CHAPTER 7 LESSONS LEARNT FROM COMPLAINTS

CHI to check with HSC if they are looking at Mrs D (daughter Mrs R – before publication)
A total of 129 complaints were made regarding the provision of elderly medicine since 1 April 1997. These complaints include care provided in other community hospitals as well as that received on the acute wards of St Mary's and Queen Alexandra Hospitals. CHI was told that the three wards at Gosport War Memorial Hospital had received over 400 letters of thanks during the same period.

Ten complaints were made surrounding the care and treatment of patients on Dryad, Daedalus and Sultan wards between 1998 and 2002. A number raised concerns regarding the use of medicines, especially the levels of sedation administered prior to death, the use of syringe drivers and communication with relatives. One recent complaint concerned admission arrangements in Sultan ward. Three complaints in the last five months of 1998 expressed concern regarding pain management, the use of diamorphine and levels of sedation. The clinical care, including a review of prescription charts, of two of these three patients, was considered by the police expert witnesses. (findings summarised on page ??)

External review of complaints

One complaint was referred to the Health Services Commissioner (Ombudsman) in May 2000. The medical advisor found that the choice of pain relieving drugs was appropriate in terms of medicines, doses and administration. A complaint in January 2000 was referred to an independent review panel, which found that drug doses, though high, were appropriate, as was the clinical management of the patient. Although the external assessment of these two complaints revealed no serious clinical concerns, both the Health Services Commissioner and the review panel commented on the need for the trust to improve its communication with relatives towards the end of a patient's life.

Complaint handling

The trust had a policy for handling patient related complaints produced in 1997, based on national guidance *Complaints: guidance on the implementation of the NHS complaints procedure*, published in 1996 and reviewed in 2000. A leaflet for patients detailing the various stages of the complaints procedure was produced, which indicated the

right to request an independent review if matters were not resolved to their satisfaction together with the address of the Health Service Commissioner. This leaflet was not freely available on the wards during CHIs visit.

Both the trust and the local community health council (CHC) described a good working relationship. The CHC regretted, however, that their resources since November 2000 had prevented them from offering the level of advice and active support to trust complainants they would have wished. The CHC did continue to support complainants who had contacted them before November 2000. New contacts were provided with a "self help" pack.

CHI found that letters to complainants in response to their complaints did not always include an explanation of the independent review process, although this is outlined in the leaflet mentioned above, which is sent to complainants earlier in the process. Audit standards for complaints handling are good with at least 80% of complainants satisfied with complaint handling and 100% of complaints resolved within national performance targets. *(CHI check date)* The chief executive responded to all written complaints. Staff interviewed by CHI valued the chief executive's personal involvement in complaint resolution and correspondence. Letters to patients and relatives sent by the trust reviewed by CHI were thorough and sensitive. The trust adopted an open response to complaints and apologised for any shortcomings in its services.

Once the police became involved in the initial complaint in 1998, the trust ceased its internal investigation processes. CHI found no evidence in agendas and minutes that the trust board were formally made aware of police involvement. Senior trust managers told CHI that the trust would have commissioned a full internal investigation without question if the police investigation had not begun. In CHI's view, police involvement did not preclude an internal clinical investigation. CHI was told that neither the doctor nor portering staff involved in the care and transfer of the patient whose care was the subject of the initial police investigation were asked for statements during the initial trust investigation.

Trust learning regarding prescribing

The trust's medical director told CHI that following receipt of a complaint in August 1998 he confirmed with a colleague

in a neighbouring trust that prescribing parameters at the War Memorial Hospital were within an acceptable range.

Action was taken to develop and improve trust policies around prescribing and pain management (as detailed in chapter??). In addition, CHI learnt that external clinical advice sought by Portsmouth Healthcare NHS Trust in September 1999, during the course of a complaint resolution, suggested that the prescribing of diamorphine with dose ranges from 20mg to 200mg a day was poor practice and "could indeed lead to a serious problem". This comment was made by the external clinical assessor in regard to a patient given doses ranging from 20mg to 40mg per day.

Portsmouth Healthcare NHS Trust correspondence states that there was an agreed protocol for the prescription of diamorphine for a syringe driver with doses ranging between 20mg and 200mgs a day. CHI understands this protocol to be the Wessex guidelines. Further correspondence in October 1999, indicated that a doctor working on the wards asked for a trust policy on the prescribing of opiates in community hospitals.

