

# Ombudsman's Commentary

## MAY 2011 REPORTS

The SPSO laid six investigation reports before the Scottish Parliament today, about seven complaints from the health sector.

## Case numbers

### March 2011

In addition to laying five reports before the Parliament (about six complaints) we **determined 383 complaints and handled 77 enquiries**. Taking complaints alone, we:

- > gave advice on 242 complaints
- > resolved 94 in our early resolution team
- > resolved 41 by detailed consideration
- > made a total of 60 recommendations in decision letters

### April 2011

We did not lay any reports in April because of the dissolution of the Parliament. We **determined 259 complaints and handled 71 enquiries**. Taking complaints alone, we:

- > gave advice on 159 complaints
- > resolved 77 in our early resolution team
- > resolved 23 by detailed consideration
- > made a total of 32 recommendations in decision letters

There are examples of some of the recommendations made during these two months at the end of this Commentary.

## Ombudsman's Overview

### MSP Guide

This week, we are publishing an updated Guide for MSPs and Parliamentary staff. It is part of the material we provide to inform people about our role in resolving complaints about public services in Scotland. As the Guide says, we are the last stage in considering complaints about a vast array of public services provided by councils, the NHS, prisons, housing associations, government agencies and non-departmental public bodies, the Parliamentary corporation, colleges and universities and most cross-border public bodies. Last year we received 3,500 complaints and 750 enquiries. There is much more information about our role and remit and what we do with the learning from complaints on our website: [www.spsso.org.uk](http://www.spsso.org.uk).

### Laying reports

We lay some cases before the Parliament each month. These are investigation reports that the Ombudsman has decided are in the public interest. As is the case today, many investigation reports are about health services. Where the NHS is concerned, we can look at the clinical decisions that led to a complaint, and many of the

recommendations for improvement we make have implications that go much wider than the individual hospital or GP practice concerned. In other sectors such as local government, we cannot normally look at the professional judgment involved in decisions, only at whether something has gone wrong in the administration of a decision.

### Links with professional/regulatory bodies

In those rare cases where, during his investigation, the Ombudsman finds evidence of significant clinical errors made by a health professional, he may draw this to the attention of the relevant body, such as the General Medical Council. He does this in line with the obligations of the SPSO Act. We have Memoranda of Understanding with the GMC and other professional and regulatory bodies. You can read these on our website. They outline how we share information and responsibilities for complaint handling.

### MSP helpline: 0131 240 8849

Members of the public can bring a complaint to the SPSO directly. They do not have to ask an elected representative to do it for them. We know, however, that some people ask their MSP for support in making a complaint. When this is the case, it is in everyone's interest that our remit is understood. In particular, it is important that those helping someone make a complaint understand the kinds of outcomes we can achieve. Our MSP Guide publicises our new MSP helpline, which we encourage MSPs and their staff to use for advice on any aspect of our service. We also have fact sheets about common subjects of complaint, such as planning, housing allocations and hospital care. Please look online at [www.spsso.org.uk/information-leaflets](http://www.spsso.org.uk/information-leaflets) or call us and we will send you copies.

### Investigation report findings

The investigation reports laid before the Parliament today contain distressing accounts of failings in NHS treatment and care and their impact on patients and their families. Their range is broad and include a complaint that a Scottish Ambulance Service crew failed to recognise a potentially fatal combination of symptoms and did not take a patient to hospital quickly enough and that the patient subsequently died (Ref: 200901107). They also include a complaint about communication between Health Boards where the medical history of a patient was relevant to the surgery he was to have, and where again the patient subsequently died (Refs: 201000102 and 201001848).

