Portsmouth Hospitals NHS
NHS Trust

COMPLAINTS, LITIGATION INCIDENT AND PALS (CLIP) REPORT

Code A

Head of Risk Management, Complaints & Legal Services

Dec 2007

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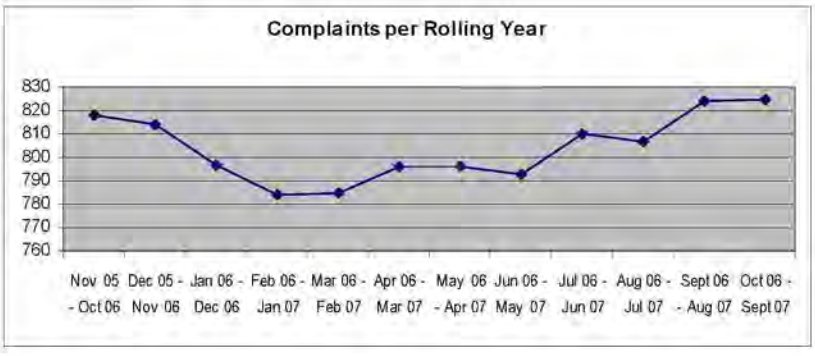
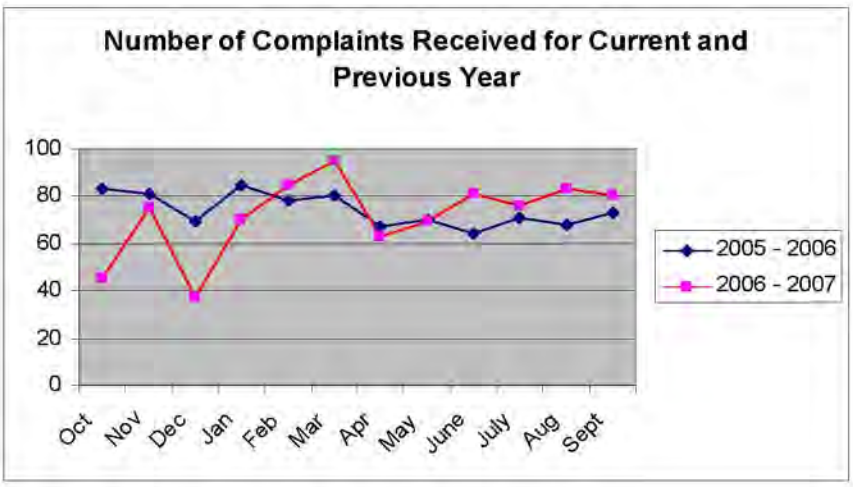
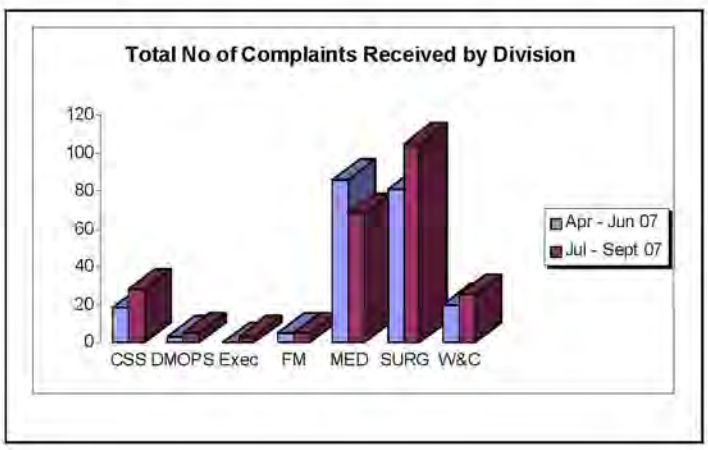
COMPLAINTS – Aggregated Report



The number of complaints received per year has again decreased slightly to 804: previously 809



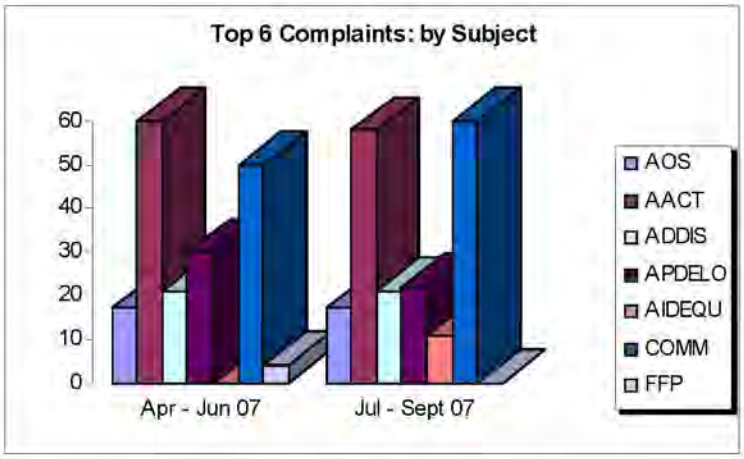
The number of complaints received ranges from 37 per month to 95, with an average of 71 per month for the reported year 2006/07, compared to 74 per month for the year 2005/06



It should be noted that no complaints were received by MOD

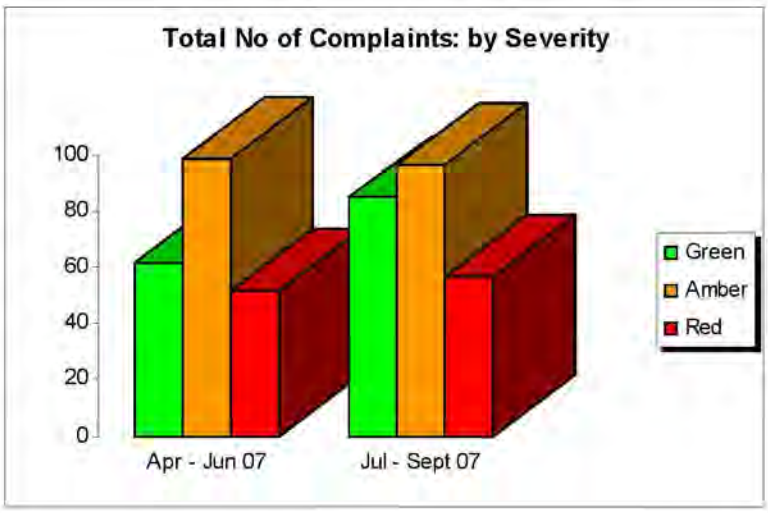
Complaints as a Percentage of Clinical Activity