A draft protocol for the prescription and adminstration of diamorphine by subcutaneous infusion was piloted on Dryad ward in 1999 and discussed at the trusts Medicines and Prescribing Committee in February and April 2000 following consultation with palliative care consultants. This guidance was eventually incorporated into the joint Portsmouth Healthcare NHS Trust and Portsmouth Hospitals NHS Trust policy for the assessment and management of pain which was introduced in April 2001.

Other trust lessons

Lessons around issues other than prescribing have been learnt by the trust, though the workshop to draw together this learning was not held until early 2001 when the themes discussed were communication with relatives, staff attitudes and fluids and nutrition. Action taken by the trust since the series of complaints in 1998 are as follows:

- an increase in the frequency of consultant ward rounds on Daedalus ward, from fortnightly to weekly from February 1999
- the appointment of a full time staff grade doctor in September 2000 increased medical cover following the resignation of the clinical assistant

- piloting pain management charts and prescribing guidance approved in April 2001. Nursing documentation is currently under review, with nurse input
- one additional consultant session began in 2000, following a district wide initiative with local PCGs around intermediate care
- nursing documentation now clearly identifies prime family contacts and next of kin information to ensure appropriate communication with relatives
- all conversations with families are now documented in the medical record. CHI's review of recent anonymised case notes demonstrated frequent and clear communication between relatives and clinical staff.

Comments recorded in this workshop were echoed by staff interviewed by CHI, such as the difficultly in building a rapport with relatives when patients die a few days after transfer, the rising expectations of relatives and the lack of control Gosport War Memorial staff have over information provided to patients and relatives prior to transfer regarding longer term prognosis.

Monitoring and trend identification

A key action identified in the 2000/2001 clinical governance action plan was a strengthening of trust systems to ensure that actions following complaints were implemented. Until the dissolution of Portsmouth Healthcare NHS Trust, actions were monitored through the divisional review process, the clinical governance panel and trust board. A trust database was introduced in 1999 to record and track trends in recent complaints. An investigations officer was also appointed in order to improve factfinding behind complaints. This has improved the quality of complaint responses.

Portsmouth Healthcare NHS Trust offered specific training in complaints handling, customer care and loss, death and bereavement, which many staff interviewed by CHI were aware of and had attended.

The trust had a well defined and respected line management structure through which staff are now confident will help to identify emerging themes from complaints.

Key findings

1. The police investigation, the review of the Health Service Commissioner, the independent review panel and the trust's own pharmacy data did not provide the trigger for the trust to undertake an review of prescribing

practices. The trust should have responded earlier and faster to concerns expressed around levels of sedation which it was aware of in late 1998.

Portsmouth Healthcare NHS Trust did effect changes in patient care over time as a result of patient complaints, including increased medical staffing levels and improved processes for communication with relatives, though this learning was not consolidated until 2001. CHI saw no evidence to suggest that the impact of these changes had been robustly monitored and reviewed.

Though Portsmouth Healthcare Trust did begin to develop a protocol for the prescription and administration of diamorphine by syringe driver in 1999 the delay in finalising this protocol in April 2001 as part of the policy for the assessment and management of pain was unacceptable.

There has been some, but not comprehensive, training of all staff in handling patient complaints and communicating with patients and carers.

Recommendations

1. That CHI work with the Association of Chief Police Officers and Investigations and Inquiries Unit of the Department of Health to develop a protocol for sharing information regarding patient safety and potential systems failures within the NHS as early as possible. CHI will also work with the Association of Chief Police Officers to develop police awareness of the NHS and its management and accountability structures.

2. That CHI ensures that any organisation demonstrating trends of serious concern arising from the prescription of any medicines, be referred immediately to the National Patients' Safety Agency.

3. That Fareham and Gosport PCT and East Hampshire PCT ensure that the learning and monitoring of action arising from complaints undertaken through the Portsmouth Healthcare NHS Trust quarterly divisional performance management system is maintained under the new PCT management arrangements.

4. That both PCTs involved in the provision of care for older people, ensure that all staff working on Dryad, Daedalus and Sultan wards who have not attended

customer care and complaints training events do so. Any new training programmes should be developed with patients, relatives and staff to ensure that current concerns and the particular needs of the bereaved are addressed.