

Your Name & Address

XXX Complaints Liaison Officer
YYY Hospital
Address

Date.

Dear X

I was admitted /received treatment at ??? by XXX on (date), which resulted in ? (i. e. More surgery, a permanent disability , caused me emotional trauma, resulted in the death of X ...) I will give you a brief overview of what happened.

(An example of what occurred.)

a) April 3rd 2008 - I was in extreme pain & was taken for a MRI to find out what the problem was. I was diagnosed that I had a serious staph infection & would need surgery. I was then taken to another part of the X-ray department for further x-rays & to insert a pick line. All in all I was away from the ward for over 2 hours. An orderly returned me to my ward, but no nurse was present. I rested for about half an hour & then noticed there was a wet patch, on my nighty & the sheet. I looked & it was blood oozing from the pick line, so I rang my bell. When nobody came after 10 minutes I again rang my bell, as the pool of blood was getting larger. Again after another 10 minutes I again rang my bell but this time I left my finger on the bell until someone came. (It had now been over an hour since I came back to the ward & 30 minutes since I first rang the bell. Nurse C came in & said what is so important that you have rang the bell 3 times to which I just took the sheet off & showed him. Within seconds there were a whole lot of nurses fixing me up.

b) April 5th 2008 - Nurse X came to change my IV drip, removing bubbles by squirting the tube into my rubbish bag. The tube touched the inside of the bag, so I asked X to wipe the tube with a steri-wipe. She refused, I then covered the place where the tube was to be attached saying I would not allow her to put it in until she had wiped the tube. Her comment, "I don't have any". To which I responded "well get one." Her response was "I was fussy & she didn't have time." Eventually she went & got a steri-wipe again making the remark that she was busy & I was wasting her time.

c) April 9th 2008 – Nurse C came to change the drip but I noticed there were 2 small bags instead of the one large & one small bag. I told him I didn't think these were my drips. He stated they were. I informed him I wanted to check the drug chart & would not allow him to put the drips in until I had checked. He went away & came back with the chart & to inform me 1 of the drips was wrong & he replaced it with the right drip.

d) April 10th 2008 - Nurse C came in to give me my medications, but I noticed there was a different coloured tablet to what I had previously had. I informed him that I thought it was the wrong tablet, to which he said no it was the right medication. Again I told C I wanted to see the drug chart, & would not take nay medications until I had checked. He eventually brought in the drug chart & on checking it was the wrong medication. I informed my doctor who was concerned & suggested C could not read.

e) April 12th 2008 late at night – I went to the nurses' station in my wheel chair to inform the nurses I was going outside for some fresh air as I couldn't sleep. Nurse C & d were behind the station but didn't see me. They were playing shadow puppets with their torches, however 4 patients lights were flashing as they required attention. One patient had buzzed a few time. I just watched, & after 10 minutes had passed I wheeled myself to where they could see me.

f) April 14th 2008 – I was discharged home with nursing agency A were contracted to provide long term wound care & assistance with showering. I had asked the discharge nurse why that agency was used as I thought RDNS would be good. I was told that this was my health fund providers "Preferred Provider"

g) May 2008 I received the 1st statement from A which informed me I would have to pay \$121.00 for consumerables (dressings & other items associated with treating my wound),. I rang A to check & they told me my health fund did not cover this. I then rang my health fund who informed me they had never been invoiced for items used for wound care in the past but had never before had dealings with agency A. I told them that the discharge nurse had said A was their preferred provider. They informed me that this was not the case. (My health fund agreed in this instance to pay for the consumerables) I changed to another agency who did not charge for consumerables.

There were several other minor incidents that occurred but for the sake of brevity. I will not list these.

My main issues & action sought:

- The lack of response to ringing for a nurse, (**point a.**) especially in light of what I saw, as pointed out at **point e.**

Action sought - I suggest that nurse C in particular needs training in appropriate response to patient care, & that procedures are developed for appropriate response times to patients bell calls..

- The lack of hygiene standard regarding IV drips.

I am extremely concerned that nurse X did not use appropriate hygienic measures when changing my drip, **point b.** Given that I already had a serious infection it could be reasonable to expect extra caution to be taken with regard to infection control. (I was later diagnosed with CLL & an IGG deficiency proving that extra care was needed.)

Action sought -I believe your hospital has procedures in place around IV drips which were not followed. I suggest that Nurse X be reprimanded for her failure to follow hospital procedure & that she be required to do an infection control course.

- Nurse C's negligent practice of near misses with medication & IV , **points c.& d**

There are many procedures in place re right patient regarding medication. For the same nurse to make similar errors 2 with me I suggest the nurse should be suspended, required to undertake additional study & only after study is completed be allowed to nurse patients,. When Nurse C does bring to nurse again that there must be a 6 month period where he is monitored closely by a senior nurse.

- Giving misinformation to patients, **point f**.

Action - The Discharge Nurse be reprimanded for giving preference to a Nursing Agency & that prior to referring a patient to a particular service the nursing staff check that no additional out of pocket expenses will result.

I would appreciate an opportunity to meet with you to further discuss the issues raised. The overall reason for writing this letter of complaint is to prevent similar events happening to other patients. I request this meeting occurs within 28 days or I will take the complaint to another forum.

Yours sincerely

XXX