

Monthly news from the Scottish Public Services Ombudsman

The SPSO laid seven investigation reports before the Scottish Parliament today, about five different health boards. We also laid a report on 65 decisions about all of the sectors under our remit. All the reports can be read on the 'Our findings' section of our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in April), we received 417 complaints. In addition to the three reports we laid before Parliament, we determined 400 complaints and of these we:

- gave advice on 252 complaints
- resolved 100 in our early resolution team
- resolved 45 by detailed consideration
- made a total of 57 recommendations in decision letters.

Ombudsman's Overview



Prison healthcare

One of today's reports (201203514) highlights serious concerns that I have publicised before about prisoners' access to the NHS complaints procedure. The NHS became responsible for prison healthcare in November 2011 – a Scottish Government change, which made my office the final stage for such complaints. Since then, we have received dozens of contacts from prisoners across the Scottish prison estate. From this, I have concluded that in some health boards at least, there is confusion about the process, which is leading to prisoners being denied access to the NHS complaints procedure. Today's investigation report is further evidence of this.

Like members of the public who are concerned about their health, some of the prisoners phoning my office are, as well as needing medical attention, very anxious and upset. Those feelings are compounded by frustration at being unable to access the NHS complaints procedure. I have been advised by Scottish Prison Service staff that this can lead to potentially difficult situations arising. I have shared this warning with Scottish Government officials and am pleased to have seen some progress in the form of reminders to relevant health boards about the correct process and the need for complaints forms to be made available. I have also raised my concerns in Parliament, most publicly in evidence to the Health and Sport Committee on 15 January 2013. It is now 18 months since the transfer of responsibility and it is high time that these issues were fully addressed.

There appear to be two main obstacles. Many of the prisoners who phone my advice team say it is difficult to get beyond the feedback stage. They say that when they want to complain, they are given a feedback form, and that complaints forms are not being provided. Others say that because of misunderstanding by prison medical centres about the process that should be used, prisoners are effectively forced to go through an additional 'feedback' stage before they can reach the complaints stage.

This is at odds with the Scottish Government guidance, *Can I help you?*, which was published in March 2012 to further the provisions of the Patients' Rights Act 2011. The guidance sets out best practice for relevant NHS bodies and health service providers to ensure their frontline staff are trained, supported and empowered to deal with feedback, comments, concerns and complaints. It is clear from the guidance that NHS users are not required to complete a feedback process before accessing the complaints procedure, and that the same applies to those receiving NHS care and treatment in prison. Relevant boards should read my investigation report and ensure that their healthcare complaints process for prisoners complies with the *Can I help you?* guidance.

Pressure sores

Another issue that needs to be urgently addressed is the treatment of pressure sores. As I have highlighted in previous commentaries, apart from in rare and exceptional situations, pressure sores should be a thing of the past in Scottish hospitals. In two of today's reports (201103459 and 201104025) patients suffered these painful sores because of poor treatment. Such low standards of nursing care are simply unacceptable.

NHS sounding board

I have welcomed the opportunity to discuss such issues in a newly established health forum. This has been established as a sounding board for sharing developments about health matters at SPSO and to provide an opportunity for feedback to help us improve our performance and service. The group comprises senior health professionals, including chief executives and chairs of boards, a medical director, a nursing director, a lead officer on infection control and a patient relations manager. The inaugural meeting was held in March and the group plans to meet again in September.

E-learning for NHS Staff

We are continuing to support good complaints handling through new e-learning modules for NHS frontline staff on feedback and complaints handling. We have developed these with NHS Education for Scotland (NES) as part of the Scottish Government sponsored 'Feedback, Comments, Concerns and Complaints' project. The project aims to provide training and education for NHS staff to support the requirements of the Patients' Rights Act. The modules will be launched this month, either via internal NHS systems or via NES' 'Little Things Make a Big Difference' website. They are a useful tool for helping staff understand the process and requirements correctly, and should help avoid the kinds of problems highlighted in today's investigation reports.

Further training and education for NHS staff on feedback and complaints handling will be delivered later this year. This will aim to provide more focused training for complaints officers, managers and senior managers on various aspects of their complaints handling responsibilities.

