First received	Location exact (primary)	Sub-subject (primary)	Outcome code	Outcome - eg, discussion with staff involved / training / change of process
05/01/2018	Gynae Outpatients QA	Dismissive	Upheld	Consultant reflected on patient's experience.
08/01/2018	A5/6	Poor nursing care	Partly Upheld	Staff to be reminded of offering support with Red Tray system and responding to requests for extra blankets if patient is cold.
09/01/2018	Maternity Services	Insensitive to patient needs	Partly Upheld	Assurance given that guidelines were followed with regard to giving pessaries. Labour managed appropriately. Apologies given for attitude of Midwife.
11/01/2018	Gynae Outpatients QA	Other	Not Upheld	No actions to be taken
11/01/2018	Gynae Outpatients QA	Painful procedure	Upheld	Consultant reflected on patient's experience and will in future try to ensure she asks if patient's have allergies prior to using the probe and learning will be shared with other members of the Clinical Team.
22/01/2018	Paediatric Unit	Inappropriate comments	Partly Upheld	Consultant Paediatrician reviewed case file. Agrees that the discussion had with parent regarding baby's weight was within the good practice guideline. Offer to see Dietician.
23/01/2018	Gynae Outpatients QA	Sexual discrimination	Upheld	Although staff member has not been identified, assurance given that all staff had been reminded to afford patient's the respect and dignity they afford. Apologies given for the upset caused.
24/01/2018	Childrens Assesment Unit (CAU)	Delay in treatment	Partly Upheld	All observations over the 3 days explained to parent and reasons for not admitting the baby given. Assurance also given that both Nursing and medical staff were aware of the parent's concerns.
05/02/2018	A5/6	Lack of support	Upheld	Apologies given for information provided during initial telephone call. Informed of the correct protocol. Apologies given for delay in discharge summary being provided.
06/02/2018	Maternity Services	Delays in medication	Partly Upheld	Patient should have had iron on discharge, although written up on discharge summary, a review shows that this was not dispensed. Assurance given the iron levels will replenish themselves within a couple of weeks. Patient's history is that she has suffered 10 years of heavy periods and has a copper coil, which would more than likely be the cause of her anaemia.
09/02/2018	Gynae Outpatients QA	Insensitive to patient needs	Partly Upheld	Apologies given for perceived attitude of Consultant. Explanation as to why they could not give patient the details she requested due to process.
15/02/2018	A5/6	Co-ordination of medical treatment	Partly Upheld	Discharge letter sent to GP explaining procedure had been cancelled due to patient's low haemogoblin and the need of the thyroid functon to be checked. Patient was due to have a follow up appointment and ensure she was re-listed for surgery. Consultant arranged for patient to be seen in clinic with another colleague to discuss what operation is required and whether a hysterectomy is necessary.
19/02/2018	A5/6	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
26/02/2018	Gynae Outpatients QA	Injury sustained during treatment or operation	Partly Upheld	An initial response was sent addressing concerns about medical care, then a meeting was held with both Specialties involved in care to be able to discuss overall experience with Consultants and Surgeons.
27/02/2018	Childrens Assesment Unit (CAU)	Wait for assessment	Partly Upheld	Explanation of COAST given to mum - Informed that all correct process were followed, and apologies given if Mum found the delay unacceptable, informed that children are seen in turn, but an unexpected emergency arrival could cause further delay. Apologise given for the attitude of the Nurse.
28/02/2018	Maternity Services	Lack of support	Not Upheld	No actions to be taken
01/03/2018	Gynae Outpatients QA	Dismissive	Not Upheld	No actions to be taken
05/03/2018	Maternity Services	Catheter Issues	Upheld	•1 minute wonder – training which describes the physiology of the bladder •Guidelines on Bladder Care have now been updated •Bladder scanner is now on the ward •Bladder care is now included on the mandatory training day for all midwifery staff provided by the Urogynae Specialist Nurse
07/03/2018	A5/6	Lack of a clear explanation	Not Upheld	No actions to be taken
20/03/2018	Maternity Services	Lack of information/communication with relatives	Partly Upheld	The Doctor who reviewed baby over the weekend, but did not discuss his concerns with the mother, has now read the complaint letter and reflected on his actions. A supervised learning event has been completed with the Doctor, to reinforce the lessons learned from this case, and he is aware that he must discuss any concerns about a baby with their parents contemporaneously.
26/03/2018	B7 Postnatal Ward	Lack of a clear explanation	Upheld	Staff member spoken to and told this is not acceptable behaviour. Apologies offered for poor communication and moving forward an incubator will always be warming to prevent recurrence.

11/04/2018	Paediatric Unit	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	The ultrasound did not obviously show appendicitis and it is felt that this was because the appendix had probably perforated and released some fluid into the tummy/abdomen. On review of the scan results, this has been amended to reflect this possibility. There is documentation confirming that the patient's observations had been stable on the ward prior to her transfer. Unfortunately, however, there is no clear documentation that her observations were checked immediately prior to her transfer, which would be good practice. The Paediatric Team have been reminded of this for any future cases.
16/04/2018	B9 NICU	Delay in discharge	Partly Upheld	Full explanation given by Clinical Director to help mum understand what was happening behind the scenes and the reason to keep both mum and baby in for longer. Acknowledgement given that communication with mum about this could have been better and complaint has now been shared with the Team for learning purposes.
18/04/2018	Maternity Services	Lack of information/communication with relatives	Upheld	All relevant staff have been reminded of the expectation of providing leaflets to families on Bruising Protocol. Team will be exploring whether it is appropriate to introduce light wiping of suspected bruises. Decision will have to involve Designated Doctors for Safeguarding Children for both Hampshire and Portsmouth. Arrangements have been made for external speakers to deliver training to staff during April and May 2018 and the Hampshire Safeguarding Children Board are also delivering similar training for their staff.
24/04/2018	Early Pregnancy Assessment Unit	Treatment didn't have expected outcome	Upheld	Apologies given for the surgery not being successful, although it is consented that there is a 10% chance that the full removal of the miscarriage not happen. Apologies given for the lack of information regarding the miscarriage and what the patient should expect.