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### Midwifery – telephone assessment

The parents of a stillborn child brought a complaint about the midwifery care and treatment provided before the mother was admitted to hospital (Ref: 200903956). I found a number of failings and made several recommendations. I found that the telephone assessment procedure for women calling in the circumstances that arose in this case was inadequate. I noted that the Board had carried out their own investigations into the complainants' experiences and that they took steps to improve their practice as a result. This included a new telephone triage system, which separates the responsibilities of midwives caring for patients on the ward from those taking calls and giving advice to women in labour calling or visiting from outside. I found, however, that further recommendations were necessary. I recommended that the Board audit midwifery staffing levels and the new triage system, and remind staff to fully document all telephone contacts to ensure continuity of care. In a previous complaint, (Ref: 200800763, published in September 2009) I recommended that a (different) Board review the use and purpose of their telephone call records, given the failure to complete any record on a particular occasion and the presence on file of a badly completed record. I urge all Boards to familiarise themselves with the findings of both reports and ensure that their telephone procedures for assessing changing presentations of pregnant women are fit-for-purpose.

### Dementia – fall prevention and communication

I regret that a common theme that emerges from complaints I receive continues to be failures in the care of elderly people with dementia. One of today's reports (Ref: 201000108) is about a woman who suffered a fall in hospital, and where, among other failings, I found that communication with the patient's family fell far below a reasonable standard. I made recommendations to improve staff understanding, knowledge and skills about fall prevention and use of bedrails. I also asked the Board to train staff in the needs of patients with dementia to address the failings identified, particularly in rehabilitative care and communication.

### Clinical errors and end of life care

In this investigation, significant clinical errors combined with poor communication and poor complaints handling led to a complaint (Ref: 200904350) that, among other things, a man had been denied the opportunity to make informed choices about his treatment and his end of life care. In another investigation, I upheld complaints (Ref: 201001180) about a wife's access to her husband in the last hours of his life and about respect for his dignity.

In these cases, as in all the investigations reported today, there are lessons for staff on wards, for clinical governance teams and for the Scottish Government Health Directorates in their role in sharing the learning from complaints across the NHS in Scotland.

## case reports

### Health

#### Diagnosis; policy/administration; complaints handling

Scottish Ambulance Service (200901107)

Ms A became unwell (with severe breathing difficulties and a swollen foot) at the home of her mother, Mrs B. Ms C, an advocacy worker, complained on Mrs B's behalf about the actions of the Scottish Ambulance Service (the Service) crew who arrived after Mrs B dialled 999. The crew thought that Ms A was suffering from a panic attack. While they were treating her for that she collapsed with a suspected heart attack. The crew resuscitated Ms A and took her to hospital, but she died from a pulmonary embolism. Mrs B believed

that Ms A should have been taken to hospital earlier. She felt that if this had happened her daughter might not have died. Having taken advice from one of my medical advisers, I upheld the complaint that the Service failed to provide appropriate care and treatment to Ms A. I found that the crew did not initially take essential equipment into the house, that the crew failed to act quickly enough to recognise that Ms A had a potentially serious combination of symptoms, and that a technician rather than a paramedic took the lead in assessing Ms A's medical condition. I recommended that the Board review their protocol for ambulance crews to ensure it gives staff clear guidance about the roles of different crew

members in assessing patients; assess this to demonstrate that ambulance crews properly understand it; and take measures to feed back the learning from this incident to avoid similar situations in future. I also upheld a complaint that the Service failed to handle Ms C's complaint properly. I recommended that they review their methods for learning from complaints, introduce comprehensive, dated action plans for follow-up action specific to each complaint, and introduce a way of ensuring that they integrate wider learning from complaints into the Service's governance structure. Finally, I recommended that the Service apologise for the failures identified in my report.

# Ombudsman's Commentary

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case reports

## Health

### **Clinical treatment; policy/administration**

Borders NHS Board (201000102) and  
Lothian NHS Board (201001848)

Mr A had a history of bowel problems and had undergone a series of operations in the care of an NHS Board. He had also suffered from post-operative infections. About three years later he was referred to a consultant in a second NHS Board who agreed to reverse one of the earlier procedures. The operation was successful but Mr A developed a severe blood infection and died soon after. His partner, Ms C, complained that the first Board failed to provide all of Mr A's relevant medical history to the second Board. She also complained that the consultant at the second Board did not obtain a full medical history during his consultation with Mr A. She believed that had the consultant done so, and if Mr A had known of the risks, the operation might not have gone ahead. I was concerned that the first Board did not send on Mr A's medical records. I did not, however, uphold the complaint about that Board as, after taking advice from one of my medical advisers, I found the information in the referral letter sent to the second Board was reasonable and indicated that Mr A had a complex medical history. I did, however, find that there were failings in the actions of the second Board. I found that the consultant who received the referral letter did not take a full medical history at the consultation, and did not ask the first Board for Mr A's medical records. I upheld the complaint against the second Board. I recommended that they apologise for these failures, and ensure that the consultant reflects on my report and reviews his practice on taking a patient's medical history. I also recommended that both Boards revise their policies to medical records protocols to ensure that, where appropriate, health professionals have direct access to patients' records.

