worker concerned and has reminded them of the need to remain professional at all times	No.
Delays in GP/patient receiving report on cardiac monitoring test (M)	A pilot commenced in October 2006 in the Cardiology Ward whereby, during the ward round, medical staff complete a pro-forma indicating whether the patient requires an outpatient follow up appointment or further procedures, for example, angiogram. An indication of the timescale for follow up/further procedures is given at this point in an effort to prevent a similar occurrence of the issues the complainant experienced	No.
Patient was unable to call for assistance as buzzer was left out of reach (M)	Ward Manager to remind all of their staff of the need to ensure that the nurse call system is within reach of all patients who are bed bound	No.
Ward nursing documentation was inaccurate and did not take account of the fact that the patient had fallen previously, as recorded on admission (M)	On admission to ERU it was noted by the receiving doctor that the patient had a “stumble fall” six weeks earlier, but there was no evidence in the nursing notes that nursing staff were aware of a previous fall. The Ward Manager has advised that they will reinforce the requirement for accurate documentation with nursing staff, as it is very important in assessing any potential problems regarding future mobility and falls risk assessment	No.
Attitude of A&E doctor (W)	Doctor was working as a locum – decision taken not to re-employ as a locum	No.
Death of son at twelve days – concerns regarding ante-natal care (W)	Midwives did not understand abbreviation used by consultant regarding a further scan to be carried out, and appointment was not made. Consultant has been made aware – abbreviation not to be used in future	No – local operational issue.
Attitude of midwifery staff/ lack of communication (W)	Ward managers have discussed all of the issues raised with staff to ensure it does not happen again	No – shared within Clinical Division.
Miscarried baby/ placenta left in fridge – should have been transported to mortuary (W)	New system has been put in place to ensure this does not happen again	No - local operational issue.
Specimen went missing within Pathology Laboratory (W)	New booking system has been put in place to ensure that this does not recur	To be shared with other sites.

January – March 2007

Issue	Action Taken	Information shared with other sites
Fracture not identified in Emergency Department (H)	Consultant has discussed complaint in detail with SHO on call to ensure this does not happen again.	No – local operational issue.
Clinical area dirty (H)	Rescheduling of cleaning in area. Staff reminded of help desk facility.	No – local operational issue.
Misdiagnosis in Emergency Department (H)	Consultant has discussed complaint in detail with SHO on call to ensure this does not happen again.	No – local operational issue.
Attitude & behaviour of doctor (H)	Doctor has taken onboard that she did not communicate well with the patient although this was not her intention.	No – local operational issue.
Patients belongings sent to laundry after family advised that they wished to take home as going missing (H)	Notice put above patient's bed to ensure that all washing was left for family to take home. Staff reminded of same.	No – local operational issue.
Patient records missing (H)	Hospital wide search carried out. Patient offered review appointment to discuss ongoing clinical needs.	No – local operational issue.
Medical and nursing staff requested that patient try to move his neck despite the fact that he had a suspected neck/spinal injury (M)	The A & E Consultants have spoken to all of their doctors regarding this incident, have reviewed all the x-rays and CT scans with the doctors and have re-emphasised to them that it is essential for them to discuss all such cases with the consultant on call. It is also the case that since, throughout the UK, junior doctors now spend only 4 months within an A & E Department before moving on, the 3 A & E Departments within Lanarkshire now run 3 day induction courses for these doctors, one day of which is taken up with trauma and spinal injuries.	Yes.
Patient on low residue diet was not sent meals from the catering department to the ward to meet their requirements (M)	The Catering Manager will ensure that a robust system on recording telephone requests to visit patients by the catering staff will be implemented. The concerns raised by the patient will also be discussed at the Food, Fluid and Nutrition Group meeting.	No – local operational issue.
The wrong wrist brace was applied to the patient's wrist (M)	The consultant will be taking this matter up with the doctor who first examined the patient and the Nurse Manager will ensure that all nursing staff are particularly careful at all times when applying a wrist brace.	No – local operational issue.

Patient advised nursing staff that they required a vegetarian and gluten free diet, but this information was not passed to the catering department (M)	Nursing staff did not refer patient to a dietician, primarily as they were fasting for theatre and would be 'nil by mouth' for several days. The Ward Manager offered the patient their sincere apologies and acknowledged that a referral should have been made to the dietician on the patient's admission to the ward. The Ward Manager will remind all of her staff of the importance of communication where specific dietary requirements have been highlighted.	No – local operational issue.
Patient's medical records contained information from a different patient with the same name (M)	The contents of the patient's medical notes were been thoroughly checked and all of the information contained in them related to the patient and there was no misfiled information. The Health Records Manager advised that staff working on the CHI Re-numbering Project had been reminded of the need to be extra vigilant when dealing with case records.	Yes.
Urinals and sick bowls were not replenished for the patient (M)	The Ward Manager apologised if there was any delay in renewing urinals and sick bowls and she can confirm that she has reminded ward staff of the importance of ensuring that patients needs are met at all times.	No – local operational issue.
Family were unhappy that they were asked to bring in clothing for their relative so that they could up and sitting in a chair the day after having had a stroke. The family felt that the patient was up sitting in a chair for a prolonged period of time (M)	Apologies were given to the family if the reasons for their relative being out of bed were not fully explained to them.	No – local operational issue.
Patient fell whilst in the ward and family were not notified (M)	Ward Manager apologised if nursing staff did not contact the family regarding the patient's fall, as this is normal practice within the ward. She has reminded nursing staff of the importance of ensuring that families are contacted if a patient sustains a fall in the ward.	No – local operational issue.
Patient was not given a pressure relieving mattress (M)	Ward Manager has spoken to nursing staff regarding the procedure for obtaining such an additional mattress. She has also ensured that there is a notice at the nurses station to remind staff of the procedure for obtaining pressure-relieving mattresses	No – local operational issue.

Member of nursing staff raised her voice to a relative during a telephone conversation (M)	The Ward Manager has spoken to nursing staff and reminded them that they must remain professional at all times when speaking to patients and their relatives.	No – local operational issue.
Patient's casenotes went missing prior to being admitted for surgery and the procedure had to be cancelled (M)	The Health Records Manager advises that an exhaustive search for the patient's casenotes was commenced. She appreciates that the consultant should have been informed of the missing casenote prior to the patient's admission, in order that a decision could be made to cancel, if necessary. The Health Records Manager has also reiterated this process to the relevant staff.	No – local operational issue.
Family unhappy with treatment their father received – father is paraplegic. Family feel that the hospital does not provide adequate equipment to deal with such patients/raised issues with communication and treatment received from nursing staff (W)	Communication issues to be raised with the staff involved. Need to look at possibility of future training for nursing staff in manual bowel evacuation. Senior Nurse given as point of contact for any future issues as patients has had several admissions.	To be shared.
Hospital closed to admissions. SAS arrived at A&E with patient – re-directed to Monklands – no assessment of patient carried out (W)	New system has been put in place – all unexpected patients must be assessed prior to transfer to another site	To be shared.
Patient fell in ward – family feel fall could have been prevented (W)	Incident form completed and mobility chart updated to state that patient required assistance from 2 nurses rather than 1.	No – local operational issue.
Waiting time at Ophthalmology clinic (W)	Review of number of patients attending the clinic has been undertaken	No – local operational issue.