Maidstone and Tunbridge Wells NHS
NHS Trust

Complaint case study for publication on Trust website January 2016:

Mrs H raised a complaint with the Trust, following an episode of poorly co-ordinated care provided to her daughter, L, and poor communication.

Two-year-old L was referred to the ENT service by her GP due to recurrent ear infections. A treatment plan was agreed, involving surgical drainage of fluid from her ears and removal of her adenoids. It was explained to Mrs H that L could not have grommets inserted as she was under three.

At the pre-operative appointment, both the nurse and the doctor (who had agreed the original treatment plan) advised that L would be having grommets.

On the day of the operation, the anaesthetist and surgeon came to see L and Mrs H and again said she would be having grommets inserted. Mrs H queried this and they corrected themselves. Post-operatively, the surgeon explained that they had not found any fluid on the ears and the adenoids had been removed successfully. However, the discharge documentation referred to grommets being inserted and the nursing staff were unable to clarify this for Mrs H.

There was further confusion during the outpatient follow-up appointment, Mrs H again being advised that L had had grommets because this was recorded in her notes, while the doctor said she could not read the notes and that it was unlikely that grommets had been inserted.

Mrs H acknowledged the care provided by the staff during L's surgery, but felt let down by the pre- and post-operative care.

Our findings

This complaint was investigated by the Complaints Team and following investigation, the complaint was upheld.

It was explained that the information around grommets not being used in patients under three was correct and apologies were offered for the poor communication around this. This issue was to be discussed at the directorate's clinical governance meeting (a meeting attended by clinical staff where complaints, incidents, complex cases and areas of learning are discussed) to reiterate the importance of effective communication and robust documentation, and highlight the relevant clinical guidance.

Confirmation was provided that no grommets had been inserted during L's surgery. It was identified that the error in the discharge documentation was due to a delay in the operation notes being filed in the healthcare records. This issue was also discussed at the directorate's clinical governance meeting.