COMPLAINTS

As a Trust, we are committed to continuously improving and learning from the complaints made by our patients and their families/carers. We are sorry when things go wrong or when the patient did not receive the standard of care we expect to deliver. All complaints are fully investigated and the lessons learned are shared amongst the teams involved and across the Trust to avoid similar situations arising.

For all of the complaints that we uphold we are happy to share with you a synopsis of what lessons we need to learn and/or specific actions we need to take.

September 2016 – closed and upheld

Complaint received by Clinical Business Unit	Outcome and actions required
Surgery, Cardiac and Critical Care Parent expressed concern regarding in-patient issues	• Poor communication from nursing staff to family regarding management of an indwelling device • Staff not following Trust policy for effective infection control procedures • Queries regarding clinical care of the child within the Intensive care setting **Action:- staff directly involved in the issues identified have met with Ward Manager and understand the impact of their actions**
Integrated Community Services Mum dissatisfied with the care her daughter received whilst an in-patient and issues with follow up in Outpatient area.	• Communication internally and subsequent documentation availability contributed to unnecessary anxiety and stress for parents **Action: - documents to be scanned onto Trust systems immediately to prevent delays. Appropriate application of Safeguarding processes**
Surgery, Cardiac and Critical Care Cancellation of surgical procedure due non availability of equipment	• Theatre safety huddle will take place before child receives pre-medication • Theatre will stock more equipment on shelves in case the issue arises again and therefore more reserve left to utilise. **Action: Theatre staff will drive safety huddles and stock management**
Surgery, Cardiac and Critical Care Post-surgical complications relating to suture material used during initial procedure	• Choice of suture in initial surgery contributed to post-operative complications requiring additional invasive procedures. • Attitude of Surgical Doctor within the Emergency department was not appropriate **Action :- medical staff both met with their Educational supervisors/**

	Clinical leads to discuss the impact this has had on the child and the wider family
Neurosurgery, Musculoskeletal and Specialist Surgery Administrative error when scheduling child for required surgical procedure	• Child was wrongly rebooked for an out-patient follow up rather than listed for surgery **Action :- staff member made aware of the error so as able to learn from this**
Clinical Support Services Administrative error when referring child for external services	• Referral was sent to the wrong Speech and Language team based in the community. • There was delay in recognising this by the receiving team that caused a delay when informing the Trust that it had been incorrectly sent. **Action – staff reminded about correct referral process and innovative ways of including process onto electronic system pursued.**