

Ombudsman's Commentary

NOVEMBER 2009 REPORTS

The SPSO laid eleven investigation reports before the Parliament today. Eight are about the health sector and three relate to local government. Our investigation reports form only one part of our work. In October, we determined 362 complaints, including 76 resolved after detailed consideration.

Each investigation may contain several complaints, and overall the eleven reports laid today:

- **Upheld 15 complaints**
- **Partially upheld 1 complaint**
- **Did not uphold 19 complaints**
- **Made 31 recommendations**

Overview

Several investigations stand out this month. I made a number of recommendations in a report about a woman whose baby was found to have cerebral palsy consistent with a lack of oxygen before and/or during delivery (Case 200702307). These included that the Board review the guidelines for electronic fetal monitoring to ensure that they are appropriate and ensure that clinical staff take note of the findings of the report and make any necessary adjustments to clinical practice.

Another report (Cases 200802262 & 200900284) coincides with recent heightened public concern about the use of anti-psychotic drugs to treat people who have a diagnosis of Alzheimer's Disease. Ms C's late mother, Mrs A, was resident in a privately run care home. Ms C complained that, based on information provided by a senior nurse employed by the home, an NHS GP and an NHS consultant psychiatrist prescribed anti-depressants and anti-psychotics to her mother without adequate assessment. It later became clear that the nurse had provided incorrect information. I did not uphold these complaints, as it was reasonable in the circumstances for both the GP and the consultant psychiatrist to believe that the information provided was correct at the time.

However, Ms C was also concerned that both doctors had failed in their professional duty to report the potential unprofessional conduct of the nurse to the appropriate authority. My medical adviser's view was:

'The provision of medical services only works when the professionals in it feel that the information passed from one to another is true. Therefore, trust is paramount even between professionals who are not known to one another. The General Medical Council (GMC) have rules regarding this ... Doctor 1 has taken his professional duty seriously by cooperating fully with every investigation and this would be enough for the normal citizen. Professionals however need to be proactive in this situation...'

I upheld these complaints and recommended that the NHS Board take steps to remind all clinical staff, including Primary Care staff and Family Health Service providers in their area, of their professional duty to act when they have a concern about the fitness to practise of another health professional.

In Case 200801379, the complainant, Mr C, had part of a lung removed following a diagnosis of cancer in hospital. Mr C was subsequently found not to have cancer and complained that the treatment had been unnecessary.

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He also said that staff at the hospital had delayed in communicating the change in diagnosis to him and had not answered his questions fully. In addition, Mr C complained that there had been a delay in putting him back on the kidney transplant waiting list and that the Board's response to his complaints had been inadequate. I upheld all the complaints and made eight recommendations for improvement.

I also decided, for the first time, to include a personal observation because, in reviewing this complaint, I had a specific concern about the lack of a clear clinical reason for using the FNA (fine needle aspiration) procedure in this case. My concern is that when the results of the procedure were discussed at the multi-disciplinary team meeting no mention or comment was made of this and no mention of this was made in the Board's response to Mr C's concerns. The recommendation to review the clinical use of such FNAs as a matter of urgency should ensure that this specific problem is resolved. However, my report continues:

'It is also not the role of this organisation to investigate matters beyond the individual complaint. However, I know members of the public reading this report will be struck by and concerned that this situation was allowed to occur. Especially since it appears this problem was not solely linked to this complaint ... and I am concerned that it has been tolerated and become, in effect, accepted practice. Combined with the failure to ensure that the error in diagnosis made in Mr C's case was not directed through the Board's own procedures, this suggests to me a cultural problem within at least this team and possibly within the broader management of the hospital. I make no specific recommendations on this broader point but would ask the Board to reflect on this carefully and, in particular, to note the need to ensure that the public are reassured that the Board operate within a culture where such situations are not tolerated and it is possible for concerns to be highlighted and acted on.'

I also upheld several complaints made by the wife and daughter of a man who died in hospital (Case 200802345). I found a number of shortcomings that meant that the man's overall care and treatment were inadequate and lacked dignity. The daughter also complained that hospital staff failed to communicate adequately with her family about her father's palliative care or to properly manage his transfer to a hospice. I upheld all the complaints and made four recommendations to the Board. In the original handling of the complaint, the Board had acknowledged several of the issues raised by the complainants and had drawn up and begun to implement an Action Plan to address the areas concerned. I asked that the Board keep me informed of progress toward achieving all the goals of the Action Plan.