17/05/2018	A5/6	Treatment didn't have expected outcome	Partly Upheld	Senior Nurse has spoken with her Team and reiterated the importance of listening to a patient when they are expressing concerns about their wellbeing. Assurance given there was no evidence of bowel perforation at the time of surgery.
23/05/2018	A5/6	Delay or failure to diagnose (inc e.g.missed fracture)	Upheld	Although nothing documented, apologies for attitude of Agency Nurse. Assurance given that all staff have been reminded of the acceptable behaviour. Explanation as to why Oramorph was not given.
30/05/2018	A7 Starfish	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Acknowledgement given that there is learning to be had from this case and that in future it may be helpful to explain to all families in more detail about the process of second reviews of CT scans, so that they are not alarmed if they receive a call from the Department, although a concern would be that going into detail about our investigation processes might cause some families unnecessary confusion and anxiety in a different way. However, the Consultant has assured family that the Service will keep this under review in the hope that they may be able to prevent other families feeling so distressed.
01/06/2018	Gynae Outpatients QA	Waiting time too long in reception to see consultant / doctor / nurse	Not Upheld	No actions to be taken
04/06/2018	Maternity Services	Co-ordination of medical treatment	Not Upheld	No actions to be taken
04/06/2018	Maternity Services	Inappropriate procedure	Partly Upheld	Following investigation into 19 specific questions, Senior Management Team are confident that the care was appropriate to the findings of clinical assessments.
05/06/2018	Maternity Services	Mismanagement of labour	Not Upheld	No actions to be taken
07/06/2018	A5/6	Failure to follow up on observations/recognise deteriorating patient	Not Upheld	No actions to be taken
12/06/2018	A5/6	Personal Care	Upheld	Matron assured patient that the matter of the ward team not acting when patient raised concern about pus coming from wound site will be used as a learning point during their next Ward Meeting. Patient's experience will be shared at the next Ward Meeting and training will be provided to ensure that there is better communication about post-operative complications and training will be given where necessary to ensure that other patients do not have a similar experience.

18/06/2018	A5/6	Medication-TTOs	Upheld	Ward staff have been spoken to about always ensuring that there is effective communication prior to a patient's discharge and to try to help resolve any concerns so that patients feel well enough and confident to go home. Ward staff have been asked to ensure that all patients are regularly offered support and are not left to feel ignored or uncared for. The Support staff's Senior Management Team have been instructed to ensure that their staff are all aware that they must not touch any equipment that they have not been trained to use and they must discuss any concerns about equipment with the Nursing or Medical Team. Ward staff reminded about the importance of responding to any requests for pain relief as soon as possible. Your complaint has been shared with all Doctors on the Unit for learning purposes, in particular on how their language or behaviour could cause unintentional anxiety. Matron has reminded staff of the appropriate process for dispensing medication and will continue to monitor this and offer training to any staff who require this. A list of drugs which interact badly with Methotrexate has been produced and displayed on the Unit for doctors or nurses to check before prescribing and administering.
18/06/2018	A5/6	Insensitive to patient needs	Upheld	Sincere apologies offered for unacceptable experience. An anonymous version of complaint letter has now been used at a Departmental Governance Meeting to allow both Doctors and Nurses to reflect on the important learning points to prevent this happening again.
21/06/2018	A5/6	Invasive procedure carried out	Partly Upheld	Patient attended an outpatients appointment with a consultanton 6 July 2018. They discussed the ablation and patient is now for Hysterectomy.
03/07/2018	Childrens Assesment Unit (CAU)	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Assurances given that Consultant would have referred patient if reflux had not improved - apologies offered for poor communication throughout experience.
03/07/2018	A5/6	Waiting to see doctor/nurse once admitted	Partly Upheld	All patients are triaged and those in a critical condition are prioritised, Matron has acknowledged that the unfortunate delay would have been extremely distressing for the patient and for her family seeing her in pain. Apologies have been offered for the poor communication with both patient and her family throughout admission and Matron has shared this with her whole Team in an effort to improve patient experience for others.
06/07/2018	Maternity Services	Mismanagement of labour	Partly Upheld	Apologies given that previous responses have not clearly addressed patient's concerns. Explanation provided regarding psychotropic medication and that this should always be discussed with a patient.
06/07/2018	Early Pregnancy Assessment Unit	Lack of support	Partly Upheld	Meeting held so that staff could explain the treatment given during miscarriage and apologies offered for negative experience.
10/07/2018	A5/6	Lack of a clear explanation	Upheld	All staff reminded of the importance to keep personal conversations to a minimum and to remain patient focussed at all times. The Team have also carried out a reflective session on what happened to prevent recurrence in the future for other patients.
13/07/2018	A5/6	Patient discharged without informing family	Upheld	The error made has been discussed with the Social Worker involved to highlight the importance of clearly documenting all family requests on the available hospital systems, including the patient's medical records and the handover sheet, in an effort to prevent this from happening to any other patients in the future.
17/07/2018	A5/6	Discharged without adequate care package	Not Upheld	No actions to be taken
20/07/2018	Childrens Assesment Unit (CAU)	Communication failure between departments	Partly Upheld	The Maternity staff involved in your case would like to apologise for the unintentional upset that was caused. They have assured our Named Midwife for Safeguarding that they have reflected extensively about how your case was managed and about how they would do this differently in the future.
23/07/2018	Gynae Outpatients QA	Appointment cancelled and patient not informed	Upheld	All members of the team have been asked to reflect on what happened and there is now additional verification required that any clinical cancellations have made known to those patients affected.
24/07/2018	Gynae Outpatients QA	Treatment postponed	Not Upheld	No actions to be taken
26/07/2018	Antenatal Clinic	Delay or failure to diagnose (inc e.g.missed fracture)	Upheld	Acknowledgement has been given that it would have been better practice to have checked these results whilst the patient was in the hospital in view of the green discharge and raised infection markers. It has been reiterated to all staff the importance of documenting all care episodes in the clinical hand held notes and to obtain a review by the Obstetric Registrar prior to discharging women when presented with an abnormal finding. Further acknowledgement given that if the blood results and the vaginal loss had been reviewed together it may have been a consideration to expedite the birth of the baby, but SMT are unable to say what the impact of an establishing infection would have had on the baby due to his prematurity at that time.