	Apr - Jun 07	Jul – Sept 07
Medicine	0.16%	0.16%
Surgery	0.11%	0.14%
W&C	0.13%	0.15%



Key	
AOS	Attitude of staff
AACT	All aspects of clinical treatment
ADDIS	Admission / discharge
APDELO	Appt delay / cancellation: o/pt
AIDEQU	Aids and equipment
COMM	Communication
FFP	Failure to follow agreed procedures

For the quarter July - September the top 6 complaints as a percentage of the total complaints received were as follows: 7% for AOS, 24% for AACT, 9% for ADDIS, 9% for APDELO, 25% for COMM, 5% for FPP. The remaining complaints received form the balance of 21%.



	Apr – Jun 07	Jul - Sept
Green	62	85
Amber	99	97
Red	52	57

Time taken to close complaints

	Apr		May		June		Jul		Aug		Sept	
	No	%	No	%	No	%	No	%	No	%	No	%
Complaints received	63		69		81		76		83		80	
Acknowledged within 2 working days	63	100	69	100	81	100	76	100	83	100	80	100
Total Closed within 25working days	50	**79**	56	**81**	69	**85**	59	**78**	68	**82**	65	**81**

Delayed responses

Days over	Now Closed	Reasons for Delay		Days over	Still Open	Reasons for Delay
1–10	18	2 Late signing 12 Late responses 4 Delay in gaining approval		1– 10	Nil	
11-20	8	7 Late responses 1 Delay in gaining approval		11-20	Nil	
21-30	4	4 Late responses		21-30	1	Late response
31-40	1	1 Complex case		31-40	1	Late response
41-50	1	1 Late response		41-50	1	Complex case
50+	Nil			50+	2	Complex cases

Healthcare Commission (HCC) status: 1 July 2004 – present

	1 July 04 – 31 Mar 07	1 July 04 – 30 Sept 07
Number of PHT complaints referred to HCC	103	112
Number of PHT responses sent to HCC	103	112
Number of PHT outstanding responses to HCC	0	0
Outcomes		
Number referred back for further local resolution	50	88
Number requiring no further action by PHT	12	19
Number for which PHT still awaiting comment from HCC	39	3
Number rejected by HCC	2	2

Please Note:
We have been notified that 8 additional complaints have been referred to the HCC in this reporting period.

LITIGATION

Claims Closed

Date of Incident	Division	Specialty	Synopsis	Outcome	Comments
JULY					
12/09/00	Surgical	Gen Surg	Alleged failure to provide timely and appropriate investigations to diagnose and appropriately treat cancer	Dropped	Whole episode review: treatment appropriate
28/08/01	W&C	Gynae	Claimant alleged substandard treatment whilst having pelvic floor repair	Dropped	Clinician involved has retired
13/12/01	W&C	Obs	Scan of baby did not reveal cord round neck: delay in delivery, baby born 'flat' and has biurnal hearing loss and developmental delay	Dropped	Unlikely outcome would have been different if no delay. Practice and training has improved since 2001
01/10/02	Surgical	Gen Surg	Bile duct cut during surgery-> surgery to rebuild bile duct	Settled for £120,000	Clinician involved has retired
27/11/03	Surgical	Ortho	Bilateral knee arthroscopies -> complications -> further surgery which showed tear to lateral meniscus (Netcare)	Dropped	Whole episode review revealed that both knees drained postop, which may have increased risk of infection
16/01/04	Surgical	Gen Surg	Alleged perforation of bowel and failure to diagnose leak at the anastomosis	Dropped	Whole episode review: treatment appropriate
02/02/04	Surgical	Gen Surg	Alleged femoral nerve damage during repair of bilateral and umbilical hernia	Settled for £52,000	Unclear how symptoms arose but no concerns about standard of surgery
22/02/04	Surgical	Ortho	Alleged poor standard of knee operation (SA Medics)	Dropped	Work carried out by SA consultants now closely monitored with work integrated into departmental workload + use of own theatre staff. Whole episode review: no obvious problems but pt lives in Plymouth
19/07/04	Surgical	Gen Surg	Alleged poor treatment following bowel resection	Dropped	Whole episode review: treatment appropriate
08/05/05	W&C	Obs/maty	Alleged inadequate obstetric care -> neonatal death	Dropped	Serious Untoward Incident investigation: recommendations made; actions being monitored
AUGUST					
17/10/03	W&C	Gynae	Alleged bladder damaged during hysterectomy (recognised risk of procedure). However there were concerns over subsequent management of complications	Settled for £25,000	Accepted that there was a short delay in performing the subsequent laparatomy, which was due in part to lack of HDU bed
20/01/04	Surgical	Ortho	Alleged poor standard of care (Netcare)	Settled for £65,000	Review of Netcare initiative. Consultants now closely monitored with work integrated into departmental workload + use of own theatre staff.