### **Care of the elderly; policy/administration; communication; complaints handling**

Borders NHS Board (201000108)

Mrs A, who suffers from dementia, fell at home and fractured her wrist. While in hospital recovering, she fell from bed and fractured her hip. Her son-in-law, Mr C, raised a number of concerns about the care and treatment provided to Mrs A, and about communication between health care professionals and Mrs A's family. He also raised concerns about the way the Board handled his complaint. While noting that falls are not completely preventable, I found serious failures in Mrs A's care and treatment, especially around the assessment and prevention of falls and took the view that this contributed to her fall from bed. My medical adviser also said that communication with Mrs A's family fell far below a reasonable standard, and pointed out that effective communication was critical in maximising the chance of a full recovery. Taken together, the poor care and lack of communication indicated systemic failure in relation to caring for people with dementia. I, therefore, upheld all Mr C's complaints. I recommended that the Board audit and improve staff understanding, knowledge and skills about fall prevention and use of bed rails, and consider amending existing policies on these subjects in the light of my report. I also recommended that the Board ensure that staff are aware of the failures identified in meeting the needs of patients with dementia and implement training to address this, particularly in rehabilitative care and communication. Finally, I recommended that the Board apologise for the failures identified in my report.

### **Communication; record-keeping; policy/administration**

Greater Glasgow and Clyde NHS Board  
(200903956)

Ms C was in the late stages of pregnancy when she began to experience discomfort, abdominal pains and a vaginal discharge. Over a three day period she telephoned the relevant hospital ward several times for advice, and described her symptoms to various midwives. She also attended the ward twice during the three days. On the second visit her baby was found to have died and she was admitted, after which her baby was stillborn. Mr and Ms C raised a number of concerns about the midwifery care and treatment provided to Ms C before she was admitted. After taking the views of my midwifery adviser I upheld Mr and Ms C's complaints that the telephone assessment procedure for women calling in these circumstances was inadequate, and that there was a failure to identify the changing presentation of Ms C. I noted that the Board had carried out their own investigations into Mr and Ms C's experiences and that they took steps to improve their practice as a result. This included a new telephone triage system, which separates the responsibilities of midwives caring for patients on the ward from those taking calls and giving advice to women in labour calling or visiting from outside. I found, however, that further recommendations were necessary. I recommended that the Board audit midwifery staffing levels and the new triage system, and remind staff to fully document all telephone contacts to ensure continuity of care. I also recommended that they provide a full apology for the failures identified.

# Ombudsman's Commentary

MAY 2011 REPORTS

## case reports

### Health

#### **Communication; diagnosis; clinical treatment; complaints handling; record-keeping**

Forth Valley NHS Board (200904350)

Mr C had been unwell, losing weight and vomiting, and was admitted to hospital three times within a three month period. During the second admission a Consultant carried out an operation which revealed a large tumour which, according to the medical notes, seemed to be inoperable. Biopsies of the tumour were taken but did not reach the laboratory. Neither Mr C nor his family was clearly told that there was a likely diagnosis of cancer or what that might mean for his life expectancy until some three months later, just a few days before he died. Mrs C raised a number of concerns with the Board about the care and treatment provided to her husband. Among other things, she said that because the Consultant involved did not tell her or her husband about the cancer, Mr C was denied the opportunity to make informed choices about treatment and his end of life care. She also raised concerns about the way in which the Board handled her complaint. After seeking the views of one of my medical advisers, I found that there were significant failures by the Consultant and the Board in relation to Mr C's care and treatment. These included the failure to communicate Mr C's condition to him or his family, mismanagement of biopsy samples and failure to reach a definitive diagnosis or to manage his nutrition and weight. I also found that the Board had not completely addressed the failings in this case, or acknowledged the extent of the failures by the Consultant. They also took too long to handle the complaint and did not take accurate notes of a meeting with Mrs C. I did not uphold a complaint that