MSP and MP Guide

We have updated our guide for MSPs, MPs and Parliamentary staff. This provides information about our service, role, governance and remit. While most members of the public bring complaints to the SPSO directly, we know that some people ask their elected representative for support. In these instances, it is important that those helping someone make a complaint understand our work. We also need to be sure that complainants are happy to be represented by their MSP or MP and that they give us their consent. The guide provides information about consent and about helping a constituent through a public body's complaints procedure, a list of bodies under the SPSO's jurisdiction, examples of the kinds of complaints we can and cannot look at, and some of the outcomes we can achieve.

Complaints Standards Authority update

Our work to create standardised complaints procedures and improve complaints handling standards across Scotland's public services continues. For previous updates and further information, visit our dedicated website at www.valuingcomplaints.org.uk

Higher and further education – compliance statement and e-learning materials

Following on from our complaints procedures standardisation work in other sectors, all universities and colleges are required to implement the model Complaints Handling Procedure (CHP) by 30 August 2013. Using the online self-assessment and pro-forma, each university and college should, by 28 June 2013, provide the SPSO with a statement confirming that they will comply.

We are currently developing e-learning materials for the higher and further education sectors, to help organisations provide training and awareness-raising for frontline staff involved in complaints handling. We aim to have these available online by June.

NHS complaints handling training

As the Ombudsman notes in his Commentary, e-learning modules for NHS frontline staff on feedback and complaints handling will be launched this month. We have developed these with NHS Education for Scotland (NES) as part of the Scottish Government sponsored 'Feedback, Comments, Concerns and Complaints' project. The project aims to provide training and education for NHS staff to support the requirements of the Patients' Rights Act 2011.

Further training and education for NHS staff on feedback and complaints handling will be delivered later this year. This will aim to provide more focused training for complaints officers, managers and senior managers on various aspects of their responsibilities for complaints handling.

Local authority complaints handlers network – performance indicators

The local authority complaints handlers network, which was established in September 2012, met on 26 April at Stirling Council. The key area for discussion was the performance reporting framework, including performance indicators and a suggested best practice internal reporting framework. The final performance indicators, against which local authorities will be required to report annually, will shortly be circulated to the network and will be published on the CSA website: www.valuingcomplaints.org.uk.

The next meeting of the network will take place on 21 June, hosted by Glasgow City Council. If you are interested in joining please contact CSA@spsso.org.uk and we will provide your details to North Lanarkshire Council, who co-ordinate the network.

Housing complaints handlers network

In response to requests, a further meeting of the network for RSL complaints handlers is being planned. We will issue further information about this shortly.

Model CHP for the Scottish Government, Scottish Parliament and associated public authorities in Scotland

A number of organisations have contacted us for further information about this model CHP. For clarification, it applies to all central government public authorities, including executive agencies, executive, advisory and tribunal non-departmental public bodies, non-ministerial departments and the Scottish Parliamentary Corporate Body and associated Parliamentary bodies and commissioners.

Each organisation is required to comply with the model CHP by the end of March 2014. By 30 September 2013 each organisation should provide the SPSO with a compliance statement, and a self-assessment confirming that their CHP complies with the published model CHP, or that it will comply by the end of March.

The model CHP and associated documents are available on the CSA website: **www.valuingcomplaints.org.uk**. Please contact **CSA@sps.org.uk** if you have any questions about the model CHP, or your obligation to implement it.

The CSA is always available to provide specific advice or support to complaints handlers across the public sector. Please address any questions to CSA@sps.org.uk.

Investigation Reports



Investigation report ref: 201203514

Prison healthcare; complaints handling; policy/administration

Ayrshire and Arran NHS Board

Summary

Mr C, who is a prisoner, complained about the process in place for prisoners receiving weekly medication at his prison. He submitted his complaint on an NHS 'feedback, comments or concerns' form (feedback form). He also submitted a complaint to the director of the prison raising concerns about the prison healthcare complaints process. I did not investigate Mr C's first complaint, as when it reached us it had not gone through the NHS complaints procedure.

