Ombudsman's **Commentary**

JUNE 2010 REPORTS

The SPSO laid twelve investigation reports before the Scottish Parliament today. Ten relate to the health sector, and two to the local government sector. Our investigation reports form only one part of our work. In May, we determined 329 complaints, including 53 resolved after detailed consideration.

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

- **Upheld 16 complaints**
- **Did not uphold 8 complaints**
- **Made 42 recommendations**

Ombudsman's Overview

This month's reports cover a typically wide range of subjects. In the **health sector**, there are lessons for individuals and groups to draw from the reports and I also highlight some good practice in the recommendations section below.

It is hard to find words to describe the woeful nursing care that an elderly woman received in one of Scotland's hospitals (200802381). Mrs C, who was 66 and had Alzheimer's disease, was admitted with a perforated ulcer and remained in hospital until she died there three months later. In their complaints to the Board and subsequently to my office, Mrs C's family catalogue the failings in nursing care. They provide vivid accounts of the lack of dignity and privacy afforded to their wife and mother, as well as inappropriate nutrition and oral care and concerns over the administration of medication. A further source of distress for the family was the recorded primary cause of Mrs C's death. My report questions its accuracy and asks the Board for a review. I criticise the Board's overall management of Mrs C's care and express concerns over the ineffectiveness of the nurse bank system that was in place to backfill staffing shortfalls. I make nine significant recommendations, which can be read in full in the report.

Unusually, two cases (200802831 and 200901866) are about child protection concerns. Both complaints were about delay in responding appropriately to issues raised by people in NHS mental health settings about childhood sexual abuse. Clearly, in this area, the importance of timely communication and, where appropriate, action cannot be overemphasised. I would urge all those who work in child safety to read both reports and reflect on the findings and my recommendations.

Complaint 200903204 is about inappropriate hospital discharge and raised concerns that amounted to what I call 'a serious shortcoming in care' when a woman's brain tumour was not diagnosed. I upheld another complaint (200902581) where a patient was discharged without any obvious management or treatment, and died three days later. In that case, I also found failings in the handling of the subsequent complaint to the Board.

Two reports (200802989 and 200901758) are about consent and communication when surgical procedures are proposed and subsequently changed. I upheld aspects of both complaints and made several recommendations including about providing information, in writing, about the potential complications of surgery, at the point of gaining consent. The issue of providing full information before treatment is also a concern in another complaint I upheld, where the cost of full treatment for new dentures was not made clear (200901763). In a separate dental complaint (200903339) I found that both the examination of the patient's mouth and the dentist's record-keeping were inadequate and I upheld the complaints.

Ombudsman's Commentary

JUNE 2010 REPORTS

I upheld a complaint about the Scottish Ambulance Service (200802131) that an accident and emergency vehicle took an unreasonable length of time to attend an emergency call-out, though not that a paramedic response unit took too long. I made a number of recommendations, including that the Service review their system for the allocation of back-up accident and emergency vehicles to ensure that unnecessary delay is minimised, and consider introducing a system to record all calls from paramedics' mobile phones to the Emergency Medical Dispatch Centre.

Both **local government** complaints are about planning. In one (200900221) I found that there were significant administrative errors in processing a planning application and failure to enforce planning conditions on a property when new owners began work on it. I upheld the complaint that the Council's handling of the planning situation was inadequate, and recommended that they apologise to the complainant for this and, where the need remains, consider how best to meet the requirements of the planning conditions.

The second complaint (200903131) was that the Council did not deal adequately with a pre-planning enquiry. I upheld the complaint as I found that the Council had failed to tell the complainant that any advice provided was 'without prejudice' and so could not be relied on to indicate what the Committee's decision would be. I noted that the Council have since taken steps to ensure a suitable caveat is put on all relevant documents, and to remind staff of the need to ensure that applicants are made aware of it. In light of this my only recommendation was that the Council tell me when the caveat is introduced and published on their website.

Recommendations

Readers of our investigation reports will notice a change this month to our recommendations. All the recommendations – and in this compendium there are a total of 42 of them – now have a completion date listed. While complaints reviewers have always given completion dates to complainants and the bodies complained about, these have not previously been made public. As part of our recent Business Review (about which we provided information in our May Commentary and in recent communication with Chief Executives of public service providers) we have decided to put the deadlines into the public domain.