18/02/04	Surgical	Ortho	Ongoing problems following hip replacement (Netcare)	Dropped	Review of Netcare initiative. Consultants now closely monitored with work integrated into departmental workload + use of own theatre staff.
07/07/04	W&C	Obs/maty	Undiagnosed breech delivery (at Grange). Baby transferred to SMH but died shortly afterwards	Settled for £70,000	Serious untoward investigation: all recommendations actioned
01/10/04	Surgical	Anaesth	Number of teeth damaged during operation	Settled for £1,000	No admission of liability
08/10/04	FM	Hot/SMH	Claimant slipped on wet floor	Dropped	Two witnesses saw claimant walk on wet floor clearly marked with cones
16/11/04	Surgical	Ortho	Claimant sustained ulnar nerve palsy during surgery	Settled for £5,500	Known complication of but no obvious factors which led to nerve compression
13/04/05	Surgical	Theatres	Tooth damaged during operation	Dropped	Whole episode review: treatment appropriate
09/10/05	FM	Estates	Claimant leaving QAH lost her footing and injured her arm: claimant had not noticed tarmac wheelchair ramp	Settled for £3,500	Ramps now painted with white lines
SEPTEMBER					
13/10/95	Surgical	ENT	Alleged late diagnose of sub-mucosal cleft palette	Dropped	Whole episode review: treatment appropriate
20/01/2000	Medicine	Haem	Alleged failure to diagnose polycythaemia and /or thrombocythaemia + failure to investigate blood abnormalities in pt suffering a stroke	Settled for £500,0000	Clinician involved now retired
21/01/01	W&C	Obs/maty	Alleged failure to refer for immunoglobulin infusion following c-section	Settled for £95,000	Currently investigating any actions taken
15/11/01	Surgical	Gen Surg	Alleged bowel perforation during incisional hernia	Settled for £160,000	Clinician involved now retired
19/03/02	Surgical	Gen Surg	Alleged altered sensation in chest and arms following sympathectomy	Settled for £20,000	Whole episode review: treatment appropriate
13/04/04	Surgical	Ortho	Delay in treatment for leg fracture sustained as a result of fall from wheelchair	Dropped	Whole episode review: treatment appropriate
14/09/04	Medicine	Emerg	Alleged mismanagement of treatment in ED	Dropped	Whole episode review: treatment appropriate

Potential Claims (i.e. request for copy records from solicitors, who are investigating potential claims against the Trust)

Claim Date	Division	Specialty	Synopsis
JULY			
02/07/07	Medical	Gen Med	Alleged breach of duty relating to MRSA infection
06/07/07	Medical	Emerg	Claimant admitted to ED with SOB: transferred to MAU and died
23/07/07	Medical	Emerg	Alleged failure to diagnose and treat cauda equine syndrome
27/07/07	Medical	Renal	Alleged deterioration in eyesight due to undiagnosed low BP
05/07/07	Surgical	Gastro	Alleged misdiagnosis of cancer
06/07/07	Surgical	Gen Surg	Allegedly contracted MRSA and died
27/07/07	Surgical	Anaes	Alleged psychological distress caused by administration of incorrect medication during anaesthesia
03/07/07	W&C	Child	Full details of claim not yet available: child born in 2005 and transferred to NNICU
18/07/07	W&C	Child	Full details of claim not yet available: child born 2004, admitted to NICU. Alleged block ET tube: blood transfusion given into tissue (immediately stopped); and snipped end of finger during removal of micropore plaster
AUGUST			
21/08/07	Medical	Emerg	Pt admitted to ED. TIA diagnosed and discharged to GP. Pt found dead in bed 4 days later
09/08/07	Surgical	Ortho	Alleged failure to provide physio following op to improve hip disability
13/08/07	Surgical	Gen Surg	Alleged poor postop care -> infection/restorative surgery/disability
15/08/07	Surgical	Ortho	Alleged mistreatment of right hip -> pain/suffering/loss of amenity
15/08/07	Surgical	Theatres	Alleged intraoperative dislocation of knee
22/08/07	Surgical	Gen Surg	Alleged failure to diagnose and treat diabetes/mistaken diagnosis of appendicitis/peritonitis. Intraoperative cardiac arrest -> brain damage
24/08/07	Surgical	Ortho	Claimant fractured right leg -> full cast. Returned for cast removal and told to walk normally. Continued to be in pain and x-ray revealed unhealed fracture
29/08/07	Surgical	Ortho	Alleged permanent disability following hand surgery
SEPTEMBER			
17/09/07	FM	Estates	Alleged injury to hip, chest and head following fall at QAH
03/09/07	Medical	Renal	Slipped on wet floor and suffered knee injury
20/09/07	Medical	Oncology	Alleged failure to diagnose second tumour

05/09/07	Surgical	Gen Surg	Claimant alleges 2 foreign bodies left in wound following hernia repair
17/09/07	Surgical	Gen Surg	Alleged perforation of bowel during hernia repair
17/09/07	Surgical	Ortho	Claimant alleges that patella tendon severed during total knee replacement + poor follow-up to repair: will require further surgery
18/09/07	W&C	Gynae	Alleged delay in diagnosing ovarian cancer: full details not yet available

Total claims received

	Jul – Sept 06		Jul – Sept 07
Potential clinical negligence	28		22
Employer liability	1		3
Public liability	0		3
TOTAL	**29**		**28**

Inquests

	Jul – Sept 06		Jul – Sept 07
Coroner request for report	33		43
Staff required to attend inquest	4		14

The number of potential claims remains steady with no significant increase.

There has been a 29% increase in inquests for the 2007 quarter in question with more staff being required to attend inquests.

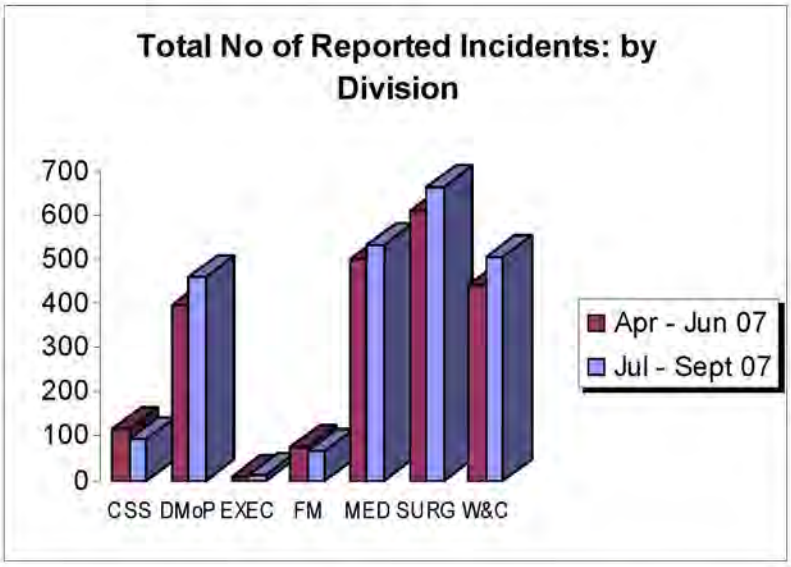
Small Claims

CLAIMS PAID	
July – September 2007	
SURGICAL	
Dentures	150.00
Glasses (repair)	35.00
Clothing	20.00
Electric shaver	40.00
Travel reimbursement/parking	23.25
TOTAL	**£268.25**
MEDICAL	
Clothing	100.00
Dentures	294.00
Glasses	50.00
Money/wallets	35.00
Travel reimbursement/parking	49.00
Electric shaver	45.00
TOTAL	**£573.00**