My investigation of Mr C's complaint highlights two major concerns about prisoners' access to the NHS complaints process, which I have raised repeatedly in different forums. As my report concludes, since the NHS became responsible for prison healthcare, I have received a number of contacts from prisoners across the Scottish prison estate seeking advice and assistance on progressing their complaint through the NHS complaints process. Prisoners have often said that it is difficult to get beyond the feedback process.

The first issue is the availability of complaints forms. It is clear that Mr C wanted to submit a complaint. However, as no complaints forms were provided, he resorted to complaining on a feedback form. Mr C said that feedback forms regularly went unanswered and were not given a reference number, which meant there was no record of them. I noted that Mr C's feedback form did not have a reference number. When he was unable to progress his complaint, Mr C asked the prison director for help. In my report, I point out that this should not need to happen. Indeed, in some cases it could be inappropriate, for example if a prisoner wishes to complain about a particularly sensitive health matter.

The second issue is the board's misunderstanding of the process for handling complaints. The Scottish Government's guidance *Can I help you?* sets out best practice for relevant NHS bodies and health service providers to ensure their frontline staff are trained, supported and empowered to deal with feedback, comments, concerns and complaints.

Information from the board indicated that prisoners are required to complete the feedback process twice and only after this can they access the formal complaints process. However, the correct procedure is for complaints to be handled separately from feedback, comments and concerns and in line with what is set out in the complaints section of *Can I help you?* It is clear that the guidance does not require NHS users to complete the feedback process before accessing the complaints process, and the same should apply to those receiving NHS care and treatment in prison. It is specifically stated that feedback, comments, concerns and complaints from patients who receive NHS treatment in a prison health centre should be handled in accordance with the guidance.

I am satisfied that Mr C was unreasonably denied access to the NHS complaints procedure. It appears that the board are using the feedback process as an additional stage of the NHS complaints process. This is restricting and over-complicates prisoners' access to the NHS process. I made a number of recommendations to the board, including that they review the local process in place for the management of prison healthcare complaints to ensure that this is brought into line with the good practice outlined in *Can I help you?*, take steps to ensure that NHS complaint forms are readily available to prisoners, and provide a reference number on receipt of feedback, comments and concerns or complaints.

Investigation report ref: 201104810

Clinical treatment; diagnosis; follow-up care

Ayrshire and Arran NHS Board

Summary

Mrs C raised a number of concerns about delays in diagnosing and treating her thyroid cancer. She believed that these were due to mistakes, confusion, poor communication and a lack of support by hospital staff.

Mrs C went to her GP after finding a large lump on her neck. She had been under the care of a consultant endocrinologist for a number of years as she had a thyroid condition. The GP thought the lump could be connected to that condition, and referred Mrs C to the consultant. Test results suggested she had a benign cyst, and Mrs C was advised that she should have it surgically removed under general anaesthetic by an ear, nose and throat (ENT) surgeon. At the time, Mrs C had a baby whom she was breastfeeding. She contacted the ENT consultant's office and asked if the surgery was essential. She said that she was told the cyst was 'nothing sinister' and that its removal was not urgent. Because of this, Mrs C decided to delay the surgery.

A year later, having had no further contact from the hospital, Mrs C asked her GP to refer her back there to discuss having the cyst removed. She was given an appointment with the ENT consultant. However, before that appointment, she had a routine appointment with the consultant endocrinologist, who discovered a nodule on her thyroid. Biopsies of the nodule and the cyst were taken, and Mrs C was told that cancer cells had been found in these. Mrs C had surgery a couple of months later. She said that the hospital's failure to tell her that the cyst could be cancerous and the delay in diagnosing her cancer had affected her chance of recovery.

I upheld Mrs C's complaint that she was not given reasonable information, advice or support about the lump on her neck and the possible risk of cancer to allow her to make informed decisions about her treatment. I also found that nobody took reasonable steps to follow up after Mrs C cancelled the first operation, to ensure that the lump had not changed or to arrange a further operation date. I did not, however, uphold her complaints that staff failed to carry out further tests when the lump was first discovered, as I found that investigations were correct, accurate and carried out without delay. Nor did I uphold a complaint that the health board failed to provide a reasonable explanation of the process to be followed in relation to a scan that Mrs C was offered and the scan results themselves.