30/07/2018	Gynae Outpatients QA	Co-ordination of medical treatment	Not Upheld	No actions to be taken
31/07/2018	Early Pregnancy Assessment Unit	Lack of support	Upheld	Patient called by Phlebotomy and EPAU. Apologies given and explanation of the actions taken as a direct result of this complaint. Patient was happy to close the complaint here, and no longer wishes to receive a written response.
10/08/2018	Maternity Services	Patient has not understood what giving consent means	Partly Upheld	Full review of patient's care carried out - complaint shared with the Consultant named within the complaint who will be reflecting on the comments raised for future practice. Assurance given to patient that from the time of the waters breaking to being brought into the hospital for an induction, it is considered that this was within the recommended timeframe.
13/08/2018	Maternity Services	Insensitive to patient needs	Upheld	Meeting held to ensure a more compassionate resolution was found - full experience discussed in full and assurances given that lessons have been learnt from her experience and apologies given.
24/08/2018	Maternity Services	Injury sustained during treatment or operation	Upheld	Concerns about being shouted at have been shared with the Registrar for them to reflect on and assist with future practice. The disagreement and negative energy that the patient felt in theatre was due to a lack of leadership and the Registrar's failure to achieve an instrumental birth easily. Lead Consultant has had discussions with the Registrar with regards to training requirements with recommendations to meet the required level of expertise as well as the need for escalation to more senior doctors.
24/08/2018	Maternity Services	Mismanagement of labour	Not Upheld	No actions to be taken
31/08/2018	Maternity Services	Rudeness	Partly Upheld	Explanation given regarding why partners cannot routinely stay on the ward, but apologies have been offered as the matter could have been more compassionately discussed and more options explored before a decision being made.
03/09/2018	B8 Labour Ward	Co-ordination of medical treatment	Not Upheld	No actions to be taken
04/09/2018	Gynae Outpatients QA	Dismissive	Partly Upheld	Explanation given of medical treatment rationale, reassurance given that it was not Consultant's intention to cause distress and shared with Clinical Director for learning and monitoring purposes.
10/09/2018	Antenatal Clinic	Lack of support	Upheld	Senior Midwifery Manager met with patient at home, apologised for negative experienced and ensured all of the right things are now in place for a more positive pregnancy experience - patient satisfied with meeting and to receive a post-meeting letter from Department and happy to close.
13/09/2018	B5 - Mary Rose Ward	Insensitive to patient needs	Partly Upheld	Assurance given that patient had appropriate management to assess the baby's wellbeing due to the previous attendances for reduced movements. Senior Midwifery Manager is keen to learn from this experience and she will also raise this issue with the Maternity staff through staff meetings to ensure that others do not have a similar experience in the future.
19/09/2018	Gynae Outpatients QA	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
26/09/2018	Gynae Outpatients QA	Staff attitude	Partly Upheld	Consultant involved made aware of the experience and feedback and has been asked to reflect and respond in full to the concerns raised - Clinical Director has been made aware of the finings of the investigation for sign off.
28/09/2018	Gynae Outpatients QA	Co-ordination of medical treatment	Partly Upheld	On receipt of complaint, decision made to get patient in to be seen in a clinical setting and the decision was made to now proceed with surgery - explanation given that all medical options available needed to be explored before surgical intervention.
04/10/2018	Maternity Services	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
15/10/2018	Maternity Services	Poor nursing care	Upheld	Meeting held where it was acknowledged that there had been a very poor level of communication, especially about the issue of carrying the baby and not using the cot. Experience will be discussed at Safety Huddle.
16/10/2018	A5/6	Patient has insufficient information to give informed consent	Not Upheld	No actions to be taken
18/10/2018	Maternity Services	Co-ordination of medical treatment	Upheld	Meeting held to discuss the findings of the SLE and it was agreed that due to the further information provided, some appendices would be added to the Report and shared with the patient. Patient has given the Team permission to use the baby's heart tracing to aid learning from the experience.
19/10/2018	Gynae Outpatients QA	Communication with patient	Partly Upheld	Meeting held to discuss concerns and experience. Apologies offered and Doctor involved will be made aware of feed back for learning purposes. Consultant now planning to discuss case with Radiologist to see whether an MRI scan may be beneficial in identifying the problem or whether there is an alternative option.

26/10/2018	Maternity Services	Ignored patient/relative/carer	Upheld	Explanation given that from the time that meconium was noticed and the patient being taken into a room, it was approximately 3 minutes, due to the rapidness of patient's progression, staff could not follow the protocol which would be to put patient on a CTG monitor. Acknowledgement given that communication was lacking and of keeping patient informed of the actions being taken. Feedback will be given at the next Ward Safety Huddle.
26/10/2018	Maternity Services	Communication failure between departments	Not Upheld	No actions to be taken
01/11/2018	A5/6	Treatment didn't have expected outcome	Partly Upheld	Full explanation given of medical decisions made, apologies offered for delay in being seen and being sent home in nightwear and made to feel she was being a nuisance. Investigations found that there was no gynaecological cause for the patient's pain, and she did not attend her next scheduled appointment.
22/11/2018	B9 NICU	Child protection	Partly Upheld	Consultant suspects that there was some difficult in finding a vein to take blood from, which in turn led the Doctor involved to cut off the identity tags to get a better view. This is not uncommon, but sometimes necessary and acknowledgement has been given that this matter should have been discussed with the Midwives at the time. Assurance given that Team now use bracelets with an adhesive strip, so that can be more easily removed and replaced.
23/11/2018	Gynae Outpatients QA	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Meeting held, although patient not happy with outcome, as she is adamant of the information she was given original, and still cannot understand why this was not acted on.
27/11/2018	Gynae Outpatients QA	Co-ordination of medical treatment	Not Upheld	No actions to be taken
30/11/2018	Maternity Services	Co-ordination of medical treatment	Not Upheld	No actions to be taken
07/12/2018	Maternity Services	Mismanagement of labour	Partly Upheld	All patients questions answered and acknowledged that the Midwife should have asked patient to contact Labour Line if they had any further concerns. Explanation given of the checking of the placenta and membranes, and that small pieces of placenta and membrane can be missed during this check. Apologies that suturing was not completed by one Nurse and accepted that the Nurse should have stayed late passed her finishing time to complete or wait until the next shift came on. Reasons given why patient was transferred to ward, and assurance that all her observations were normal at the time.