they unreasonably refused her a meeting with the Consultant. I made a number of recommendations including that the Board review their complaints procedures and how feedback from these is used. I also said that they should undertake an external peer review of the hospital's biopsy management procedures, strategy for the policy *Living and Dying Well* and training, particularly of consultants, about end of life care. Finally I recommended that they apologise for the failings identified and that these failings are raised with the Consultant at his next appraisal to ensure that he learns lessons from these events.

#### **Communication; complaints handling; record-keeping**

Ayrshire and Arran NHS Board (201001180)

Mr A suffered a cardiac arrest and was admitted to hospital. His condition deteriorated overnight and he suffered two episodes of bleeding. He died after the second bleed while his family were talking to a consultant about his condition. His daughter, Mrs C, complained that staff failed to explain to family members the severity of Mr A's condition and so his family were not with him when he died. She also said that after Mr A died, when she and her mother were eventually allowed to see him they found him with blood on his head and arm, which failed to respect Mr A's dignity. I upheld Mrs C's complaint about explanations given to the family. I found that although some of the decisions made by staff were reasonable, there was a failure of communication between the consultants involved, and between staff and the family, who could have been given more, or clearer, information about Mr A's condition. This led to me upholding her complaints about access to Mr A in the last hours of his life and about respect for his dignity, as both of

these issues hinged on communication from the staff involved. I upheld a complaint about the accuracy of information provided in the Board's complaint response, but not a complaint that the clinical records were inaccurate. I made a number of recommendations, including that the Board review procedures for handing over care of patients between consultants and review communications between consultants and nursing staff in this case, with a view to identifying any failures in communication from consultant to nurse to family members. I also made recommendations about taking account of Mrs C's comments about the condition in which she found Mr A's body, and about accuracy of information in clinical records and complaints handling.

# Ombudsman's Commentary

## MAY 2011 REPORTS

### Recommendations made in decision letters in March and April 2011

#### Recommendations to Health Boards and Healthcare Providers

##### Administration

- That if a complainant decides to attend a different dentist, the Board refer him there and send him a copy of the referral letter before his appointment.
- That a health centre ensure that they have a protocol to deal with requests for urgent appointments or telephone conversations, and interim systems in place to record requests for emergency appointments or for telephone discussions with a doctor.
- That a Board ensure that a written record is completed and filed after the completion of therapeutic sessions to comply with NHS record-keeping guidelines.
- That a Board update the Ombudsman on action taken about out of hours reporting arrangements with a hospital, the protocol for using a CT scanner and written and verbal communication between consultants involved with a patient's care.
- That a GP apologise to a complainant for inappropriately asking a family to chase up his referral letter.
- That a medical practice apologise for removing a woman and baby from the practice list without any prior warning, discussion or reasonable explanation.

##### Care and treatment

- That a medical practice review their management of cases of recurrent skin infections in the light of relevant guidance.
- That a Board ensure that sufficient communication tools are in place to ensure families and carers of patients at a hospital are informed of care and treatment issues.
- That a Board remind staff of procedures for manual handling.
- That a Board apologise for their failure and in recognition of the distressing, extenuating circumstances endorse it with a small financial payment.
- That a Board apologise that a complainant was not seen by a specialist epilepsy nurse before being discharged from hospital.
- That a Board emphasise to staff the importance of taking into account a patient's medical history when prescribing drugs.
- That a Board apologise for misplacing a sample and for the upset and distress this caused.
- That a Board emphasise to nursing staff the importance of properly completing patient profile documentation.
- That a GP maintains his records in accordance with the standard set out by the General Medical Council and provide confirmation that he will do so.
- That a Board review documentation provided to patients about intrathecal Phenol injections and consider written materials.
- That a Board provide the Ombudsman with a copy of their nutritional care strategy as outlined in the NHS Quality Improvement Scotland Clinical Standards for Food, Fluid and Nutritional Care in Hospitals and provide details of the action plan for a particular hospital.
- That a Board put in place a plan to monitor the quality of record-keeping at a hospital, to ensure records are kept in line with the principles of good record-keeping outlined in the NMC Record Keeping Guidance for nurses and midwives.
- That a Board ensures a doctor has established a tinnitus protocol for his patients.