We are doing this to provide greater reassurance to the public that complaints do bring about positive change, and to indicate the timescales for those improvements. The best responses we receive from service providers lay out action plans detailing each recommendation, the action to be taken, the deadline for the action, the person responsible for delivering it and the date on which it was completed. I have received a number of excellent action plans from Greater Glasgow and Clyde NHS Board. The most recent one that has come to my attention is from the Board's Acute Services Division and includes a letter of apology; highlighting the policy for checking, maintenance and repair of clinical monitoring equipment with all ward nursing staff; reviewing care planning documentation; presenting the SPSO report in a variety of governance, clinical and nursing settings; introducing new national tissue viability standards throughout the Board incorporating NHS QIS standards and flowchart; a programme of TV educational updates for staff and an ongoing programme of bed frame replacement in orthopaedics.

Finally, I would like to draw attention to a further instance of good practice. Although I found failings in clinical treatment and complaints handling in case 200902581 published this month, I commend Lothian NHS Board for recent changes made that have resulted in complaints now being discussed quarterly at a clinical governance steering group. I would encourage other bodies to follow this example. It is the kind of practice that the consultation document ***The Principles of Good Complaints Handling and Guidance on a Model Complaints Handling Procedure*** that I published last week will ensure is spread throughout our public services, driving improvement and reassuring people that complaints are taken seriously and result in change.

Ombudsman's Commentary

JUNE 2010 REPORTS

case reports

Health

Nursing care; cleanliness and hygiene; patient dignity; clinical treatment

Lanarkshire NHS Board (200802381)

Mrs C, who had Alzheimer's disease, was admitted to hospital with a perforated ulcer. Earlier the same day she had been sent home from Accident and Emergency (A&E) with an incorrect diagnosis of gallstones. Mrs C remained in hospital until she passed away some three months later. Mr C and his family raised a number of concerns about Mrs C's care and treatment, including that Mrs C was not respectfully treated and her needs in relation to her Alzheimer's were not met. I did not uphold a complaint about the diagnosis of the perforated ulcer and inappropriate discharge from A&E. I did, however, uphold the complaints that the death certificate showed an inaccurate reason for the primary cause of death, that Mrs C's Alzheimer's was not managed appropriately and she was not treated with respect, and that her nutrition and oral care were managed inappropriately. My report raises real concerns about aspects of Mrs C's care and treatment, the administration of medication and the maintenance of her dignity. I have, therefore, criticised the Board's overall management of her care and made nine significant recommendations, which can be read in full in my report. These included reviewing Mrs C's death certificate, and an external review of the nursing care on the wards on which she was treated after her release from intensive care. They also included measures designed to ensure that the Board in future properly implement and monitor policies and processes, and that relevant staff are fully aware of their record-keeping and complaints-handling responsibilities.

Policy/administration; record-keeping

Greater Glasgow and Clyde NHS Board (200802831)

Mr C was assessed by Clinical Psychology and the Specialist Sexual Abuse Service (the Service) for the Board's area. Mr C and his wife, Mrs C, raised concerns that the assessment process was inappropriate and that the reports produced were inaccurate. They said that Mr C was not asked to clarify aspects of the reports that were inaccurate, misleading and damaging to his reputation. I did not uphold Mr and Mrs C's specific complaint, but the investigation raised serious concerns for me about how mental health staff handled a possible risk to child safety. Although in this case staff concerns about Mr C were unfounded, I found maladministration in the assessment process, particularly in terms of delay and referral, with potential to have compromised child safety in a case where concerns might lead to a different conclusion. I, therefore, recommended that the Board take appropriate action to review procedures, ensure appropriate staff training on child protection duties and related record-keeping, and ensure that all the communication issues identified in my report are addressed. I also commented that I would be reassured if the Board were to consider an independent review of this case to check their process for any gaps that could lead to child safety being compromised.

Delay in treatment; child protection issues; complaint handling

Lothian NHS Board (200901866)

Mr C was referred by a GP to Mental Health Services in the Board's area, which resulted in him seeing a Community Mental Health Nurse Therapist. Mr C raised concerns about delays in accessing appropriate care, reporting child protection issues and responding to his complaint. I upheld his complaint that child protection issues that he raised were not reported early enough, and that he was not offered appropriate support. My professional medical adviser noted in particular that there was a period of some six weeks during which potential child protection issues raised by Mr C were not reported. On reading my adviser's comments the Board took urgent and significant action to address this. As the Board took this action, my only recommendation is that they now write to Mr C, acknowledging that the Community Mental Health Nurse Therapist should have acted sooner on the issue of child protection and apologising to him for the delay in doing so. I did not uphold his complaints about accessing care and complaints handling.