17/12/2018	A8 Shipwreck	Lack of pain management	Partly Upheld	Confirmation of reason why IV was removed, apologise that Mum felt patient did not receive enough pain relief, all pain relief given explained. Also apologies for the way the Nurse spoke with Mum and patient.
07/01/2019	Maternity Assessment Unit	Insensitive to patient needs	Not Upheld	No actions to be taken
17/01/2019	Childrens Assesment Unit (CAU)	Wait for assessment	Partly Upheld	Apologies given for the lack of communication. Assurance given as to why it was felt that baby should be checked in CAU following discussion with their GP.
18/01/2019	A5/6	Injury sustained during treatment or operation	Partly Upheld	Due to small perforation patient required Key Hole surgery - explained that this is one of the risks, which was listed on her consent form. Appt given to seen Consultant in clinic to go over her concerns.
18/01/2019	Maternity Theatres QA	Wait for assessment	Partly Upheld	Meeting held, during which it was explained that the Escalation Policy is currently being reviewed. Apologies offered for baby's birth time being recorded incorrectly as a result of human error (patient now has paperwork with all the details on).
01/02/2019	Early Pregnancy Assessment Unit	Lack of a clear explanation	Partly Upheld	The importance of good communication around bleeding in early pregnancy will be raised at the junior doctors' teaching in the department. The Staff Nurse will discuss this complaint with regard to pain management in the next team meeting and look at improving communication.
01/02/2019	Maternity Services	Sexual discrimination	Upheld	Response sent addressing each individual question raised. A decision then made to organise a meeting for patient, however, she would prefer for now to proceed under the legal process.
04/02/2019	Maternity Services	Delay in treatment	Upheld	Explanation of process given and reasons why patient felt that there was an initial delay was discussed. It was acknowledged that in highsight her case should have been escalated and a second Theatre opened.
08/02/2019	A5/6	Treatment didn't have expected outcome	Partly Upheld	Meeting held with patient, apologies that notes were still unavailable, but assurance given that from all medical information available (electronic) but did not have a vulvectomy performed (only an excisional lesion biopsy). The problem has occurred due to the scar tissue and the way it has healed, which meant the patient had to undergo another procedure. Apologies also given for the comment made by the Consultant.

08/02/2019	A7 Starfish	Wrong diagnosis	Upheld	Clinical Director of Paediatrics apologised for any distress that was caused, staff have been reminded of the importance of checking that the sample results they are looking up are fro the correct patinet using NHS Number to search and that they are looking at the most recent sample. In order to reinforce and share this learning this message has been shared at the Paediatric departmental meeting.
18/02/2019	Childrens Assesment Unit (CAU)	Delayed treatment	Partly Upheld	Consultant apologised that patient's experience in the Paediatrics Department was not as they would have wanted it to be. This was fed back to the Team for learning purposes. Apologies given for the lack of more frequent input from the Team or that a drink was not offered and this has been shared with the Senior Nursing Lead to share with the CAU Nursing Team.
26/02/2019	Maternity Services	Mismanagement of labour	Partly Upheld	Meeting held and during this it was acknowledged hat the care and treatment received could have been better, so apologies were offered. Assurance given, however, that Caesarean was in both mum and baby's best interest.
27/02/2019	Paediatric Unit	Breach of confidentiality	Not Upheld	No actions to be taken
28/02/2019	Gynae Outpatients QA	Lack of a clear explanation	Not Upheld	No actions to be taken
18/03/2019	Gynae Outpatients QA	Inappropriate comments	Upheld	Apologies given by Consultant for his comments, and the upset caused.
25/03/2019	Gynae Outpatients QA	Admission date continue to be rescheduled	Upheld	Procedure cancelled due to winter pressures, then urgent cancer case. Surgery re-booked for 11.4.19
01/04/2019	Gynae Outpatients QA	Treatment didn't have expected outcome	Not Upheld	No actions to be taken
12/04/2019	A7 Starfish	Treatment to patient (not clinical treatment)	Not Upheld	No actions to be taken
17/04/2019	Gynae Outpatients QA	Co-ordination of medical treatment	Upheld	Issue about professionalism, compassion and care has been discussed at the Ward daily handover meeting to ensure standards are improved. All staff reminded to document why any medication prescribed are not given. A statement will be added to the aftercare leaflet explaining what patients should so when they suffer severe pain.
18/04/2019	Gynae Outpatients QA	Cancelled procedure whilst an inpatient	Upheld	Apologies given for cancellation of procedure. Due to capacity on beds, there were none available post surgery, and patient required an overnight stay. Patient had surgery 12 days later.
24/04/2019	Maternity Services	Co-ordination of medical treatment	Not Upheld	No actions to be taken
29/04/2019	B8 Labour Ward	Mismanagement of labour	Not Upheld	No actions to be taken
30/04/2019	Gynae Outpatients QA	Patient not being verbally told things	Partly Upheld	Confirmation that way forward was discussed prior to procedure, patient agreed and following surgery thanked Anaesthetist. No perforation to womb.
07/05/2019	A7 Starfish	Poor nursing care	Upheld	Apologies offered for breakdown in communication at handover. Documentation error has now been corrected and staff involved have been asked to reflect on patient's and mother's experience.
08/05/2019	B5 - Mary Rose Ward	Treatment to patient (not clinical treatment)	Upheld	Meeting held with patient and husband, all concerns around cord clamping discussed, as well as explaining the guidance.
10/05/2019	A8 Shipwreck	Lack of information/communication with relatives	Not Upheld	No actions to be taken
14/05/2019	Maternity Services	Inappropriate comments	Partly Upheld	Director for Midwifery & Maternity met with the patient to thank her for taking the time to raise her concerns about an individual member of staff's current practice. The patient has been assured that an internal review will be undertaken and the Director will report back to the patient towards the end of the year with any actions that she has been able to make as a result of the complaint.