CLAIMS NOT PAID: July – September 2007		
Amount	**Items**	**Reason for non-payment**
1,750.00	Hearing aid	Recorded in notes that pt always wrapped aid in tissue and not in correct holder – Trust not liable
200.00	Glasses	Pt deceased
210.00	Jewellery	Pt declined to put in Trust safe – recorded in medical records
350.00	Jewellery	Pt declined to put in Trust safe – recorded in medical records
20.00	Hearing aid	Replaced
250.00	Mobile phone/money	Pt deceased: family claim – property found
14.40	Travel reimbursement	Pt arrived 2 days early for appt
4.50	Parking	Operation cancelled due to emergency
38.00	NOK A/L day	Misunderstanding over date of operation: wife took A/L
450.00	Hotel/travel/hire car	Procedure cancelled due to pt being unwell
£3,382.40		

Total small claims paid = £ 841.25
Total small claims not paid = £3,382.40

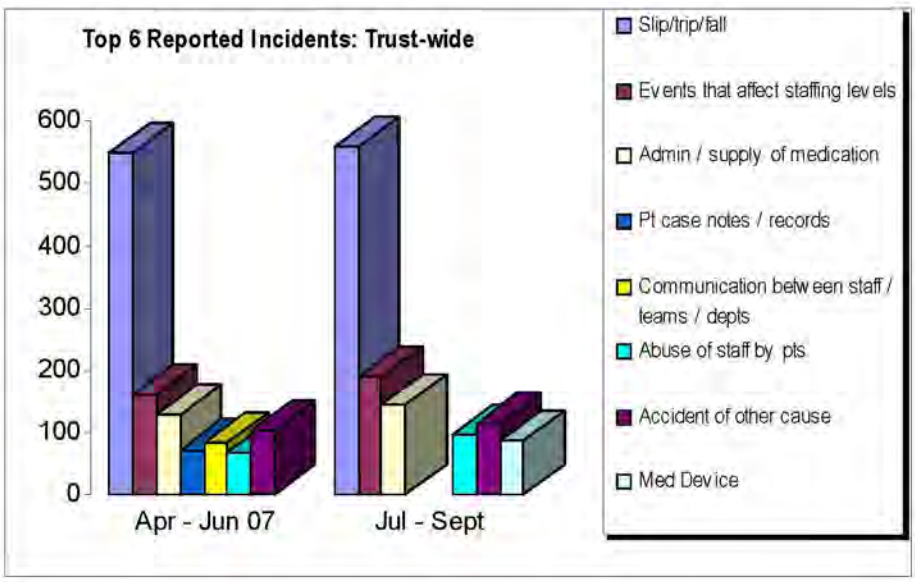
INCIDENTS – Aggregated Report



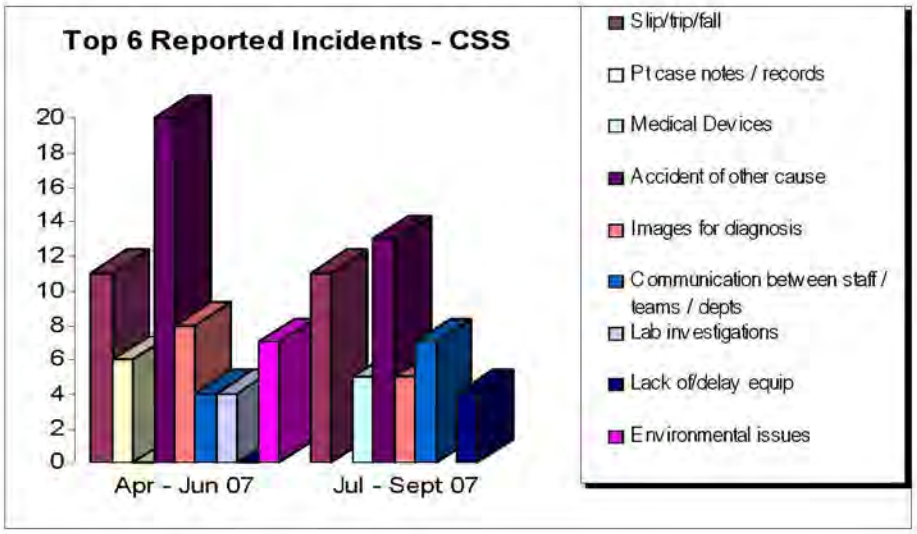
A total of 2334 incidents were reported in the quarter Jul - Sept 07 compared to 2153 in the previous quarter

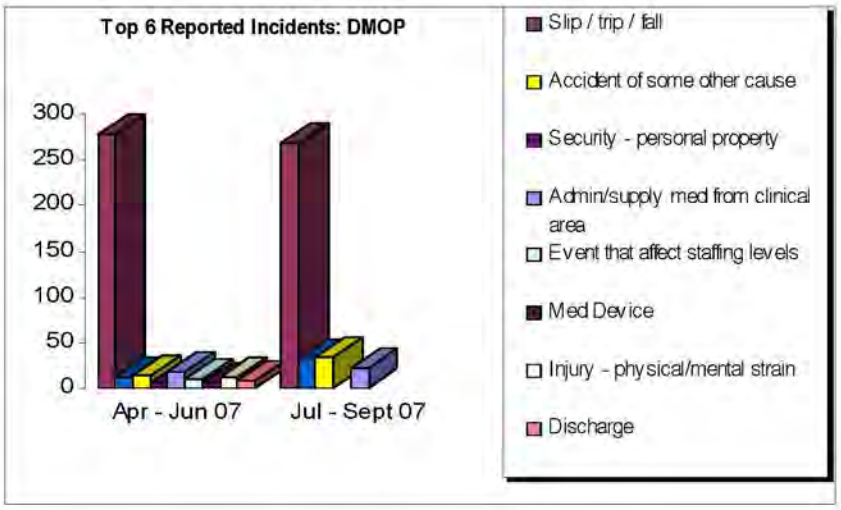
Reported Incidents as Percentage of Clinical Activity