I made four recommendations, including that the board provide Mrs C with a full and sincere apology for the failings identified. In relation to the complaint about information, advice and support, I recommended that the board share the comments of my medical adviser with relevant hospital staff to ensure that full information is given to a patient about the need for surgery and that this is documented in the medical records. I also recommended that they consider changing their current practice so that when a patient cancels surgery for a putative benign lesion, the hospital department contacts the patient again, documents this, and records either the need for surgery or a follow-up appointment.

Investigation report ref: 201004234

Clinical treatment; complaints handling; policy/administration

Tayside NHS Board

Summary

Miss C had problems with her ears from childhood, and had had grommets inserted (a grommet is a very small tube inserted into the ear to drain away fluid in the middle ear and help to maintain the air pressure in the middle ear cavity). This, however, led to her right eardrum being perforated, which meant Miss C had frequent ear infections and conductive deafness. As an adult, she underwent a myringoplasty (a surgical procedure to repair a perforated eardrum using a patch) in order to treat this. Miss C experienced significant problems after the procedure, including balance problems, sickness and significant hearing loss in her right ear. She underwent a hearing test which confirmed the hearing loss, with limited options for treating this. Miss C complained to the board twice about the treatment she received including the treatment following the myringoplasty, but did not receive a final response until fifteen months after her second complaint.

I am very critical of the board's handling of Miss C's complaints. She first complained in January 2011, and asked for her medical records. She also requested a second opinion. She said that she had been advised this was a procedure with little or no risk, yet she was left with a significant disability. This had a lasting and enormously distressing impact upon her life, both personally and professionally. The board responded in February 2011, explaining the care Miss C had received. Miss C was not satisfied with this response and complained again in March 2011, asking that the second opinion she had requested be arranged. She also noted that she had undergone an MRI scan, which had ruled out the possibilities that the ENT consultant had given for the cause of the hearing loss. She believed that this confirmed the cause of the problem as lack of care and skill during the procedure itself.

Miss C was seen by another ENT consultant in April 2011 and was referred to a hearing therapist. The board wrote to Miss C the same month advising they would conduct a formal investigation into her concerns. However, Miss C then had to keep writing to the complaints and advice team asking about her request for medical records and the outcome of the investigation. The records were not provided until December 2011, nearly a year after Miss C's request. Miss C did not receive a full response to her second letter of complaint until June 2012, fifteen months later. She also wrote to the board's chairman, and I consider that it was only due to her tenacity in making contact with him that she ensured herself a proper response. It should never be the case that a complainant has to make such repeated efforts to receive a response to a complaint.

Miss C's complaints to me were that her hearing loss was now severe, and she faced the prospect of wearing a hearing aid for the rest of her life. She continued to be afflicted with ear infections, balance problems and nausea, was unable to exercise as she had done before, and had a polyp and perforation in the affected ear which continued to be monitored. She described her post-operative care and the board's complaint handling as 'appalling'. Miss C said she wanted the board to accept responsibility for her hearing loss.

After reviewing the medical records, complaints correspondence and taking independent advice from my consultant ENT adviser, I did not uphold Miss C's complaints that the board failed to carry out appropriate surgery and follow-up treatment. The advice I received clearly indicated that the complication had occurred during the surgical procedure itself, despite this having been carried out appropriately. So although Miss C's post-operative care was not optimal, this did not impact upon the outcome as the advice I received clearly indicated that the complication had occurred during the surgical procedure itself, despite this having been carried out appropriately. On balance I did not uphold that complaint but I criticised the apparent lack of frank discussion with Miss C about what had happened. I also did not uphold Miss C's complaint that the board failed to explain that the surgery could result in hearing loss or balance problems. I did, however, strongly criticise them for their complaints handling failings and made several recommendations to the board for redress and improvement. These included that they offer Miss C an appointment with a senior otologist to discuss possible surgical options; provide evidence that staff on the ENT ward are aware of the procedure to be followed when patients report post-operative problems; amend their Informed Consent Policy to ensure that patients who sign a consent form prior to treatment are given the option of receiving a copy; remind the medical staff involved of the need to confirm consent; conduct an audit of their internal complaints handling process to ensure that all complaints received are properly handled as per the board's complaints procedure; and give a full and sincere apology to Miss C for the outcome of the myringoplasty, and for all the failings identified within this report.