14/05/2019	Maternity Assessment Unit	Delay or failure to diagnose (inc e.g.missed fracture)	Upheld	On reflection of experience, Registrar acknowledges that the manner in which she approached the patient was not appropriate and has reflected on this. Staff training around hyperemesis has now been undertaken within the Team as a result of this complaint.
17/05/2019	B8 Labour Ward	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
20/05/2019	Gynae Outpatients QA	Delays in inpatient treatment/procedure	Not Upheld	No actions to be taken
20/05/2019	Gynae Outpatients QA	Treatment didn't have expected outcome	Not Upheld	No actions to be taken
20/05/2019	B8 Labour Ward	Mismanagement of labour	Upheld	Patient had a rapid labour, which is unusual for 1st time mums. Meeting held, acknowledged that her pain could have been better managed, and apologies given for unacceptable comment made by Midwife, who has been asked to reflect on this. Issues relating to buzzer are now discussed twice daily at the safety huddles.
20/05/2019	Gynae Outpatients QA	Long wait for appointment	Not Upheld	No actions to be taken

28/05/2019	A5/6	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Meeting held with patient and Sister, explanation given by Consultant that any vaginal trauma can be difficult to see. Apologies given that staff did not listen to patient, whens he knew something was seriously wrong. Also Consultant advised that learning had come from complaint around in such circumstances again, staff should do a rectal examination, which would have help spot the tear.
05/06/2019	Gynae Assessment Unit	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Assurance give that despite all the tests, the levels did not show that this was still a viable pregnancy, and that it was ectopic. Patient assured that this should not impact on having any further children.
06/06/2019	Early Pregnancy Assessment Unit	Test results not communicated to the patient	Partly Upheld	Apologies for distress that was caused and reassurance that since patient's experience improvements have been made to try to prevent this happening to others. New policies, staff members and processes have been implemented to support families through the bereavement process.
06/06/2019	Gynae Assessment Unit	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Patient declined to go down the medicine management route, and wanted a surgical management, although it was explained that the Trust do not do this, they patient again declined. Advised to come back with any further concerns, all attempts were made by Staff to contact patient to encourage her to go down the medication route. Also assured that if patient had returned to the Trust when it became clear that there was retained products she would have received surgery, but this was not the case.
07/06/2019	B5 - Mary Rose Ward	Breakdown in communication between staff	WDN- Withdrawn	Decision made to withdraw formal complaint and re-register as a PALS. Patient has informed Department locally that she never raised a formal complaint and is due to meet them on 7 August to discuss her concerns. They have already discussed her supporting the service to make improvements and she feels this is a positive step.
15/06/2019	Maternity Services	Lack of support	Partly Upheld	Reassurance given that the trace was correctly classified as reassuring even though patient was experiencing reduced foetal activity. Apologies offered that the documentation does not detail patient's full conversation at that time and case has been discussed at Ward-level Safety Huddle Meeting.
20/06/2019	Gynae Outpatients QA	Co-ordination of medical treatment	WDN- Withdrawn	Concerns are for GP Service, not PHT.
25/06/2019	Maternity Services	Delay or failure to diagnose (inc e.g.missed fracture)	Partly Upheld	Explanation of the investigations that took place and assurance given that all the examinations that took place were required. APologies given for the problems with the bereavement paperwork which caused a delay to the family.
25/06/2019	A8 Shipwreck	Co-ordination of medical treatment	Partly Upheld	Explanation given that blood results did not show that patient was dehydrated, therefore no IV fluids were prescribed. Apologies given for the way complainant was spoken to, and assure given that all staff have been reminded of the Trust values.
27/06/2019	Maternity Services	Cannula Management	Upheld	Meeting held with patient, apologies given for the problems the insertion of the cannula caused. Also assurance given that the Midwife involved has been met, and has done a reflection of her interaction with the patient and her partner.
27/06/2019	B7 Postnatal Ward	Insensitive to patient needs	Upheld	Explanation as to why ED have to use the corridor on occasions, when the number of patients being admitted is high. Apologies for delay in receiving medication.
28/06/2019	A5/6	Delay in discharge	Not Upheld	No actions to be taken
01/07/2019	B8 Labour Ward	Co-ordination of medical treatment	Partly Upheld	Acknowledged that the care plan documented for patient was not followed, in that it is noted that they should have had a follow up appointment at 38 weeks, which was not arranged. This was discussed in detail and it was agreed that this may not have changed what happened, but the patient would have been more informed of the choices available and how things may have proceeded. Apologies offered that this was not the case and for the distress this has caused.
01/07/2019	Grange Maternity Centre	Insensitive to patient needs	Upheld	Informed that nurse has been spoken about her professionalism. Apologies given for the upset caused by the Nurse.
02/07/2019	Maternity Services	Mismanagement of labour	Not Upheld	No actions to be taken
18/07/2019	Gynae Outpatients QA	Inappropriate comments	Partly Upheld	Consultant explained why the weight was mentioned, risk for surgery, also being overweight can cause heavy periods and if the patient wanted to take the IVF route there is a criteria and the BMI has to be under 30. Consultant felt that she was showing support in how much patient had lost at Slimming World.
23/07/2019	Maternity Services	Error with prescription	Upheld	Following feedback regarding E-coli being present not being shared with patient, process have been changed. On review it was clear that the Midwife had not checked the results, which led to patient becoming symptomatic. the process for all 'urgent' samples results has also been changed and are checked daily to ensure that they are escalated in a timely manner to enable the right treatment.

26/07/2019	Maternity Services	Failure to admit	Upheld	Explanation of what assessment was carried out and confirmation given that Midwife should have palpated patient's stomach, which would have then led to a vaginal examination. Apologies that this did not happen.
31/07/2019	A5/6	Treatment didn't have expected outcome	Not Upheld	No actions to be taken
06/08/2019	Maternity Services	Communication failure between departments	Upheld	System software has a 72 hour delay in processing cancellation requests which is why lady received a second text message following miscarriage. Issue has been escalated to the parent company; The Service has requested that if the system cannot be amended then it will stop using the text function. All staff reminded that women are able to self refer and the Trust website has been updated to ensure that the information is simple and the process is easy to follow.