Ombudsman's Commentary

JUNE 2010 REPORTS

case reports

Health

Diagnosis; clinical treatment; record-keeping

Grampian NHS Board (200903204)

Ms A collapsed and was admitted to hospital. She was discharged a few days later with a diagnosis of possible labyrinthitis/sinusitis, but had to return to hospital the next day having again collapsed at home. She was readmitted, and after a scan it was found that she was suffering from a brain tumour. She complained through an advice worker that the treatment she received during the first admission to the hospital was inadequate. My professional medical adviser considered that Ms A should not have been discharged from the hospital. Accordingly, I upheld her complaint. I note that this was a rare and difficult case to diagnose and that staff gave reasonable thought to the cause of Ms A's problems. However, no well founded diagnosis was in fact made and no scan was carried out during the first admission. This represented a serious shortcoming in care. I recommended that the Board share my report with the staff concerned so that they can reflect on their actions, and that the Board remind all staff of the importance of good record-keeping. I also recommended that the Board apologise to Ms A for the failings identified in my report.

Care of the Elderly; clinical treatment; discharge planning; complaint handling

Lothian NHS Board (200902581)

Mr A fell at home. He was taken to a hospital in the Board's area, but was discharged a short time later. Early the following morning he was found some distance from his home in a confused state. He was taken to another hospital in a different Board's area, where he died three days later. His clinical records did not reach the second hospital. Mr A's daughter, Ms C, complained that the decision to discharge him was inappropriate and that the Board's complaints handling and information were inadequate. I upheld both complaints as I found that Mr A was discharged without any obvious management or treatment, and that until my office became involved the Board failed to properly follow up on actions to be taken as a result of the complaint. I recognised that there was some good practice evident in the handling of the complaint, but recommended that in future the Board document key actions in their complaint investigation, and ensure complainants are provided with a full response. I also noted that the Board put in place an action plan relating to the clinical elements of Mr A's case. I recommended that they audit this and let me have details of the outcome, as well as satisfying themselves that records transfer between hospitals is now being carried out quickly and efficiently.

Clinical treatment; consent; communication

Greater Glasgow and Clyde NHS Board (200802989)

Mr C had Peyronie's disease and had surgery to correct it. He encountered complications, and needed further corrective surgery. Mr C complained that the operation he had was not the one discussed before surgery, and that it was not carried out properly. He also complained that the Board failed to offer appropriate aftercare. Although the operation carried out was indeed not the one planned and discussed with Mr C, I did not uphold his complaints about treatment and aftercare. This is because after taking advice from my medical adviser I found that the Board's actions were still appropriate in the circumstances. I found, however, that not enough information was given to Mr C beforehand, and upheld his complaint that the Board did not properly warn him of the potential problems of the procedure that was carried out. I recommended that in future the Board give patients written information about the potential complications of surgery when gaining consent for a procedure, advise them of the possibility that a surgeon may provide a different surgical procedure to that planned, and that they remind staff of the importance of recording any advice, medication or supplies provided to patients.

Consent; clinical treatment; complaint handling

Lothian NHS Board (200901758)

Ms C underwent a surgical procedure which resulted in the removal of a fallopian tube. She complained that this was not properly discussed with her beforehand and that she was not given time to fully consider the options and risks before consenting fully to this potential additional surgery. Her Member of Parliament (MP) complained on her behalf. Their complaint to me extended to include delays in the Board's complaint handling, as it took 17 months for the complaint to complete local resolution. I upheld both complaints and recommended that the Board apologise to Ms C and her MP. I also recommended that the Board clarify their consent forms and ensure that these are clearly understood and signed by the patient or representative, and that they ensure their new complaints process provides all the components set out in the NHS complaints procedure, to guarantee a consistent approach to complaints handling within the Board.

