

November 2011

The SPSO laid six investigation reports before the Scottish Parliament today. Five are about health boards and one is about a council. We also laid a report about 41 decisions about all the sectors under our remit. These can be read on the 'Our findings' section of our website.

Ombudsman's Overview

Vulnerable people

A theme linking three of this month's reports is vulnerability. These cases are all from the health sector and they highlight how important it is that those delivering treatment and care truly understand the needs of those receiving it. Patients should be involved as much as possible in their own treatment and care, but there are cases, in particular those involving mental health care treatment, where patients are unable to provide the information that would help staff deliver the most appropriate treatment and care. The first two complaints I draw attention to today provide powerful evidence of the value of involving family members in decision-making in these circumstances. They also emphasise the importance of ensuring that health professionals have a sound understanding of key legislation and supporting guidance such as the Adults with Incapacity (Scotland) Act 2000 and NHS Education for Scotland: A Capability Framework for Working in Acute Mental Health Care (2008).

In the first case (201003775), Mrs C was the named person (someone who looks after the person's interests if he or she has to be treated under the Mental Health (Care and Treatment) (Scotland) Act 2003) of her sister, Ms A, who was a patient. Her sister was admitted to hospital with low mood and thoughts of self-harm. Our investigation was in part into the complaint into a decision to grant unescorted leave, during which Ms A took an overdose. While we found that the decision itself was reasonable, we were critical of the failure to discuss the decision with the named

person, Mrs C. We found that she was insufficiently involved in the decision-making process and that there was a failure to provide her with a range of support and information to ensure that she was able to participate as fully as possible in decisions about her sister's care.

The second case (201002867) raised the issue of consent as well as that of involving family members in decisions about treatment. The patient, Miss A, was admitted to hospital having suffered a fall and then, following concerns about the deterioration in her mental state, prescribed a short to medium term tranquillising drug and then an antipsychotic drug. She had additional needs as she had significant hearing impairment. The advice we accepted in this case was that it was likely that Miss A lacked capacity to provide informed consent to treatment or participate in treatment decision-making during her admission to the hospital. Although we did not uphold the complaint, we did express serious concerns about the Board's actions in relation to the Adults with Incapacity Act.

The third case (201004743) is an example of where a patient's physical needs did not receive sufficient attention because the focus was on her mental needs. We upheld the complaint that a psychiatric hospital where the complainant's mother, Mrs A, had been treated before her death paid little regard to Mrs A's physical condition and did not assess this properly before her release. Mrs A had died of heart failure soon after being discharged from a psychiatric hospital after her mental health problems had been resolved.



This month's findings

Clinical treatment; communication
Lothian NHS Board – Royal Edinburgh and Associated Services Division (201003775)

Care of the elderly; consent; policy/administration
Tayside NHS Board (201002867)

Clinical treatment; referrals, complaint handling
Fife NHS Board (201004743)

Diagnosis; clinical treatment; record-keeping
Highland NHS Board (201003473)

Clinical treatment; diagnosis; record-keeping
Dumfries and Galloway NHS Board (201003216)

Housing; statutory repairs notices; complaint handling
City of Edinburgh Council (201005204)

Ombudsman's Commentary

November 2011

Complaints Standards Authority Update

Local government

The development of the local government model complaints handling procedure (CHP) is progressing well with a draft being discussed at a meeting of the Working Group of local authority representatives on 9 November. Further comments are being received on the draft and the group's aim is to produce a final draft by early December. We would like to place on record our thanks to the sub-group of the working group who produced the draft model CHP.

We remain on track to introduce the model CHP for implementation by March 2012. We are particularly encouraged with progress in some councils with one council having implemented a 2-stage model across most council services and two others having approved the implementation of a 2-stage model.

Following discussion with SOLACE and COSLA, further detail will be provided to all local authorities in due course on the

publication of the model CHP by the Ombudsman. Following publication, each local authority will then have a duty to comply with the model CHP. This compliance will be monitored through existing regulatory structures, as we detailed in earlier versions of the SPSO Commentary.