# Ombudsman's Commentary

## MAY 2011 REPORTS

### Recommendations made in decision letters in March and April 2011

#### Recommendations to Health Boards and Healthcare Providers

##### Complaints handling

- That a Board feed back the Ombudsman's views on an officer's handling of a case, to try to prevent another occurrence.
- That a health centre conduct a Significant Event Analysis for a complaint, share its conclusions with staff and ensure that any training needs are identified.
- That a Board consider implementing cover arrangements for signing off correspondence which otherwise would be held up due to periods of annual leave.
- That a Board apologise for failing to clarify the purpose of a meeting and that notes were not taken, and remind Patient Relations staff of the need to take notes of meetings with complainants.

#### Recommendations to Local Authorities

##### Administration

- That a Council ensure that they keep a written record of when parents making placing requests have been provided with, or been referred to, the Scottish Government guide to choosing a school and the Council's policy on school transport.
- That a Council apologise to a complainant for failing to resolve maintenance issues at her property in good time and ensure that their records hold details of her special requirements so that future maintenance requests are prioritised where appropriate.
- That a Council put steps in place to ensure that they check, approve and, where appropriate, clarify the charges on invoices before they send them to tenants.
- That a Council refund mileage charges that they have agreed a person should not have to pay.
- That a Council review current procedures to ensure that due process is followed when terminating tenancy agreements – so that a distinction is made between a refusal to transfer tenancy and the formal decision that a tenancy is being terminated – and that sufficient information is provided to the tenant.
- That a Council amend the guidance notes on a submission form for formal objection and representation of support to include a statement that only the person signing the form will be formally registered as an objector, and an explanation of why this is the case.
- That a Council Revenues Department undertake a review of current procedures to ensure a clear process is in place and is communicated effectively to all stakeholders in enquiries or disputes about council tax.

##### Complaints handling

- That a Council place a matter before a Complaints Review Committee.
- That a Council review their process for examining complaints about service providers, and their complaints handling record-keeping standards.
- That a Council ensure tenants involved in antisocial behaviour complaints are provided with regular updates.
- That a Council review procedures to identify what improvements can be made to ensure that responses to customers are made in line with customer standards.
- That a Council ensure that senior staff from a school participate in the first refresher sessions that they are planning on handling formal complaints.

# Ombudsman's Commentary

## MAY 2011 REPORTS

### Recommendations made in decision letters in March and April 2011

#### Recommendations to Further and Higher Education providers

- That a University apologise for the delay in handling an appeal.

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#### Recommendations to Registered Social Landlords

- That a registered social landlord put steps in place to ensure that before deducting from refunds any money due to them they contact tenants and offer them the opportunity to make payment by another method.
- That a registered social landlord take action to improve record-keeping with proper recording of phone notes and ensure that they give staff appropriate guidance about mediation timescales.

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#### Recommendations to Scottish Government and other devolved bodies

- That a prison ensure they follow relevant procedures in the Scottish Prison Service (SPS) Financial Policy and Guidance Manual in relation to obtaining a prisoner's signature for any cash enclosed with mail for that prisoner.
- That the SPS remind staff to document discussions with prisoners about important issues, such as removing them from a hall, downgrading and progression.
- That a prison ensure that responses to complaints from ex-prisoners who are banned from visiting the prison are in line with SPS procedures for dealing with complaints from non-prisoners and ensure that these procedures, once in place, are well publicised.
- That a prison take steps to remind staff what documents are available for prisoners to access from the prisoner library.

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## 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, 18 May 2011**

The compendium of reports can be found on our website [www.spsso.org.uk](http://www.spsso.org.uk)

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# Ombudsman's Commentary



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, prisons, 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](http://www.spsso.org.uk)**

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