Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 5403

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Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Paediatric department complaints.

You asked:

Please provide me with number of complaint raised against paediatric department (nurses, doctors) from patient in 2018, and if possible to clarify each complaint nature and what action taken.

Trust response:

Please see the following table.

Description (Policies)	Outcome
Delay in baby receiving an ultrasound scan which was required as baby was breech. Concerns that the delay in the scan caused a delay in treatment. . Compliments offered to obstetric team, emergency maternity, theatres and antenatal and delivery suite.	Explanation and reassurance offered around timing of scan. As an outcome of complaint, protocol will be developed to ensure consistency and optimal timing of scan.
Concerns raised that, despite EDN stating the opinion must be sought from Royal Brompton; consultant went against this advice and said all was fine with the patient. The following day patient suffered another lung collapse and was readmitted to hospital. Parents want to know the current plan for the treatment of the patient and whether Royal Brompton are involved in the management plan.	Apologies offered for poor experience. Consultant explains that patient did not need to be referred to RBH, but junior team had done so as a precaution. Assurance that results had been discussed with RBH. Patient now under the care of another consultant and appt arranged to see him to discuss next steps.
Concerns raised that incorrect medications were prescribed and with the attitude and manner of the doctor who reviewed the patient. Concerns raised that prescriptions are issued in the incorrect name.	Explanation provided for treatment plan and clinical advice given. Assurance offered that clinical management was not inappropriate. Apologies offered that old set of stickers was being used hence the incorrect name - this has been rectified. Apologies offered that complainant was upset by doctors comment.
Concerns raised that when attending Woodlands, a fracture of the ankle was missed, despite mother advising pain seemed to be originating in the ankle. No x-ray of the ankle was taken . When contacting Woodlands to ask for advice, the staff member was rude and put the phone down.	Explanation provided that no concerns about the ankle were raised with staff and therefore this was not investigated and no x-ray was taken. Apology offered to attitude of staff member.

Concerns raised that RSV injections not offered for her daughter, given that her daughter was born with underdeveloped lungs. Also is unable to contact consultant's secretary to arrange follow up appointment.	Vaccination was not clinically indicated for baby, hence not offered. Secretary was on leave but alternative instructions were provided on answerphone message to contact staff covering - apologies offered nonetheless.
Concerns with how system is organised with regards to referrals for a baby with trisomy 21 (Down's syndrome). Concerns raised that not enough information is provided during pregnancy for those at high risk of Down's syndrome baby.	Explanation provided that information for Down's syndrome pathway given once a confirmed diagnosis has been made. Information was provided to this lady when she received her screening results with links to appropriate websites with sources of information.
Concerns raised about GP referral being accepted despite lack of beds, lack of beds, why contact with CAMHS was not made earlier.	Explanation provided that patients are accepted to treat acute condition even if there are no beds available. Assurance offered that the CAMHS service were contacted and that this is a single point of contact.
Pt's father is unhappy with information provided by clinician following a request for a letter.	Request for letter was appropriately directed to specialist at GSTT. Any concerns regarding their response need to be directed to GSTT.
Concerns raised that staff on unit mixed up 2 patients referred from ED and as a result, did not examine and admit a patient being treated for sepsis until the consultant intervened. Questions raised regarding handover of care and access to notes.	Apologies that handover from ED to Woodlands was not effective. ED nurses are responsible for providing a hand over to the receiving staff. ED Matrons will ensure all paediatric ED staff are aware of this responsibility. Apologies that parent was misinformed that an application needed to be made to PALS (which was outside of their opening hours at the time) to view the records. PDN will ensure all woodlands staff are aware of the correct process in the future. Assurance offered that concerns have been shared with all staff involved for professional reflection under NMC code of practice. All staff advised to contact the paediatric consultant/registrar if they encounter similar situation int he future.
Concerns raised that patient attended for surgery, however his medical records were not available and therefore procedure was cancelled. Waiting for six hours NBM causing distress to child.	Apology offered. Assurance offered that meetings are taking place to determine the correct process to mitigate this risk.
Concerns raised regarding the inappropriate discharge of patient and that required blood tests have not been ordered,	Assurance offered that discharge was appropriate and all tests had been undertaken.
Adult patient inappropriately offered an appointment in the paediatric clinic.	Apology offered that this appointment was made in the incorrect clinic due to referral being incorrectly managed. Breakdown in communication between staff meant that a cancellation letter was not sent to patient. Concerns discussed with staff involved.
Concerns raised that patient sustained a friction burn which were identified post operatively. Patient also prescribed iron tablets, but not sure why?	No evidence to support friction burn was caused by any poor moving and handling techniques. Iron medication prescribed as HB low following surgery.
Concerns raised that patient was treated incorrectly and following discharge attended another hospital where he was diagnosed with a ruptured appendix and underwent surgery. Concerns raised with the manner and attitude of the doctor and that he breached confidentiality a couple of times.	Explanation provided that examination and investigations did not indicate appendicitis and therefore patient was discharged. Apology offered for the manner of the doctor although this is not his usual practice and explanation provided around discussions, and assurance the doctor did not breach confidentiality.
Difficulties in obtaining healthcare records, delaying surgery for a child. Both surgeon and anaesthetist were unaware of child's kidney difficulties. Request for reimbursement of loss of earnings and child care costs.	Apology offered that healthcare records were not available for the planned surgery. Assurances offered that notes have now been found. No reimbursement offered.
Patient attended for ophthalmology appointment and eye drops administered. Mother advised could make child lethargic. Patient brought to ED with periods of lethargy and limpness, admitted to Hedgehog where saw 5 paediatricians before a diagnosis was made.	Consultant is clear he did inform mother of all risks associated with use of eye drops. The involvement of eye drops was noted at triage and at the assessment in the ED so no delay in knowing that presenting symptoms may have been related to their use.
Concerns that due to staff member, baby had to wait longer than necessary for surgery. Nurse did not know which leg was being operated on and baby was left for several hours without milk.	Apologies offered for 30min delay to surgery caused by physio assistant not alerting ward staff that the patient had been returned to the ward from the plaster room. Individual was a new member of staff and learning was discussed with them and the wider team on the day. Parents were advised in the morning that the patient could have milk, however they were reluctant to feed the baby despite this advice.
Concerns raised that treatment offered in ED not appropriate given the symptoms and distress of this child.	Investigate concludes that treatment in the ED was appropriate.
Concerns raised that paediatric nurse has discussed patient details with somebody outside of the Trust.	Assurance offered that the nurse did not treat the patient and did not pass on any confidential information. Apology offered for concern caused.