Investigation report ref: 201201639

Clinical treatment; policy/administration

Lanarkshire NHS Board

Summary

Mrs C was undergoing fertility treatment. She raised concerns that sub-standard ultrasound equipment or human error meant that a pregnancy she conceived during her fifth cycle of fertility treatment was not detected. She believed that this resulted in the pregnancy being destroyed during a sixth cycle of treatment. After examining documentation from Mrs C and the board, relevant national and local guidance, and taking independent advice from two advisers (a consultant gynaecologist and a senior nurse) I upheld part of Mrs C's complaint and made a number of recommendations.

Mrs C was undergoing IUI (Intra Uterine Insemination) treatment at an infertility unit and had been through five cycles. She had three ultrasound scans in preparation for her sixth cycle. No pregnancy was detected and Mrs C underwent an IUI procedure. During the procedure she experienced and reported unusual irregular pain and discomfort.

Mrs C started bleeding a few days after the procedure and went to hospital. Bleeding and abdominal cramps were noted and an ultrasound scan showed a small intrauterine gestation sac (the first sign of early pregnancy). Further scans were carried out throughout that month with the sac still visible, but a miscarriage was eventually confirmed. Mrs C complained that, due to the failure to detect her pregnancy, she not only lost a viable pregnancy but had possibly also lost the opportunity to conceive in the future.

After reviewing the evidence and advice provided, I did not uphold Mrs C's complaint that her pregnancy was not detected at two ultrasound sessions. I found that, based on the information available to the clinicians at the time, it was reasonable for them not to pick it up at that early stage. I also found that it was not inappropriate that the irregular pain and discomfort she experienced during the IUI procedure was not recorded. However, I disagreed with the board's view that the scanner was of a reasonable standard, as it was clearly not fit for purpose in the context of the infertility unit. As the board has now replaced the scanner and images are reported to be far superior to those previously made, I made no recommendation in respect of equipment. I did, however, express dissatisfaction that, despite being aware of staff concerns about the quality of images from the previous scanner, the board did not replace it until it became due for replacement under their 'rolling replacement programme'. Nor did the board mention staff concerns in the responses to either Mrs C or to my office.

Although I did not uphold the complaint about the lack of recording of Mrs C's pain and discomfort during the IUI procedure, I did find that it would be reasonable for the nurse to be able to record such symptoms. I recommended that the board review the form to incorporate space for symptoms reported by the patient. I also recommended that the board issue a written apology to Mrs C in relation to the scanner.

Investigation report ref: 201104025

Care of the elderly; clinical treatment; consent; communication

Greater Glasgow and Clyde NHS Board

Summary

Mrs C and other members of her family raised a number of concerns about the care and treatment that their 78 year old mother (Mrs A) received over a three month period in hospital before her death. Mrs A was admitted for investigation of a possible gastrointestinal bleed against the background of a deterioration in her physical and cognitive function. While in the hospital an existing pressure sore deteriorated in association with the development of a bone infection (osteomyelitis).

Mrs A's family believed that poor management of the pressure sore led to osteomyelitis of the spine, which ultimately led to Mrs A's death. Mrs A was eventually put on the Liverpool Care Pathway (LCP – an end of life care planning system for dying patients) and all treatment was stopped. Mrs C said that, whilst her mother was on the LCP, her pain relief needs were routinely not met and she was nursed in an open ward until she died. Mrs A's family considered that communication about Mrs A's care and treatment was poor, in particular during a phone conversation and at a meeting. Mrs C also complained that she only learned that a Certificate of Incapacity (saying that a person is not capable of deciding about medical treatments) was in place when she requested a copy of her mother's medical records after her death.

