	A	B	C	D
1	**Description**	**Action taken (Investigation)**	**Decision made (done)**	**Investigating Mgr**
2	My husband, was admitted to the Sultan Ward at Gosport War Memorial Hospital to receive respite care due to bowel cancer and was due to be discharged home on the 28 July 2008, as wanted to be home when the time came for him to pass way. My husband received excellent care whilst a patient at Gosport War Memorial Hospital however I am extremely unhappy with the transport arrangements following his discharge and would not want other patients to go through the same experience. problem with the transport and myhusband arrived home at 03.45am on 29 July by ambulance. My husband was suffering from severe diarrhoea and I had to call out my GP for help following his return home and 2 District Nurse were also called to help me with his care. Unfortunately my husband was admitted back to the Sultan Ward later that day and he sadly passed away.	Action required: "patients not to be transferred from ward after 2100, ward team made aware at ward meeting "Member of staff spoken with by Modern Matron on issues of confidentiality also be discussed at ward meeting "Communication with families to be documented in nursing notes to be discussed at ward meeting The importance of communication with patients and their families too		TS
3	Complainant is concerned at the level of care his father received whilst an inpatient at GWMH. Patient subsequently died following transfer to Countess Mountbatten Centre. Complainant feels that father should have remained at GWMH.			EE
4	Unhappy with the nursing care received at GWMH	Complaint to be discussed as part of Steering Group To be discussed at Ward Meeting re lack of recordings, specimen not sent and request to dietician not acted upon Complaint to be taken to Steering group for discussion ,Actions as part of minutes Matron/HOS - 1/10/08 To discuss nursing issues at ward meeting Lack of reporting dietary and fluid intake - improvement in recording Medics not actioning blood results - Blood results to be signed that they are seen and actioned in medical notes Referrals to other services to be actioned within 24 hours		TS

	E	F	G
1	**Lessons learned**	**Outcome**	**ID**
2	As a result of the learning from the complaint it has been agreed that in future Gosport War Memorial Hospital will not transfer any patients home from the Sultan ward after 2100 hours. experience that you did. - Educational/training needs identified Communication with families and patients Importance of confidentiality A	Meeting held. As a result of the learning from the complaint it has been agreed that in future Gosport War Memorial Hospital will not transfer any patients home from the Sultan ward after 2100 hours. experience that you did.	223
3	the ward staff have been spoken to and reminded of the importance of contacting relatives with any changes of condition.	the ward staff have been spoken to and reminded of the importance of contacting relatives with any changes of condition.	152
4	"there was poor recording of dietary and fluid intake "request for dietician not acted upon "Progressively worsening renal failure not acted upon by medics although highlighted to them by pharmacist "Length of time before transferred to acute services "No stool specimen sent when patient had diarrhoea	Letter of explanation and apology sent to complainant.	245

	A	B	C	D
5	Complaint regarding care that patient had whilst an inpatient in Sultan Ward, Gosport. Patient is now deceased. Complaint is from patient's husband.	All the above lessons have been discussed fully with the Clinical Manager, and will be actioned following an open forum during the staff meeting that was held on 5 November 2008.		TS
6	Complainant has raised concerns regarding the letter of care received by father whilst an inpatient in GWMH.	All the concerns you have raised regarding staff communication have been discussed fully with the Clinical Manager, and will be actioned at an open forum in the pending staff meeting.		BG2

	E	F	G
5	The actions taken regarding this are to link closely with the ward over nutritional training, a new policy and screening tool is being implemented, with the supervision of the PCT Dietician. Also, the Clinical Managers and the Modern Matron will be attending specialist nutritional training in February 2009, in order to promote good practice and high standards of patient care. Both the Clinical Manager and the Modern Matron support the fact that the care planning should be consistent and adhered to by the multi-disciplinary healthcare team. Mark Roberts, Clinical Manager, has agreed to access specialist training for staff regarding diabetic care, including regularity of blood sugar monitoring and administration of insulin the team have discussed how they could have supported you more to prepare for her end of life care. In view of this further training for the nurses has been arranged with both the chaplain and the specialist palliative care team regarding care of relatives and the dying patient. A link nurse has also been allocated within the nursing team, in order to communicate directly with all of the wider networks involved in providing optimum end of life care to our patients, carers and relatives	See lessons learned	259
6	if the doctors were happy for patient to have these foods, this needed to be communicated and discussed within the multidisciplinary network, and this is an action point that the team need to learn from. ensure that there is suitable signage on the ward so that patients and relatives are aware of the areas that can be accessed. Clinical Manager will be implementing a policy as a working draft to ensure that the nutritional needs of patients are being met.	see lessons learned	262