The CSA team would be happy to provide further information on the emerging model CHP and can be contacted at CSA@spsso.org.uk.

Housing

We met with our group of key housing stakeholders, including the Scottish Housing Regulator (SHR), the Chartered Institute of Housing and tenants groups, to discuss the outcomes from the recent survey and to discuss the future plans for developing the RSL model CHP. We will be publishing results of the survey next month. We will also shortly be providing further information to those who have volunteered to act as advisors on the development of a model CHP for further input from them on a draft model CHP.

This month we will be contributing to the SHR consultation on their approach to assessing the Scottish Social Housing Charter. As outlined previously we intend to monitor compliance of the model CHP through the Charter building on the SHR approach to measuring the Charter outcomes.

Again, please contact the CSA team at CSA@spsso.org.uk for further information.

The Ombudsman's complaints handling principles and guidance can be found at www.valuingcomplaints.org.uk

Case numbers

Last month (in October) in addition to the four full reports laid before the Parliament we determined 411 complaints and handled 56 enquiries. Taking complaints alone, we:

- > gave advice on 278 complaints
- > resolved 103 in our early resolution team
- > resolved 26 by detailed consideration
- > made a total of 38 recommendations in decision letters.

Case Summaries

Health

Clinical treatment; communication

Lothian NHS Board – Royal Edinburgh and Associated Services Division (201003775)

Mrs C complained about the care and treatment provided to her sister, Ms A, after she was admitted to hospital. Mrs C was also unhappy with the Board's responses to her complaints. We upheld both complaints.

Ms A had a diagnosis of Borderline Personality Disorder. Our investigation found that the hospital had not carried out a satisfactory assessment when Ms A was admitted. There was no evidence of a clear documented care plan. They also failed to provide Mrs C, Ms A's sister and named person, with a range of support and information to ensure that she was able to participate as fully as possible in decisions about Ms A's care. The hospital should have been contacting Mrs C and not leaving it to her to initiate contact with them. In addition, no one contacted Mrs C to discuss Ms A's unescorted leave to attend an appointment with her psychologist. While on unescorted leave, Ms A took an overdose.

We found that the decision to grant unescorted leave was reasonable, but we were critical of the failure to discuss the

decision with Mrs C and the failure to review the decision in light of all the concerns expressed by the family and nursing staff. We found that the hospital failed to take reasonable action to minimise Ms A's risk of self-harm and there was no evidence that they reviewed her observation status after she tried to abscond. Staff also failed to take reasonable precautions to minimise risk when Ms A went on unescorted leave. Our report describes these as *'extremely serious failings. The consequences of this for Ms A could have been much more serious.'*

We made recommendations including that the Board undertake an external peer review in the hospital to include: the assessment of patients on admission; care-planning practice; the completion of risk management plans and proformas; and communication with the named person and relatives and their involvement and participation in decision-making. We also recommended that practices in these areas should be audited against relevant professional body expectations; national standards, policies and codes of practice; and existing local policy intentions. We asked that the Board provide this office with details of the findings and the action plan created as a result of this recommendation.

Ombudsman's Commentary

November 2011

Case Summaries

Health

Care of the elderly; consent; policy/administration

Tayside NHS Board (201002867)

Mrs C raised a number of concerns about the prescription of antipsychotic drugs to her aunt, Miss A, during her admission to hospital. Specifically, Mrs C complained that the Board wrongly prescribed the antipsychotic drug haloperidol to her aunt. Our investigation found that it was reasonable for the Board to prescribe the drug to Miss A on medical grounds. In reaching that decision, we took into account the failures by the Board to meet Miss A's needs as a patient with sensory impairment (Miss A had significant hearing impairment and required the use of bilateral hearing aids) and the impact this had on her behaviour. The Board could and should have done more to better manage Miss A's needs.