This month's reports, then, contain a wide range of issues concerning treatment and care provided by the NHS. Research shows that the vast majority of people are satisfied with their interaction with health professionals and many have high praise for the standards of clinical and nursing care they receive or witness. There is much that other sectors under my jurisdiction could learn from the more streamlined NHS complaints process, and I frequently stress that my office sees only the very small minority of complaints that have not been resolved locally by GP Practices, hospitals and Health Boards.

Nevertheless, the NHS complaints we investigate, while small in number, are significant. A negative experience in hospital or a care home will often have had a profound and lasting effect on the person or people concerned. Of course, complaints also matter very much to the individuals and organisations complained about. And, importantly, our investigations are a key source of feedback for NHS leaders and policy makers who are charged with sharing the learning from complaints across the NHS in Scotland.

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This month's reports also provide learning across the local government sector. We investigated a complaint (Case 200801344) about the way in which a Council administered repair works to a private tenement instructed as a result of statutory notices. When the owners failed to carry out the works, the Council were requested to intervene. There was a considerable delay before the works were carried out, and the complainants ended up with a much larger bill than they expected for a property that they no longer owned. Restrictions in the SPSO Act limit our jurisdiction and I am unable to comment on contractual elements. It is clear however, that there were significant delays while the scope of the work was decided and that costs rose partly as a result of that. I partially upheld the complaint and recommended that the Council review the extent to which they were responsible for the delays and increase in contract price and commute part of their administration charge to the complainants as a result.

Another complaint (Case 200800711) concerned homeless procedures. The complainant, Mrs C, was made homeless when she was evicted from a privately rented property. She raised a number of concerns regarding the service provided to her by the Council at that time. I upheld her complaint that the Council made inadequate arrangements to uplift and store her personal belongings when she was made homeless, as there was clearly an internal failure to pass on the relevant information. As a result the Council did not collect Mrs C's belongings for storage. I did not uphold Mrs C's complaint that there were failings in the Council's administration of her mainstream housing application and the assessment of rent arrears. The Council have since reviewed all their homeless procedures, and I made a number of recommendations to address the shortcomings identified in my report.

Summaries of all the reports laid today are below and can be accessed on the SPSO website at www.spsso.org.uk/reports/index.php

Health

Clinical treatment

Western Isles NHS Board
(200702307)

A baby was found to have cerebral palsy consistent with a lack of oxygen before and/or during delivery. Mrs C, her mother, raised a number of concerns about the care and treatment the Board provided to her and her daughter, before and during labour. I upheld Mrs C's complaint about inadequate care, as my medical advisers identified areas of care that could have been improved. I recommended that the Board apologise to Mrs C for failing to provide adequate care to her before and during

labour; review the guidelines for electronic fetal monitoring to ensure that they are appropriate; and ensure that clinical staff take note of the findings of my report and make any necessary adjustments to clinical practice.

Clinical treatment; diagnosis; staff attitude; record-keeping

Highland NHS Board
(200802376)

Mr C raised a number of concerns about the care and treatment he received during Accident and Emergency hospital admissions. He was ultimately diagnosed with appendicitis, which required surgery. My medical advisers said that the standard of record keeping in

this case was unacceptable and that the care provided was not satisfactory. I therefore upheld Mr C's complaint. I did not, however, make any recommendations about clinical practice as, after seeing my advisers' comments, the Board accepted that there were inadequacies and put appropriate steps in place to address the failings identified. I have asked them to keep me informed of progress on these. I recommended that the Board apologise to Mr C in writing for the failing identified in this report and their failure to provide him with adequate care and treatment.