08/08/2019	B8 Labour Ward	Mismanagement of labour	Not Upheld	No actions to be taken
09/08/2019	Gynae Outpatients QA	Long wait for appointment	Not Upheld	No actions to be taken
12/08/2019	Gynae Outpatients QA	Staff attitude	Partly Upheld	Team reminded by Business Manager what is expected of them moving forward and apologies have been offered for perceived attitude of staff. Explanation given of waiting list for surgery being suspended due to patient's holiday - which has now been booked.
14/08/2019	A5/6	Treatment to patient (not clinical treatment)	Partly Upheld	Senior Sister apologised for the attitude of the receptionist, and as a result of patient's feedback, further training is being provided to ensure this does not happen again.
14/08/2019	Early Pregnancy Assessment Unit	Treatment didn't have expected outcome	Partly Upheld	Procedure notes indicate that an uncomplicated procedure was undertaken; and that 'products of conception' were removed until the cavity felt empty. Following this procedure, the pregnancy tissue was sent and received, by the laboratory - In cases where the chorionic villi are not seen, this would have alerted the staff at the EPAU (Early Pregnancy Assessment Unit) and triggered the need to arrange for the patient to be reviewed. However as this was seen and the products of conception confirmed, no such concern was raised.
19/08/2019	A5/6	Treatment didn't have expected outcome	Not Upheld	No actions to be taken
20/08/2019	Gynae Outpatients QA	Delays in inpatient treatment/procedure	Not Upheld	No actions to be taken
28/08/2019	A5/6	Treatment didn't have expected outcome	Not Upheld	No actions to be taken
28/08/2019	Gynae Assessment Unit	Injury sustained during treatment or operation	Upheld	Meeting held with patient, accepted that the burn happened, and explanation given as to how this occurred, it was also explained that this is a recognised complication of this procedure, but assurance given that changes will be put in place.
30/08/2019	Gynae Outpatients QA	Lack of continuity	Upheld	All patient's concerns addressed, explained that patient was given 3 options and although she asked the Consultant to make the decision, which he could not she made the decision to have an hysterectomy. Also assurance given that patient was put on the waiting list following her appointment in 2018, not after she had her scan in 2019. Meeting held - further investigation undertaken, confirmation given that unfortunately, she was not taken off the waiting list and there was no record of this in her notes. APologies given, and offer to see her again in clinic re bladder problems since the surgery.
11/09/2019	Maternity Services	Mismanagement of labour	Upheld	Confirmation that Midwife has reflected on her actions and behaviour and recognised that this was not her usual level of care. The importance of using appropriate language that reinforces confidence while Midwifes are providing care has been reiterated. Discussion was also had with Midwife about failing to document the local anaesthetic during suturing.
13/09/2019	B9 NICU	Dismissive	Partly Upheld	Apology given for any unintentional distress that was caused.
24/09/2019	A5/6	Post-treatment complications	Partly Upheld	Explanation offered in relation to the issues with cannula and assurance offered that no issues were found with the cannula during the time in Theatre or Recovery. Apologies offered for the communication issues relating to discharge of patient without family being contacted and the information on the discharge paperwork.
03/10/2019	B8 Labour Ward	Error in performing a procedure on patient	Upheld	Following suture, it was noted that there was a graze towards the clitoris and a Drs opinion was required, but at the time the Dr was dealing with an emergency. Unfortunately in the process of that the suture being placed the needle was released and came away from the suture thread. The Doctor attended with 5 mins but was unable to locate the needle despite examination with local anaesthetic. Patient taken to theatre, but needle still could not be found. Interventional Radiologist attend and the needle was found. Apologies given to partner if they felt that they were not kept up to date with what was happening, and for the distressing this clearly caused.

09/10/2019	Maternity Services	Dismissive	Upheld	Community Midwife is carrying out an RCA to establish why she was not referred to the Perinatal Mental Health Service during pregnancy as she had antenatal depression and she will contact the patient in the new year to provide details of her findings.
09/10/2019	Maternity Services	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
21/10/2019	A5/6	Failed discharge requiring readmission	Partly Upheld	Meeting held with patient and mother. Agreement given that a further investigation would take place.
21/10/2019	A5/6	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
24/10/2019	Maternity Services	Co-ordination of medical treatment	Partly Upheld	All questions have been answered in full, including diagram for explanation. Apologised for experience.
29/10/2019	Gynae Medical	Delay or failure to monitor wound	Not Upheld	No actions to be taken
31/10/2019	Gynae Outpatients QA	Date for admission can not be given to the patient	Not Upheld	No actions to be taken
31/10/2019	B7 Postnatal Ward	Error in performing a procedure on patient	Partly Upheld	Explanation given that unfortunately, the issue regarding iron infusion and staining is a risk, which is explained beforehand. This can be down to the cannula being sited wrong. Apologies given that Dad found a pin in the babies hat, and assurance given that staff have been reminded to thoroughly check all hats donated.
08/11/2019	Gynae Medical	Communication with patient	Partly Upheld	Explanation of why patient had surgery and the type of surgery performed. Apologies that the paperwork was incorrectly completed. This has been discussed with the Team, and staff sorry that patient did not receive pain relief in an adequate time frame.
13/11/2019	Childrens Assesment Unit (CAU)	Failed discharge requiring readmission	Upheld	Meeting held with parents, and apologies given that they did not feel that the standard of Nursing Care was to the standards expected. Assurance also given that the Doctor involved has met with the Clinical Director for Paediatricss and reflected on their approach to both child and parents.
14/11/2019	B5 - Mary Rose Ward	Mismanagement of labour	Partly Upheld	Patient informed that the consensus from the Care Group, is that although they regret that patient believes that our review cannot be seen as independent and impartial, as the case has already been referred to the NMC, the Care Group did not believe that it would be appropriate to instigate another review at this time. Assurances given that as a learning organisation, the Trust will be happy to consider any recommendations the NMC may make in relation to our handling of this case.