So, while we did not uphold Mrs C's complaint, we did express serious concerns about the Board's actions in relation to the Adults with Incapacity Act. The advice we accepted is that it was likely Miss A lacked capacity to provide informed consent to treatment or participate in treatment decision-making during her admission to hospital. The Board failed to assess her capacity, which was a matter of concern. Had they done so and found, as the evidence suggested, that Miss A lacked capacity to consent to treatment, then they should have completed a certificate of incapacity and consulted Mrs C about treatment. Our report goes on to say:

'Good communication with carers is an underpinning principle of the Act and ensures that patients receive a reasonable standard of care. Had the Board acted properly, which includes completing its own documents properly, healthcare professionals would have had a full and proper discussion with Mrs C about Miss A's needs and treatment decisions. This would have given healthcare professionals an opportunity to explain the risks and benefits of the use of drugs to control Mrs A's agitation and hostility, and Mrs C an opportunity to inform treatment decisions.'

We made a number of recommendations to the Board in this regard, including that they carry out an audit of their practice on implementation of the Adults with Incapacity Act with particular reference to consent and report to the Ombudsman on the findings; amend their guidance on managing patients with delirium to include the requirements of the Adults with Incapacity Act; share the report with staff to ensure they complete documentation properly and meet the communication needs of patients with cognitive or sensory (or both) impairment.

Clinical treatment; referrals, complaint handling

Fife NHS Board (201004743)

Mrs C complained that the psychiatric hospital where her mother, Mrs A, had been treated before her death paid little regard to Mrs A's physical condition and did not assess this properly before her release. Mrs A was admitted to the hospital because she was hearing voices and suffering from hallucinations and paranoia. She was discharged three months later after her mental health problems had been resolved. She died from heart failure soon afterwards, following an emergency admission to a different hospital. Mrs C was also unhappy with the responses she received from the psychiatric hospital where she had first made her complaint. We upheld both complaints.

Our advisers highlighted concerns about Mrs A's change of medication and the insufficient response made to her oedema. The significance of signs of heart failure were not recognised and our advisers considered that Mrs A should have been seen by a cardiologist for review. The investigation found that *'It was clear from the notes that Mrs A's physical condition was deteriorating even though her mental condition had improved. The Consultant Psychiatrist was responsible for Mrs A's overall care while she was a patient in the hospital and it has been seen that this was not satisfactory. There were also anomalies in the referral letters and the Board should consider these.'*

We made a number of recommendations to the Board, including that they offer Mrs C a full and sincere apology for their failures with regard to her mother's treatment; share the report with the team involved and with the consultant psychiatrist and remind him of his overall responsibilities in such cases; and look into the process of issuing referral letters, to ensure that any failures to respond are chased up. We also recommended that they apologise to Mrs C for their failures in investigating her complaint; and review the rigour of their complaint handling process, with particular relevance to timescale and investigative thoroughness.

Ombudsman's Commentary

November 2011

Case Summaries

Health

Diagnosis; clinical treatment; record-keeping

Highland NHS Board (201003473)

Mr C raised a number of concerns that his brother, Mr A, had been inappropriately cared for and treated in hospital. Mr A was a 57-year-old man with a history of laryngeal cancer. He received treatment for this cancer which was completed in the summer of 2008. In early 2010 he experienced difficulty swallowing and, during the year, this worsened. Mr A was seen by staff in two hospitals. Mr A died in October 2010, the cause of death being recorded as carcinoma of the oesophagus and carcinoma of the larynx. In complaining to my office, Mr C said that Mr A felt let down by the Board, as his last six to eight weeks were an unpleasant experience that Mr A felt should have been managed better. Mr C's view was that the Board needed to learn lessons about the rapid management of cancer care.

Mr C had three specific complaints – that the Board delayed in diagnosing Mr A's cancer, including a delay in him being reviewed by Gastroenterology; that Mr A was discharged inappropriately; and that the communication to Mr A of his diagnosis and prognosis were inadequate. We upheld the first two complaints and did not uphold the last one. Our investigation found that there clearly were unreasonable delays in this case. Of particular concern was the initial four-week delay for an urgent endoscopy referral. There was then a further delay in carrying out a further endoscopy, with no clear management plan in place. There was a two-week delay in inserting an oesophageal stent. While the CT scan confirmed cancer, two endoscopies failed to obtain adequate histology and corroborate the diagnosis. Consequently, the diagnosis of cancer was delayed. While the advice we received was that the delays would most likely have not affected the outcome, the failures added to the distress and discomfort for Mr A and his family over the period.