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Care of the elderly; clinical treatment; nursing care; record-keeping

Lothian NHS Board (200800148)

Mr C complained that the Board failed to provide reasonable care and treatment to his wife, Mrs C. Mrs C was admitted to hospital after a fall in which she suffered a fracture of her left ankle, and a plaster cast was applied to her leg. Mr C did not consider this treatment was reasonable given Mrs C's other medical conditions. Mrs C subsequently had an above knee amputation of her leg after an ulcer failed to heal. Mr C further complained that Mrs C contracted an infection while in the hospital and was unhappy with the overall standard of nursing care. My medical advisers were of the view that overall the standard of care and treatment was reasonable, although there should have been review of Mrs C's plaster cast. Although, therefore, I did not uphold these complaints, I did recommend that the Board review their policy for reviewing plaster casts and apologise to Mrs C and her family for failing to make a review in her case. I also recommended that the doctor concerned should be encouraged to reflect on the case at their next appraisal. During my investigation I also found the standard of record keeping in respect of Mrs C's medical records to be inadequate. I recommended that

the Board provide me with copies of the next Scottish Patient Safety Programme audit documentation in relation to all patient records within the orthopaedics department of the hospital and remind staff of the importance of fully completing all significant documentation, paying particular attention to the omissions identified in my report.

Care of the elderly; clinical treatment; policy/administration

A Medical Practice (Fife NHS Board) and Fife NHS Board (200802262 & 200900284)

Ms C's late mother, Mrs A, was resident in a privately run care home. Ms C complained that, based on information provided by a senior nurse employed by the home, an NHS GP and an NHS consultant psychiatrist prescribed anti-depressants and anti-psychotics to her mother without adequate assessment. It later became clear that the nurse had provided incorrect information. I did not uphold these complaints, as it was reasonable in the circumstances for both the GP and the consultant psychiatrist to believe that the information provided was correct at the time. Ms C was also concerned that both doctors had failed in their professional duty to report the potential unprofessional conduct of the nurse to the appropriate authority. I upheld these complaints and recommended that the NHS Board take steps to remind all clinical staff, including Primary

Care staff and Family Health Service providers in their area, of their professional duty to act when they have a concern about the fitness to practise of another health professional.

Nursing care; hygiene; patient dignity; communication; complaint handling

Tayside NHS Board (200802345)

Mr A was admitted to hospital, where he was diagnosed with terminal cancer and only a short time to live. His daughter, Miss C, and wife, Mrs A, raised a number of significant concerns about the care and treatment that he received in hospital in the days leading up to his death. They were particularly concerned that the Board had delivered sub-standard care to Mr A in a number of important respects such as assistance with feeding, hygiene, cleanliness, management of symptoms and pain as well as failing to accord him dignity and respect. They also complained that hospital staff failed to adequately communicate with Mr A and his family about palliative care, or to properly manage his transfer to a hospice. Miss C was also unhappy with the handling of her complaint. I found a number of shortcomings that meant that Mr A's overall care and treatment was inadequate, and lacked dignity. I upheld all of these complaints. I recommended that the Board review the following policies: documentation of the administration of controlled drugs and patient symptom control;

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insertion of chest drains; and documentation of complications during procedures such as chest drains. I recommended that they also review their support to foundation level doctors in the management of patients at the end of life. Finally, I recommended that the Chief Executive apologise directly to Mrs A and Miss C for the failings identified in this report; and that the Board keep me informed of progress towards achieving the goals of the Action Plan that they implemented as a result of these complaints.

Diagnosis; communication; delay; complaint handling

Ayrshire and Arran NHS Board (200801379)

Mr C was diagnosed with cancer, and had part of a lung removed. After the operation, it was found that the tissue removed was not cancerous. Mr C complained that the operation was unnecessary, and that hospital staff delayed in communicating the change in diagnosis to him and did not fully answer his questions. He also complained that there had been a delay in putting him back on the kidney transplant waiting list and that the Board's response to his complaints had been inadequate. I upheld all his complaints and noted my advisers' view that it would have been possible to diagnose the problem more accurately before operating. I also noted my concern about the use of a particular procedure,

which may not have been the best way to diagnose the problem. I asked the Board to carefully reflect on this. I recommended that the Board quickly audit and review the use of the procedure in the hospital. I recommended that they emphasise to staff the importance of documenting a full clinical history, and that they remind them of the importance of appropriate communication and file management. I recommended that they: urgently review the operation of their complaints process and the relationship of this to clinical governance; ensure that staff handling complaints follow the relevant procedure, and establish why no incident review was considered as a result of this complaint. Finally I recommended that the Board fully apologise to Mr C for the failings identified in my report.