20/11/2019	Childrens Assesment Unit (CAU)	Insensitive to patient needs	Partly Upheld	Meeting held with parents, all concerns answered around uniforms, lighting, medication and their son's play box. Action from meeting, is that the Play Therapy staff member will now devise a book with all the children that she has access to and the code for the play box.
25/11/2019	Maternity Services	Insensitive to patient needs	Not Upheld	No actions to be taken
17/12/2019	Gynae Assessment Unit	Treatment to patient (not clinical treatment)	Upheld	Explanation given of the plan and areas in the ED and why patient was moved onto a chair. Confirmation also given that patient was given IV Morphine, but apologies given for not providing further pain relief or water during patients time in ED. Ward Sister apologies for the poor communication on the ward, and that there was a delay in the call bell be answered.
24/12/2019	B8 Labour Ward	Poor nursing care	Not Upheld	No actions to be taken
03/01/2020	B8 Labour Ward	Failure to follow up on observations/recognise deteriorating patient	Not Upheld	No actions to be taken
13/01/2020	Maternity Services	Mismanagement of labour	Not Upheld	No actions to be taken
23/01/2020	B9 NICU	Communication with patient	Upheld	Acknowledged that the NICU does not have a family room, although they do provide toys for children. All staff involved have been made aware of the complaint and how their actions made the patient feel. Explanation of why headphones are now worn in the NICU, this is for confidentiality when Consultants/Drs are doing their ward rounds, and this enables all parents to stay with their babies.
27/01/2020	B8 Labour Ward	Staff not trained properly	Not Upheld	No actions to be taken
06/02/2020	Gynae Outpatients QA	Dismissive	Not Upheld	No actions to be taken
10/02/2020	Maternity Assessment Unit	Incorrect entry on medical records	Not Upheld	No actions to be taken
10/02/2020	Gynae Outpatients QA	Discrimination/Race	Partly Upheld	Apologies given, although it was recognised that it was a difficult consultation from the beginning. Assurance given that Consultant was given the patient time to speak and engage with her.
21/02/2020	Maternity Services	Problems with medication	Not Upheld	No actions to be taken
24/02/2020	Antenatal Clinic	Inappropriate comments	Not Upheld	No actions to be taken
24/02/2020	B8 Labour Ward	Poor nursing care	Not Upheld	No actions to be taken

24/02/2020	Maternity Services	Communication with patient	Upheld	1.The Midwifery Matron has spoken with the staff member involved and asked that a detailed reflection is completed 2.Items discussed in detail with the staff member: a.Communication processes b.The need to actively listen to the woman and the language she uses c.To discuss the term risk with the National Team to identify another term that can be used in the screening process
27/02/2020	B9 NICU	Birth Injury (including fetal laceration at LSCS)	Not Upheld	No actions to be taken
02/03/2020	Maternity Services	Insufficient information provided	Partly Upheld	Explanation of process regarding 'bruising policy' given and the reason this one done, including the investigations and discussions that happened. Apologies given for the distress this process caused the family.
04/03/2020	Maternity Services	Birth Injury (including fetal laceration at LSCS)	Not Upheld	No actions to be taken
13/03/2020	B4	Injury sustained during treatment or operation	Not Upheld	No actions to be taken
30/03/2020	B4	Communication with patient	Partly Upheld	Apologies given to patient, as it has been acknowledged that a CRL measurement on the ultrasound should have been taken. Explanation of the strict visiting measures that are now in place due to COVID-19, but apologies that the Security Guard did not contact the Ward to confirm that patient was expected. Acknowledged that a wheelchair should have been offered, and this is an area of learning that will be shared with the Team.
02/04/2020	Gynae Medical	Error in performing a procedure on patient	Not Upheld	No actions to be taken
05/05/2020	B4	Discharged without adequate care package	Not Upheld	No actions to be taken
12/05/2020	Maternity Services	Test results lost or mislaid.	Upheld	The Midwife checking FBC was unaware that she was required to check the platelet section of the blood results. The checking of platelets should be a routine part of a Midwife's check of blood results and they have discussed the implications with the Midwife involved and she has now changed her practice to ensure that this error will not occur again. In addition to this, the Community Matron has written to all midwives to remind them of their responsibilities in checking blood results Midwife has produced a professional reflection and this will form part of her professional portfolio going forward. The Midwife who cared for patient previously is aware of the need to check platelets when reviewing blood results and is aware of the correct process for referral of women with low platelets. Unfortunately, she was covering for a colleague who was absent and did not review the bloods she took in clinic and left this task for another midwife without adequate communication. She has also reflected on this error and is aware that it is her responsibility to hand over any outstanding tasks.
18/05/2020	Maternity Services	Neonatal Death	Not Upheld	No actions to be taken
08/06/2020	Gynae Medical	Incorrect entry on medical records	Partly Upheld	Patient was previously advised not to go ahead with surgery as the cyst appeared benign. Confirmation given that the patients ovary and cyst were both removed in theatre (patient requested surgery). Clinical director advised that fluid collection seen on a scan does not mean that another cyst has formed (fluid can gather in pockets in the scarring) - this does not require further surgery. Apologies given for the incorrect information was put on the original discharge summary. The Junior Doctors have been reminded of the importance of recording the correct information.
16/06/2020	Childrens Assesment Unit (CAU)	Lack of a clear explanation	Not Upheld	No actions to be taken
17/06/2020	Maternity Services	Staff attitude	Not Upheld	No actions to be taken
02/07/2020	Gynae Outpatients QA	Long wait for appointment	Not Upheld	No actions to be taken
03/07/2020	Gynae Medical	Surgery cancelled other (non-bed related) reason	Not Upheld	No actions to be taken
06/07/2020	Maternity Services	Insensitive to patient needs	Not Upheld	No actions to be taken
14/07/2020	B8 Labour Ward	Mismanagement of labour	Not Upheld	No actions to be taken
15/07/2020	B4	Negligent	Not Upheld	No actions to be taken
15/07/2020	B4	Co-ordination of medical treatment	Not Upheld	No actions to be taken
27/07/2020	Portsmouth Maternity Centre	Staff attitude	Not Upheld	No actions to be taken
29/07/2020	Paediatric Unit	Lack of information/communication with relatives	Not Upheld	No actions to be taken
10/08/2020	Gynae Medical	Injury sustained during treatment or operation	Not Upheld	No actions to be taken

13/08/2020	Gynae Medical	Insensitive to patient needs	Partly Upheld	Apologies have been given that no follow up appointment was offered to the patient after her procedure. The staff believed the patient was in a fit enough state to retrieve the information given.