Ombudsman's Commentary

JUNE 2010 REPORTS

case reports

Health

Dental care and treatment; communication

A Dentist, Lothian NHS Board (200901763)

Mrs C complained that her dentist did not fit her with correctly sized dentures, and believed that this led to additional unexpected expense and further dental work. I did not uphold her complaint about the fitting of the dentures, as I found that the dentist followed normal and accepted practice. I did, however, uphold a complaint that the dentist did not detail all the expected treatment charges at the start of the process. This was because I found no evidence that the dentist explained to Mrs C that the first denture fitted was temporary, and she would have to pay for a second, permanent, denture. I recommended that the dentist introduces a policy of discussing the full treatment plan and costs with her patients before treatment starts and that a note of this discussion is recorded in the clinical records.

Dental care and treatment; record-keeping

A Dentist, Lothian NHS Board (200903339)

Ms C went to her dentist with toothache. She believed the pain was coming from a particular tooth (tooth A) but the dentist removed the neighbouring one. This did not resolve the problem. Another dentist later removed tooth A and the pain stopped. I found that both the examination of Ms C's mouth and the dentist's record-keeping were inadequate and upheld her complaints. My professional dental adviser said that the dentist should have reviewed the possible causes of pain in order to establish a diagnosis, and that he could have carried out an x-ray then decided on appropriate treatment. He was of the view that the dentist did not carry out a proper investigation at Ms C's first consultation and pointed out that the dental records were very sparse, containing no information at all about tooth A. I recommended that the dentist apologises to Ms C for the shortcomings identified, and in future ensures adequate investigation of patients with toothache and improves his record-keeping to the standard described in my report.

Delays; policy/administration

Scottish Ambulance Service (200802131)

Ms C's brother was visiting her when he collapsed with chest pains. Ms C called 999, and a paramedic response unit (PRU) and accident and emergency vehicle were sent to the scene. Mr A later died in hospital. Ms C complained to the Scottish Ambulance Service (the Service) that both vehicles took an unreasonably long time to arrive. I upheld her complaint about the accident and emergency vehicle as I found that there was a short period during which it could have been allocated to the emergency but was not, and because there did not appear to be a robust system in place to back up the PRU. I recommended that the Service review their system for the allocation of back-up accident and emergency vehicles to ensure that unnecessary delay is minimised, and consider introducing a system to record all calls from paramedics' mobile phones to the Emergency Medical Dispatch Centre. I did not uphold the complaint about the PRU, but during the investigation raised concerns about the Service's own investigation of this element of Ms C's complaint, as it did not examine the matter in enough depth. I noted that the Service has compiled a list of action points related to this, and I recommended that they provide me with evidence that these have been carried out. I also recommended that they apologise to Ms C for the failings identified in my report.

Local Government

Handling of planning application

The Highland Council (200900221)

Mr C had a croft house on his land, which had fallen into disrepair. He applied for planning permission to build a new house, which was granted on condition that the croft house reverted to use as a byre. He later decided to apply for permission to convert the byre back to a house. Outline permission was eventually granted but with significant planning conditions relating to access. Mr C sold the building with the planning consent as he felt the conditions were too onerous. When the new owners carried out work on the property without complying with the planning conditions, Mr C complained to the Council. They said that they had told the new owners that compliance was not necessary in the circumstances. I found that there were significant administrative errors in the processing of Mr C's application and in the failure to enforce planning conditions on the property when the new owners began work on it. I upheld Mr C's complaint that the Council's handling of the planning situation was inadequate, and recommended that they apologise to him for this and, where the need remains, consider how best to meet the requirements of the planning conditions.

Ombudsman's Commentary

JUNE 2010 REPORTS

case reports

Local Government

Planning advice

The Highland Council (200903131)

Mr C complained that the Council did not deal adequately with his pre-planning enquiry. He was unhappy that as a direct result of the advice received he spent time and incurred costs in preparing and submitting planning applications which were ultimately rejected by the planning committee. I upheld the complaint as I found that the Council had failed to tell Mr C that any advice provided was 'without prejudice' and so could not be relied on to indicate what the Committee's decision would be. I noted that the Council have since taken steps to ensure a suitable caveat is put on all relevant documents, and to remind staff of the need to ensure that applicants are made aware of it. In light of this my only recommendation was that the Council tell me when the caveat is introduced and published on their website.

Compliance & Follow-up

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

Jim Martin, Ombudsman
23 June 2010

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

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

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

Contact us at:

SPSO
4 Melville Street
Edinburgh EH3 7NS

Tel: **0800 377 7330**
Tel: **0800 377 331**
Text: **0790 049 4372**