In the course of the investigation I reviewed Mrs A's medical records, the complaints correspondence from the board and information supplied by Mrs C. I obtained independent advice from two medical advisers, a tissue viability nurse and a consultant in acute medicine for older people. The advice I received was that this was a complex and difficult clinical case. There were reasonable clinical decisions and nursing care, but also what I conclude to be clear and unacceptable failings by staff in relation to Mrs A's pressure sore (mainly from a nursing perspective) and in communicating with Mrs A's family. There was also no evidence that staff consulted the family about the Certificate of Incapacity or enquired about the legal decision-making status of any family member, such as whether a power of attorney was in place. I therefore upheld the complaint that Mrs A's care and treatment, including the management of her pressure sore and the use of a Certificate of Incapacity, was inadequate.

Although I did not uphold the complaint about the LCP, I accepted the view of one of my advisers about the failure to judge the correct dose of morphine in the period leading up to Mrs A's death, for which the board had already apologised to Mrs A's family. I also noted the adviser's view that ideally terminal care of a patient in hospital should be delivered in a single room where the appropriate privacy and dignity can be given to the patient and their family. However, I also accepted that, given the number of single rooms in the majority of Scottish hospitals at present, it can be difficult or even impossible to provide this. In addition, single rooms are also required for patients with infections or disturbed or agitated behaviour, all of which are common in hospitals. I did, however, make a recommendation about this, which can be read in the report.

I also upheld the complaint about poor communication. As there was a lack of documentary evidence in the medical records, and as the board failed to respond to these concerns, I was unable with certainty to draw conclusions about the content and tone of discussions. Given the serious nature of Mrs C's concerns about two named members of staff, however, I consider that the board should have addressed this in their response to the complaint. I agreed with my adviser that it would be good practice for medical staff to do so.

In all, I made ten recommendations to the board, which can be read in full in my report.

Investigation report ref: 201103459

Clinical treatment; discharge planning; record-keeping; communication

Lothian NHS Board

Summary

Mrs C is paraplegic (where the lower half of the body is paralysed) and uses a wheelchair. She developed pressure ulcers (also known as pressure sores) in hospital and her husband (Mr C) complained that the board failed to prevent these. He also raised concerns about hospital staff's communication with Mrs C and the appropriateness of the initial decision to discharge her.

Mrs C attended an accident and emergency department, complaining of severe headache and neck pain. She was transferred to the hospital's Infectious Diseases Unit where she remained for seventeen days, being treated for meningitis. When she came home, Mr C found that his wife had pressure ulcers on her buttock, and left heel. A further ulcer developing on her hip then got worse. Mr C contacted the district nurse for help dressing the ulcers. The nurse was reportedly unaware that Mrs C had these. Mrs C had to return to hospital because extensive pressure ulcers and associated complications meant she could not be nursed at home. She remains in hospital.

Mr and Mrs C were keen to praise the treatment provided by hospital staff in relation to meningitis. However, Mr C complained about the discharge process and a lack of coordination between clinical, nursing and physiotherapy staff. In his view there was a lack of a multi-disciplinary assessment of Mrs C's suitability for discharge and her ability to transfer from bed to wheelchair to toilet. He said that there was no discussion about arrangements for his wife's care at home or any particular equipment needed to manage her pressure ulcers. To help with Mrs C's care, a hospital bed was brought into their home about two weeks after she left hospital, but Mr C felt that this requirement should have been identified and put in place before his wife was discharged.

Mr C also noted that the meningitis caused Mrs C to completely lose her hearing. With this in mind, as well as his wife's other physical problems, Mr C questioned whether it was appropriate for her to be discharged. He was unhappy with the way most staff communicated with her after her hearing loss although he acknowledged that one consultant communicated well by writing on a notepad. He believed that Mrs C missed important information about her treatment as a result of staff assuming she had understood what was being said to her.