	Apr – Jun 07	Jul – Sept 07
Medicine	1.2	1.3
Surgery	0.9	0.9
W&C	2.7	3.1



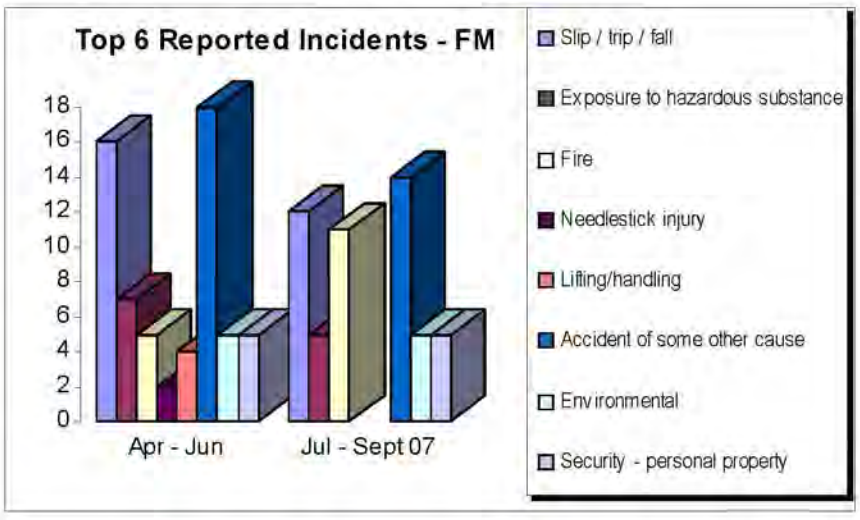
The graph opposite demonstrates that the top 10 reported incidents have remained largely similar over the two quarters.

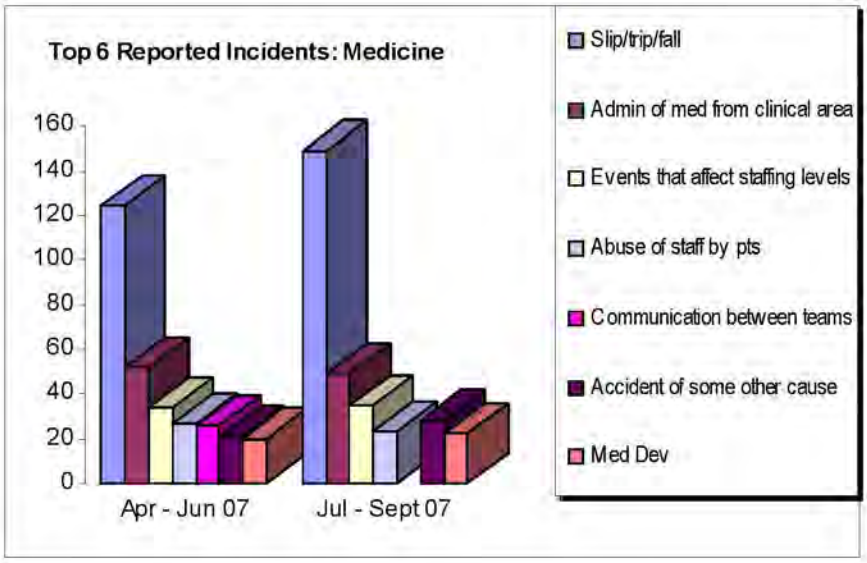




These graphs demonstrate that slips/trips/falls has been the most reported incident in both quarters.

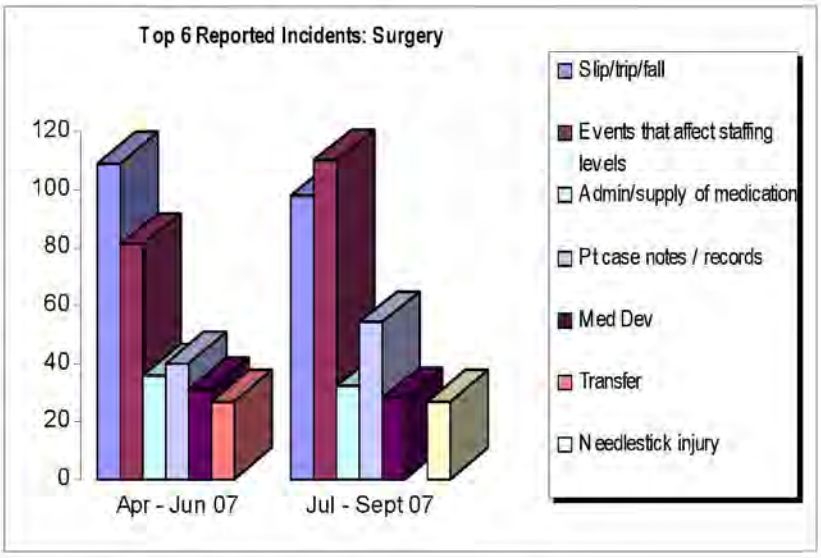
No graph has been produced for the Executive Division, as there were only 11 reported incidents, four of which were fire related.





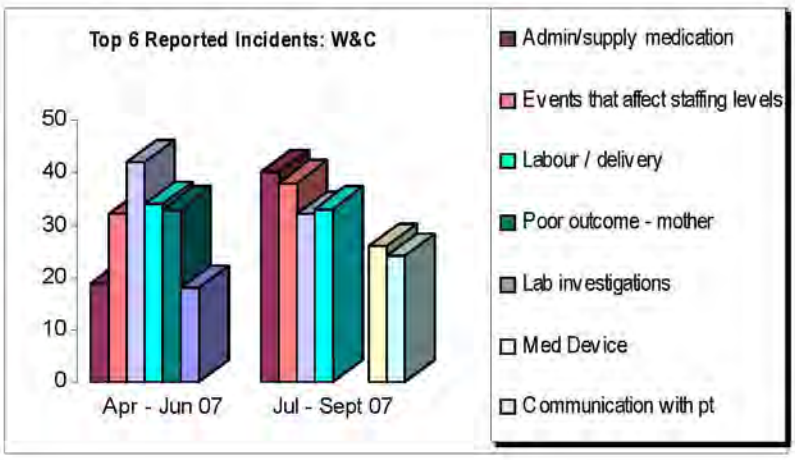
Slips/trips/falls and medication errors remain two of the top three reported incidents.