We made several recommendations to the Board, including that they review endoscopy waiting times, taking into account SIGN and NICE guidance, and report on what steps will be taken to address capacity issues to avoid delays such as that identified in this case; explain how cancelled endoscopies will be treated as adverse events; review the circumstances of Mr A's admission and discharge, with a specific focus on the potential for an inter-hospital transfer, and discharge criteria, and report on the lessons learned.

Clinical treatment; diagnosis; record-keeping

Dumfries and Galloway NHS Board (201003216)

Ms C raised concerns about the treatment that she received before the birth of her son and the treatment he received after he was born. Specifically, Ms C complained about the lack of action by staff in relation to her baby's rapid breathing. She also complained about delays to his treatment and the diagnosis of Persistent Pulmonary Hypertension of the Newborn (PPHN). The baby suffered damage to his brain, liver and kidneys due to oxygen deprivation and the extent and impact of this damage will not be known until he is older.

We did not uphold Ms C's complaint that the Board failed to diagnose that she had pre-eclampsia, nor that the midwife failed to recognise that there were problems with the baby's feeding when she gave him formula milk. We also did not uphold Ms C's complaint that the doctor treating her baby did not know how to increase the oxygen when this was requested by the consultant. We did, however, find that the paediatrician's arrival was excessively delayed, despite Ms C and her family's concerns over the baby's breathing, and that the paediatrician failed to properly prioritise him. We were critical of the treatment provided by the Board following the baby's diagnosis of PPHN, and of Ms C's refused entry into neonatal when he required a heart massage.

We recommended that the Board remind midwifery staff of the importance of maintaining consistent records of babies' physiological observations; present this case, and one of our adviser's comments, to neonatal staff to highlight any learning points that can be taken from this case; and apologise to the baby's parents for the issues highlighted in this report.

Ombudsman's Commentary

November 2011

Case Summaries

Local Government

Housing; statutory repairs notices; complaint handling

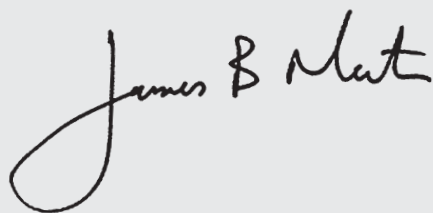
City of Edinburgh Council (201005204)

Mr C complained that the Council had failed to respond reasonably to his enquiries about a statutory notice that had been served on his property. He complained to the Council's Customer Care Team (within the Corporate Contact Centre) that his enquiries were not being responded to. Thereafter he complained that the Customer Care Team had failed to respond to his complaints. We upheld the complaints that the Council did not reasonably respond to Mr C's enquiries about a statutory notice served on his property, and that they failed to respond to his complaints about the Edinburgh City Development Department and the Customer Care Team.

We recommended that the Council provide a full apology from the Edinburgh City Development Department to Mr C for failing to appropriately respond to his enquiries about an outstanding statutory notice affecting his property. We also asked the Council, following consideration of the findings of the external enquiry that they are undertaking, to report back to this office about the measures being put in place in the Edinburgh City Development Department in relation to customer care and in particular in relation to enquiry handling, to ensure a similar situation does not occur. We recommended that they provide a full apology to Mr C for the failures identified regarding the handling of his complaints by the Customer Care Team, review the Corporate complaints policy, and provide evidence to us that procedures are being adhered to effectively when handling complaints from customers.

Compliance and 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, 16 November 2011

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

Gráinne Byrne, Communications Officer

Tel: **0131 240 8849** Email: gbyrne@spso.org.uk

Emma Gray, Head of Policy and External Communications

Tel: **0131 240 2974** Email: egrays@spso.org.uk

Ombudsman's Commentary

November 2011

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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, 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
4 Melville Street
Edinburgh EH3 7NS

Tel: **0800 377 7330**
Fax: **0800 377 7331**
Text: **0790 049 4372**