I asked my nursing adviser about Mrs C's care, who said that no consideration was given to the fact that Mrs C was paraplegic or that she was acutely ill. She was concerned by the lack of evidence of action to minimise the risk of pressure ulcer development, and I concluded that record-keeping in this case was poor. I also found that the lack of a tissue viability nurse was a basic service failure at the time, although this service has since resumed. I found that communication between hospital and community nursing staff was poor, and meant that the district nurse lacked key information and equipment. Mrs C should not have been discharged until a suitable bed had been provided for her return home. Communication between nursing staff and Mr and Mrs C was also poor.

In their response to Mr C's complaints, the board acknowledged a number of shortcomings. They accepted that their risk assessment of pressure sores was incorrect, there was a lack of a tissue viability nurse service, there were communication issues and concerns around the discharge arrangements. The board provided an action plan created as a result of Mr C's complaint, setting out procedural changes and points for staff training. I found these actions to be appropriate. That said, I found the key problem to be a lack of cohesion between written policy and staff performance. The board have clear policies and tools in place for pressure ulcer prevention and for discharge. However, staff carried out only parts of the policies, so the action taken was ultimately ineffective.

I made a number of recommendations, including that the board provide staff training on the proper implementation of pressure ulcer policies, including completing relevant documentation in the clinical records; apologise to Mr and Mrs C for the failings highlighted in my report; and provide me with evidence of the action taken to implement the action plan, with particular reference to ensuring a multi-disciplinary assessment of a patient's suitability for discharge.

Investigation report ref: 201201570

Care of the elderly; clinical treatment; communication

Greater Glasgow and Clyde NHS Board – Acute Services Division

Summary

Mrs C complained about the care and treatment provided to her 90 year old husband (Mr C) following his hospital admission. Mr C was admitted because he was suffering pains in his legs. Before he was admitted he was living independently with no other immediate health concerns. However, he developed pneumonia in hospital and, while being treated for this, developed diarrhoea, kidney failure, a pressure sore and severe oral thrush. Mr C died within a month of admission.

Mrs C felt that a lack of timely action contributed to her husband's death. She said that her husband's leg pain had never been properly diagnosed, asked why he was not given fluid earlier, why the pressure sore on his back was not detected earlier, and why the oral thrush had been allowed to develop to such a severe state. She said she felt that because her husband saw a different consultant every week there was no continuity of care, and that it had been assumed that because of Mr C's age, he was a sick and frail old man, despite the fact that he had entered the hospital relatively fit and well for his age.

I reviewed the complaints correspondence and medical records and obtained independent advice from my advisers, a consultant in geriatric medicine and a general hospital adviser who gave their opinions about Mr C's medical care. I also received advice from a nursing adviser.

I upheld the complaint that staff did not reasonably respond to Mr C's dehydration. My geriatric medicine adviser said that, had Mr C's fluid management been good and intravenous infusion not delayed, kidney failure could have been avoided. In his opinion, this aspect of Mr C's treatment was suboptimal and may have contributed to Mr C's eventual death. Blood tests that were of concern were recorded but not followed up, and Mr C was not reviewed by a senior doctor for at least four days, possibly longer, during which time his condition deteriorated rapidly. As a result of this, Mr C continued to receive medicine which adversely affected his kidney function. I am very critical of the fact that Mr C did not receive timely assessment by a senior doctor. I made four recommendations for action to avoid this happening again, including that the board conduct a significant incident review.

While I accepted advice that Mr C's leg pain was properly diagnosed and treated, I found no evidence that either Mr or Mrs C was told about the diagnosis, so I also made a recommendation about this. I did not uphold the complaint that there was an unreasonable delay in carrying out an x-ray or scan following diagnosis of a chest infection, or that staff failed to respond to Mr C's complaints of pain in his back or to the development of oral thrush. I did, however, make a number of further recommendations, one of which aims to improve the scope for patients, carers and their families to discuss care and treatment with a named person in the medical team. My final recommendation was that the board apologise to Mrs C for the shortcomings identified in my report and for the distress she has suffered.

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, 22 May 2013

The compendium of reports can be found on our website: <http://www.spsso.org.uk/our-findings>

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The 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 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 complaints procedure of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or writing to us, or filling out our online complaint form.

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 complaints handling in bodies under our jurisdiction.



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