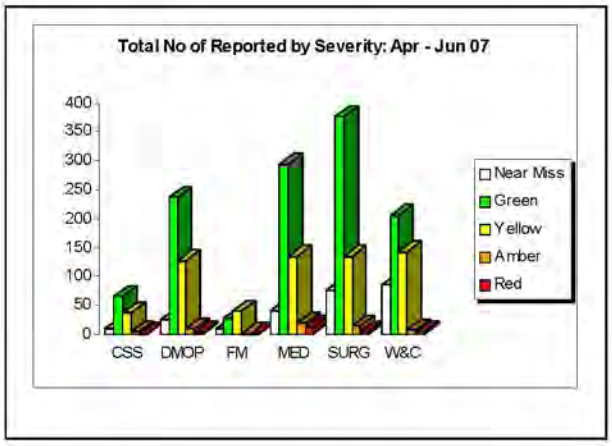
It is interesting to note that slips/trips/falls and medication errors were also the top two reported in the seven previous quarters

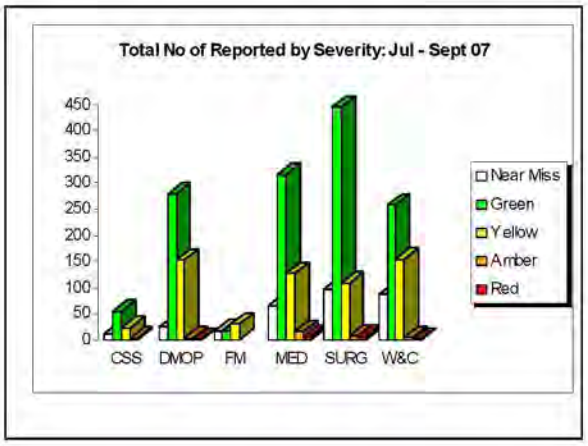


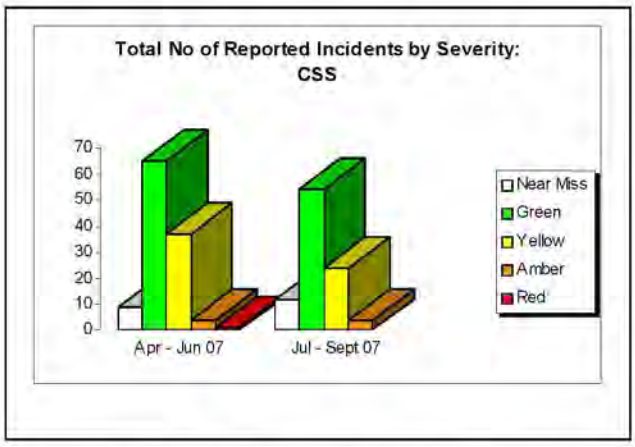
Slips/trips/falls remain the top reported incidents in both quarters.

It is interesting to note that slips/trips/falls was also the top reported incident in the seven reported quarters.

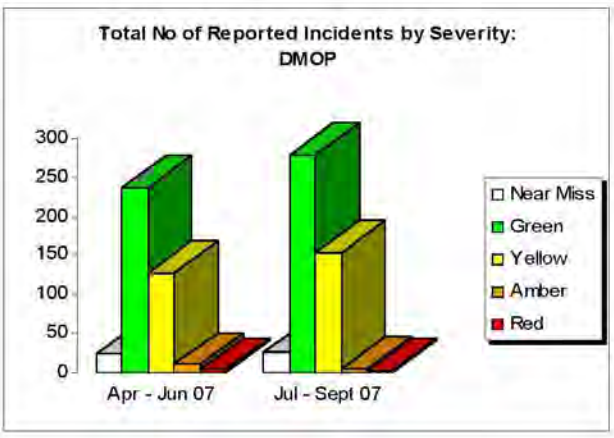




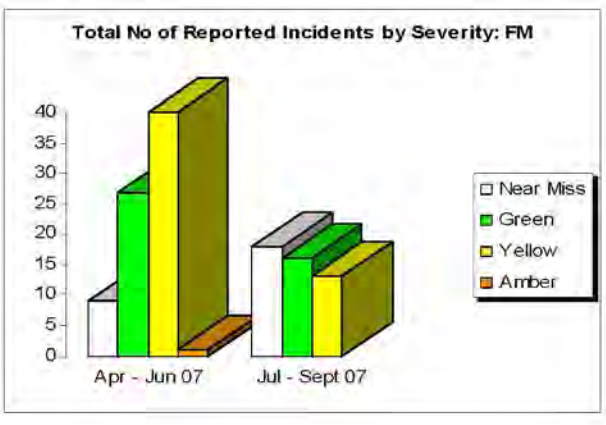




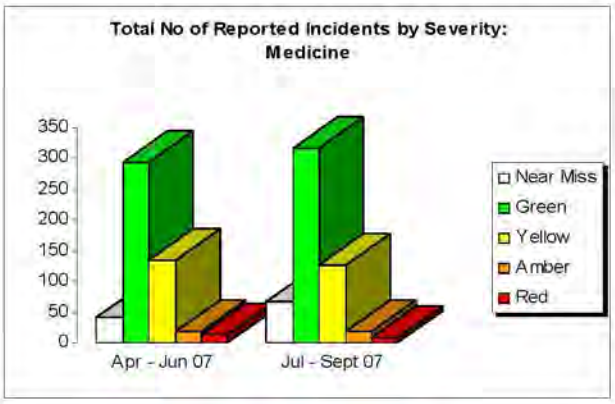
	Apr – Jun 07	Jul - Sept
Total reported incidents	116	94
Red	1	0
Amber	4	4
Yellow	37	24
Green	65	54
Near Misses	9	12