25/08/2020	B4	Co-ordination of medical treatment	Partly Upheld	Senior Sister explains that the patients cannula was inserted correctly and was being used to administer intravenous antibiotics. Senior Sister acknowledges that a small amount of blood loss can appear significant; however the patients vital signs remained stable indicating that this was not a significant blood loss which would not affect the patients overall well being. From the Senior Sister's review she can confirm that the Nursing staff did communicate the patients request to the Doctor, but the Doctor was not available to attend immediately, and the Nursing staff did discuss this with the patient at the time explaining that he was busy with emergencies. Senior Sister confirms that her vital signs remained stable during this time so there was no cause for concern. Once the patient had informed the staff of the issue with a wet bed, it was noted that the staff did offer to change the bed linen, but she declined this at the time. Learning has been shared with the ward staff regarding the correct disposal of plastic needles.
10/09/2020	Portsmouth Maternity Centre	Injury sustained during treatment or operation	Not Upheld	No actions to be taken
11/09/2020	Maternity Services	Birth Injury (including fetal laceration at LSCS)	Not Upheld	No actions to be taken
22/09/2020	Maternity Services	Staff attitude	Upheld	Community Matron assured patient that the mentioned member of staff was extremely upset to learn that ther attitude had caused such distress and was extremely apologetic. The staff member reflected on how her communication needs to improve and how she would respond in the
24/09/2020	Maternity Services	Patient not listened to	Partly Upheld	Patient assured that her experience will be highlighted to remid staff that compassion and consideration of a patient's reason for attendance should be inculded in the allocation of a care space. Apologies given for the delay experienced waiting to be seen.
02/10/2020	Early Pregnancy Assessment Unit	Insensitive to patient needs	Upheld	Consultant in Emergency Medicine sincerely apologised that on this occasion patient care did not meet the standards which he would expect for patients attending the Emergency Department with these symptoms. The Trust has a pathway/policy for patients attending the ED in early pregnancy with vaginal bleeding. This pathway states that a number of blood tests should be taken, and a referral made to the Gynaecology Team, for assessment within their Early Pregnancy Assessment Unit (EPAU). The member of nursing staff who had assessed you was acting on the advice of the Gynaecology doctor on call. Following your telephone conversation with Senior Sister on 10 November 2020, she would like to ensure her apologies are reiterated in this response and confirm that your concerns have been shared with her team to learn from.
09/11/2020	Maternity Services	Poor nursing care	Partly Upheld	There is now an electronic system in place that transfers all information in mother's maternity notes through to NICU when a baby is admitted thereby reducing the risk of crucial information not being shared with the NICU Team and nsuring support required is put in palce as soon as possible. Senior Nurse will ensure that all staff reflect on the concerns raised and will remind them that clear verbal consent must be obtained prior to any procedure.
18/11/2020	Portsmouth Maternity Centre	Communication with patient	Not Upheld	No actions to be taken
26/11/2020	Paediatric Unit	Inappropriate comments	Upheld	Paediatric Clinical Director provided assurance that the Consultant recognised that it is difficult to get the balance between ensuring that a family understands the seriousness of a particular condition, and not causing upset. The Consultant will reflect upon all your concerns and this will be undertaken as part of her CPD (Continuous Professional Development) to ensure this does not happen again.
15/12/2020	Gynae Assessment Unit	Co-ordination of medical treatment	Partly Upheld	LRM took place. All concerns were discussed in meeting with Clinical Team and patient appreciated the answers provided.
22/12/2020	Maternity Services	Neonatal Death	Complaint Ongoing	
13/01/2021	Early Pregnancy Assessment Unit	Wrong information/advice given	Not Upheld	No actions to be taken

20/01/2021	Maternity Assessment Unit	Communication with patient	Upheld	Consultant Obstetrician & Gynaecologist, and Lead Consultant for the Maternity Assessment Unit has contacted their Educational Supervisor (the named Consultant who looks after the training needs for that trainee throughout their training) and has highlighted the deficiencies in the consent process. She believes that it is essential for a doctor to have good documentation, consent and communication skills and has asked that this doctor's skills are reviewed. The doctor would also have to do a "Reflective Practice" whereby they formally reflect on their actions, the impact that it had, discuss them with the educational supervisor and put together some action plans to ensure that this does not happen again.
25/02/2021	Portsmouth Maternity Centre	Communication with patient	Partly Upheld	Director of Maternity was dysmaied to read about patient's experience of our service and how your wishes were overruled. She explained that the care received and the experience that patient had, had fell well below the level that we would expect and for patient to be left feeling disempowered in this way was unnaceptable. Assurances given that appropriate corrective action is being taken to ensure that women and parents do not experience this standard of care or behaviour in the future.
01/03/2021	Maternity Services	Staff attitude	Partly Upheld	Director of Maternity Services & Midwifery reviewed the matter and is sorry that patient's concerns were not resolved but confirms that all of the appropriate actions were taken to address the situation byt the Clinical Lead Midwife and the Matron for Community Services.
08/03/2021	B8 Labour Ward	Mismanagement of labour	Not Upheld	No actions to be taken
15/03/2021	Gynae Outpatients QA	Delay or failure to diagnose (inc e.g.missed fracture)	Not Upheld	No actions to be taken
23/03/2021	Maternity Services	Communication with patient	Partly Upheld	Patient assured that all aspects of communication were not dealt with sensitively or compassionately and for this the Team is very sorry.
06/04/2021	Maternity Services	Communication failure within department	Upheld	Matron offered her apologies about the care the patient received at the beginning of the pregnancy and ensured an immediate change in practice to ensure other families did not have to undergo a similar experience.
14/04/2021	Gynae Outpatients QA	Treatment didn't have expected outcome	Complaint Ongoing	
14/04/2021	B9 NICU	Cannula Management	Complaint Ongoing	