Delay in treatment; communication; nursing care

Ayrshire and Arran NHS Board (200801457)

Ms A was admitted to hospital as an emergency and was operated upon two days later, when her right ovary and tube were removed because of a cyst. Ms C complained on Ms A's behalf that there was a delay in performing surgery and a failure to tell Ms A about the removal of the ovary and tube until the day after the operation. I upheld both of these complaints. I recommended that the Board apologise to Ms A for the delay in surgery and take steps to ensure

that such delays do not recur, and that they let me know of the measures being undertaken to avoid this in future. I did not uphold complaints that there was failure to take into account Ms A's description of her pain while she was an out-patient or that she felt she was sometimes forgotten about when she was an in-patient.

I did not uphold the following complaint against an NHS Board:

Delay in diagnosis; clinical treatment; complaint handling

Greater Glasgow & Clyde NHS Board (200800569)

Although I did not uphold the complaint about diagnosis and treatment, I did recommend that the Board consider reviewing Mrs C's case with a view to identifying if any aspects of the communication between consultants and her GP could be improved. As the Board declined Mrs C's request to investigate the complaint due to the time that had passed, I further recommended that they consider how NHS Scotland's publication: *Can I help you? Learning from comments complaints and suggestions* should be taken into account when making decisions on time limits.

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Local Government

Statutory repairs notices

The City of Edinburgh Council
(200801344)

Mr C complained about the way in which the Council administered repair works to a private tenement instructed as a result of statutory notices served under section 24(1) of the City of Edinburgh District Council Order Confirmation Act 1991. When the owners failed to carry out the works, the Council were requested to intervene. There was a considerable delay before the works were carried out, and Mr and Mrs C ended up with a much larger bill than they expected for a property that they no longer owned. Restrictions in the Act limit my jurisdiction and I am unable to comment on contractual elements. It is clear that there were significant delays while the scope of the work was decided and that costs rose partly as a result of that. I partially upheld the complaint and recommended that the Council review the extent to which they were responsible for the delays and increase in contract price and commute part of their administration charge to Mr and Mrs C as a result.

Policy/administration; homeless procedures

Perth and Kinross Council
(200800711)

Mrs C was made homeless when she was evicted from a privately rented property. She raised a number of concerns regarding the service provided to her by the Council at that time. I upheld her

complaint that the Council made inadequate arrangements to uplift and store her personal belongings when she was made homeless, as there was clearly an internal failure to pass on the relevant information. As a result the Council did not collect Mrs C's belongings for storage. The Council have since reviewed all their homeless procedures and I recommended that they: advise me of the measures introduced as a result of that review; share this investigation report with their insurers, so that they may reconsider if any liability attaches to the Council for the loss of Mrs C's property; and apologise to Mrs C for the poor service experienced, which led to the loss of her belongings. I did not uphold Mrs C's complaint that there were failings in the Council's administration of her mainstream housing application and the assessment of rent arrears.

I did not uphold the following complaint about a Council:

Policy/administration

Perth and Kinross Council
(200800352)

Compliance & Follow-up

In line with SPSO practice, investigators will follow up with the organisations concerned to ensure that they implement the actions to which they have agreed.

Jim Martin, Ombudsman
18 November 2009

The compendium of reports can be found on our website, www.spsso.org.uk

For further information please contact:
**SPSO, 4 Melville Street,
Edinburgh EH3 7NS**

Communications Manager:
Emma Gray
Tel: **0131 240 2974**
Email: egray@spsso.org.uk

SPSO

Scottish
Public
Services
Ombudsman

The Scottish Public Services Ombudsman (SPSO) provides a 'one-stop-shop' for individuals making complaints about organisations providing public services in Scotland. Our service is **independent, impartial** and **free**.

We are the final stage in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland. We have a programme of outreach activities that raise awareness of our service among the general public and promote good complaint handling in bodies under our jurisdiction.

Further details on our website at: **www.spsso.org.uk**

Contact us at:

SPSO	Tel: 0800 377 7330
4 Melville Street	Fax: 0800 377 7331
Edinburgh EH3 7NS	Text: 0790 049 4372

E-mail us at: **ask@spsso.org.uk**