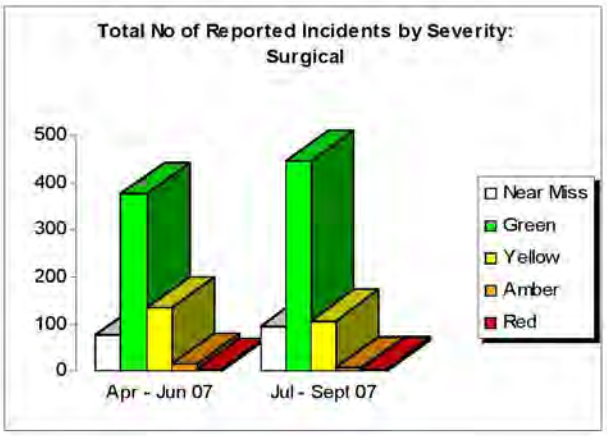
	Apr - Jun 07	Jul – Sept 07
Total reported incidents	339	463
Red	3	2
Amber	9	4
Yellow	127	153
Green	236	279
Near Misses	24	25



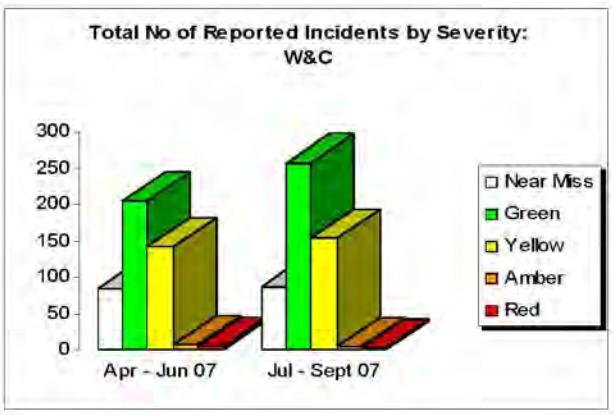
	Apr - Jun 07	Jul – Sept 07
Total reported incidents	77	64
Red	0	0
Amber	1	0
Yellow	40	30
Green	27	16
Near Misses	9	18



	Apr – Jun 07	Jul – Sept 07
Total reported incidents	500	533
Red	13	7
Amber	19	17
Yellow	134	127
Green	293	316
Near Misses	41	66



	Apr – Jun 07	Jul – Sept 07
Total reported incidents	610	664
Red	5	7
Amber	15	8
Yellow	135	108
Green	376	444
Near Misses	76	97



	Apr - Jun 07	Jul – Sept 07
Total reported incidents	444	505
Red	5	2
Amber	7	5
Yellow	142	154
Green	205	257
Near Misses	85	87

SERIOUS ADVERSE EVENT SUMMARY

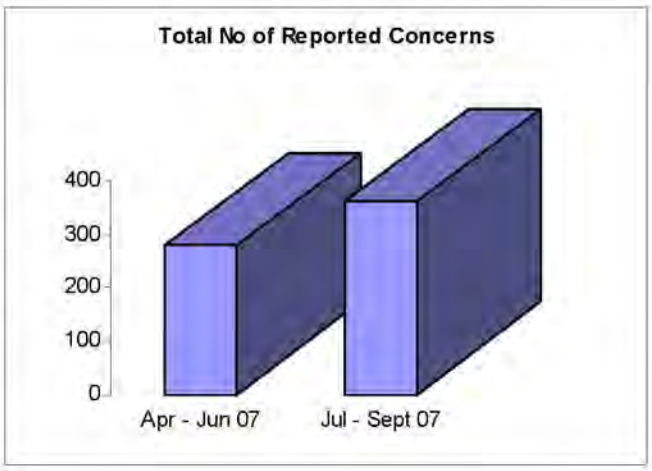
A Serious Adverse Event is one which, for whatever reason, is classified as major or catastrophic: commonly known as a 'red' incident. They are classified as major/catastrophic according to outcome, number of patients involved, effect upon Trust services or litigation costs.

All Serious Adverse Events, or potential Serious Adverse Events, are investigated in line with Trust protocol

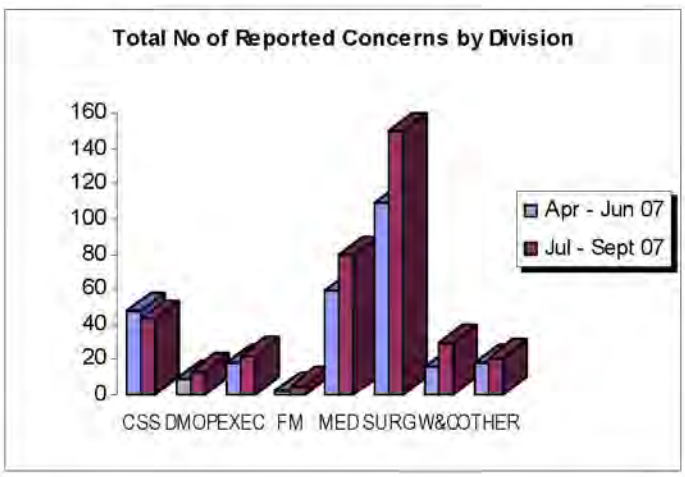
April – June 07			July – September 07	
Division	**Brief Summary**		**Division**	**Brief Summary**
CSS	Alleged assault by staff on patient		DMOPS	1 x MRSA
DMOPS	2 x MRSA		DMOPS	Problem with PEG feeding -> pt died
DMOPS	Pt died following a fall		Medical	3 x MRSA
Medical	10 x MRSA		Medical	SCAST invoking operational directive
Medical	Misfiling of ECG -> cardiac arrest -> died		Medical	Medication error: pt died
Medical	Unsafe transfer of respiratory patient		Medical	Allegation of sexual assault
Medical	Inappropriate treatment for oncology patient		Medical	Transfer from ED -> DCCQ: died 10 mins after arrival
Surgical	4 x MRSA		Surgical	4 x MRSA
Surgical	Pt died following right total hip replacement		Surgical	Death of pt post-colonoscopy
W&C	5 x MRSA		Surgical	Pt received wrong unit of blood: unharmed
			Surgical	Pt died post surgery: developed renal failure
			W&C	1 x MRSA
			W&C	Inappropriate admission to gynae: pt died

