



Ombudsman's Commentary

DECEMBER 2005 REPORTS

Background

It is a requirement of our founding legislation (The Scottish Public Services Ombudsman Act 2002) that the SPSO lay a report of all investigations into complaints before the Scottish Parliament. To date, the SPSO has laid individual reports of its investigations. Today, for the first time, a compendium of reports is published by the SPSO. This brings into effect a change in our practice and new arrangements for laying reports.

Following feedback from others and particularly complainants, the SPSO has made changes to the way in which we report the outcome of our decisions on complaints. As a result there will be significantly more reports being laid before the Parliament than has been the case in the past (see our Annual Report for 2004-2005 for further details: www.scottishombudsman.org.uk).

An important aspect of complaint handling is that valuable lessons should be learned from the investigation of complaints in order to avoid the same problems arising for other members of the public and users of the service. This desire to maximise the learning is the basis for the changes we have made, and the reports contained in this first compendium bear out our view that wider lessons can be drawn from the specifics of individual cases.

Housing and Health Reports

This compendium contains five reports, four in respect of complaints about the NHS in Scotland and the fifth relating to the Housing sector.

While the complaint about Clydebank Housing Association Ltd was not upheld, the other four complaints about Greater Glasgow NHS Board, Lothian NHS Board and Tayside NHS Board were all upheld in part. The health cases that feature in this compendium all identify lessons that can be learned not only within the setting in which the complaint arose but for the wider delivery of health care in Scotland. These relate especially to poor

communication between medical staff and patients, failure to document discussions between patients and medical staff, and deficiencies in record-keeping and nursing care plans, all of which can impact adversely on clinical outcomes.

Key recommendations of individual reports

The following summary identifies the key recommendations for change:

Greater Glasgow NHS Board – Maternity Services

This case involved the care and treatment of a woman (referred to as Ms C) and her newborn daughter at the Maternity Unit of the Southern General Hospital, Glasgow. Ms C complained to me about a lack of proper care during her labour which may have affected her daughter's chances of survival and thus contributed to her death. My investigation upheld a number of Ms C's complaints but did not conclude that the actions of staff had contributed to the death of her baby. I found, however, that there were shortcomings in communication with Ms C and significant deficiencies in her clinical records. I recommended that the Board:

- (i) review their current practice regarding communication with and documentation of discussions with patients by medical staff and produce internal guidance to meet the General Medical Council standard;
- (ii) undertake to monitor and evaluate the quality of their maternity records, in line with the Clinical Standard for Maternity Services IC.7 (NHS Quality Improvement Scotland, March 2005) and provide me with a plan for, and results of, such monitoring and evaluation;
- (iii) review their guidelines for transfer into the community and post-transfer care and consider how guidelines might best ensure that the relevant primary care staff are aware of any possible significant complications following discharge of the patient; and

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- (iv) consider adopting the Scottish Women Held Maternity Record and inform me of the outcome of the action they are taking in this regard.

Lothian NHS Board – Care of the Elderly

There were two cases involving complaints about care of elderly patients while they were in the Edinburgh Royal Infirmary. The two cases had very similar features. In the first a man (referred to as Mr C) complained that failures in the treatment and care of his mother led to her death. My investigation did not uphold Mr C's central complaint but I found that there were shortcomings in communications with the patient's family and significant deficiencies in her clinical records. In the second case, a man complained that the treatment and care of his elderly mother was inadequate and contributed to her death. Again, the central complaint was not upheld but similar shortcomings in communication and poor record-keeping were identified. My recommendations covered the failures highlighted during these investigations and I recommended that the Board:

- (i) review the scope of the unitary patient record and nursing responsibilities for documenting in this record;
- (ii) provide further training for staff in relation to maximising the benefits of care plans, in particular by addressing the specific issues for each patient;
- (iii) establish an ongoing framework for evaluating nursing care to include auditing of documentation and of the overall patient experience;
- (iv) consider the feedback on poor record-keeping alongside any recommendations made by the independent panel which has been established in Lothian to look into the care of older patients.

Tayside NHS Board – Treatment of a Young Patient

A complaint was received from a man (referred to as Mr C) that there were failures in the treatment and care of his 17 year-old son which may have contributed to his subsequent death. Mr C also complained about the poor handling of his complaint by NHS Tayside. My investigation partially upheld Mr C's complaint and found that there were several failings and matters of concern. In the light of these findings, I made a number of recommendations including some addressed to the need for improvements in clinical and administrative practice.

These included recommendations that the Board:

- (i) apologise for the failure to ensure appropriate consideration was given to providing follow-up care to Mr C's son and apologise for not providing such follow-up;
- (ii) review their arrangements for case review and hand-over of a consultant's caseload in the event of an unplanned cessation of employment and provide me with evidence of this review and the resulting (or existing) arrangement for such review and hand-over;
- (iii) apologise to Mr C for the failure to administer and advise him of the NHS complaints procedure properly;
- (iv) apologise to Mr and Mrs C that clinical problems identified both at local resolution stage of the NHS complaints process and by the assessors at independent review were not addressed by the Board.

The full list of recommendations is contained within the report, which can be accessed at: www.scottishombudsman.org.uk.

In addition, I recommended that the Board pay a sum to Mr C to cover costs of his legal fees, although I acknowledge that achieving financial redress was not Mr C's purpose in bringing the complaint.

I am aware that NHS Tayside have already made a number of the necessary changes, particularly with regard to complaint handling and I welcome these.

Ombudsman's overview

I am pleased to report that in each case outlined above, the Board concerned have accepted my recommendations. In line with the SPSO's responsibilities and practice, the office will follow up with Boards to ensure that they implement the actions to which they have agreed.

Unfortunately, many of the above failures and weaknesses in the delivery of health care in Scotland have been identified by my office in past investigations (for an example that highlights care of the elderly, please see our report of 3 August 2005 the case about Hairmyres Hospital in Lanarkshire). It is crucial that these matters are addressed to ensure

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that patients and relatives do not encounter similar problems in the future. My concern relates not just to the narrow clinical aspect but more generally to values of dignity and respect that should be part-and-parcel of the treatment and care of all patients, particularly of the most vulnerable such as the elderly.

These cases highlight an important issue that might be described as the 'continuum of care'. This relates first to ensuring that there is good communication with patients (and their relatives where appropriate) so that they are involved in the different aspects and stages of treatment and care; and second to ensuring that there is effective communication between staff in the delivery of such treatment and care. These cases underline too the importance of identifying clearly who has overall responsibility for the treatment and care of patients at any given time.

In conclusion, I would emphasise that these process issues are not peculiar to the bodies subject to these investigations. I would urge other Health Boards in Scotland to consider to what extent the lessons learned and recommendations made in handling these particular complaints are relevant to circumstances in their own areas.

The compendium of reports can be found on the SPSO website, www.scottishombudsman.org.uk.



Alice Brown. 20.12.2005

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