PATIENT ADVICE AND LIAISON SERVICE

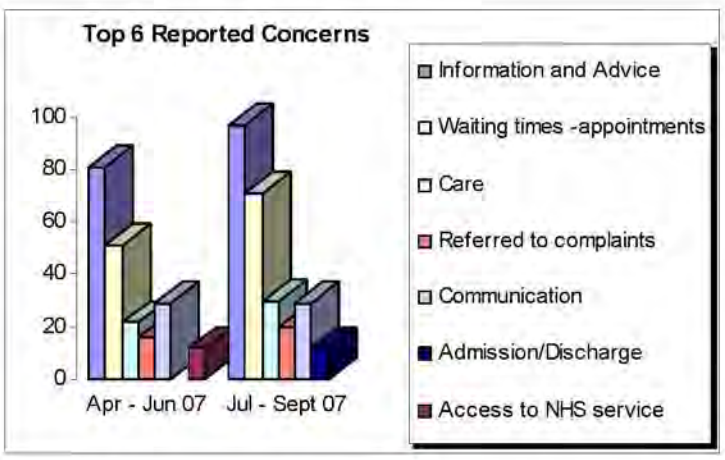
PALS continues to play a significant role in the patient and relative experience within the Trust, with 362 concerns being reported this quarter, against 279 the previous quarter, demonstrating an increase of 30%



Although this figure represents a 30% increase, this is more in line with quarter Jan – Mar 07 when 377 concerns were reported



Of the Reported concerns	Apr – June 07	Jul – Sept 07
CSS	48	43
DMoP	9	13
Executive	18	22
Medical	59	79
Surgical	109	150
W & C	16	29
Other	18	21



Top 6 Reported Concerns	Apr – Jun 07	Jul - Sept
Admission/Discharge	0	12
Care	22	30
Communication	29	29
Referred to Complaints	16	20
Information & Advice	81	97
Waiting Times	51	71
Access NHS Service	12	

Care

- Concerns raised that transfer from one ward to another late in the evening was disorientating for a patient already suffering from vascular dementia
- Concerns that a patient was discharged without medication

- Concerns that an elderly patient with an old fracture to his right arm was not supervised when using his urine bottle and feel, fracturing other arm
- Incorrect blood test performed on oncology patient
- Patient not offered hand-washing facilities after using the commode
- Wet bed as a result of disconnected I/V infusion
- Doubly incontinent patient not placed on nappy/incontinence pad

Communication

- Lack of nutritional advice whilst on chemotherapy treatment programme
- Patient not asked about normal insulin regime, throughout the course of her stay
- No documentation of food or fluid intake for diabetic patient
- Conflicting advice from ward staff concerning elderly lady with dementia and a fractured femur
- Lack of acknowledgement of dementia and no note made in records despite repeated reminders from relative

Complaints Referrals

- Complaint received regarding conflicting advice from doctors about amount of chemotherapy treatment required

Waiting Times

- Patient waited 6 hours in clinic for her appointment to see a doctor

Health Information Centre

No information is available due to the closure and refurbishment: information will be available for the next reporting quarter, as the Centre re-opened in October 2007

PLAUDITS

The recording of plaudits continues to provide the Board with a more balanced representation of patient opinion on the services provided and it is unfortunate that not all specialties have the resources to capture the number of plaudits received – as positive gestures clearly continue to be far greater than the number of complaints received. However, all plaudits received by the Chief Executive and by the Complaints Team are recorded and the surgical division should be congratulated for the work they have done, and propose to do, in collecting information with regard to their plaudits.

Ward/Dept	No		Ward/Dept	No
ED	25		HNU	68
Alton Wards	31		Labour Ward	23
Child Health	20		MAU	59
Coronary Care	28		Maternity	213
DCCQ	35		NICU	63
Dermatology	74		Onc/Haem	57
DMOPs	143		Orthopaedics	11
DSU	5 + donation		Other	15
D Wards	108		Plastics	28
Exton 3	40		Radiology	9
F Wards	197		Radiotherapy	208
G4	29		Renal	52
Gastro	4		Respiratory High Care	30
General Surgery + SAU	192		Rheumatology	33
Gynaecology	19		Y wards RHH	80+
TOTAL	**1,929 + donation to DSU**			

Even this snapshot demonstrates that the Trust received far more plaudits than complaints in this quarter 239 complaints compared to 1929 plaudits.
The category 'other' refers to those plaudits received in the Chief Executive's office. They comprise a number of wards who receive one or two plaudits

ORGANISATIONAL LEARNING

Changes made or to be made in the light of complaints, incidents and PALS include:

Complaints

- Patients who are to have plastic surgery at St Richards following consultation at RHH, will receive an information sheet on the proposed procedure prior to leaving RHH. In addition, this will be recorded in the patient's notes together with an entry concerning any possible complications that might occur during/as a result of the procedure
- All women of child-bearing age will have a pregnancy test prior to a pipelle endometrial biopsy being performed
- The format of the questionnaire concerning pipelle endometrial biopsy has been amended, to ensure the receipt of appropriate and effective information

Incidents

- Specialist care plans to be devised for patients on G3 who have complex physical and mental health needs
- Formal teaching sessions regarding mental health issues to be introduced onto G3
- Increased education provided to laboratory staff following an incident in which a patient received the wrong unit of blood
- Improvements to the training for inserting chest drains under difficult conditions
- Review of I/V infusion practice on DCCQ
- Improvement to training with regard to I/V infusions on DCCQ + register of training to ensure nurses can provide evidence of competency
- Review of HR policy, to include guidance on couples not working same shift on same ward
- Chaperone advice now included in local induction on G3

PALS

- Amendment to discharge leaflet to inform patients to contact their local Environmental Health Department regarding the safe disposal of full sharps containers. An advice sheet has also been made available which lists specific chemists who will accept full containers for disposal.
- New advice sheet with regard to patients being nil by mouth prior to surgery on the CEPOD list

RECENT AND FUTURE DEVELOPMENTS

- Two portable mini-tech loop systems for the hard of hearing have been purchased and are available either from PALS or Equality and Diversity Officer
- Meeting held between Director of Estates, PALS and Fareham Access Group to review the height of the desk in the hydrotherapy reception area: this will enable easier access for disabled patients.
- Complaints leaflet and policy amended to further reinforce the fact that patients' care will not be adversely affected, should they raise a complaint or concern
- Complaints page on internet updated to reflect current practice
- All draft final responses are now approved by appropriate clinicians before forwarding to CEO's office for signature
- Further enquiries made with regard to purchasing a web-enabled incident reporting system and administrator: outline business case to be written
- Intention to appoint to position of both Healthcare Commission coordinator and Serious Untoward Incident coordinator