

---

## Monthly news from the Scottish Public Services Ombudsman

---

The SPSO laid five detailed investigation reports before the Scottish Parliament today about the health sector. We also laid a report on 79 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](http://www.spsso.org.uk/our-findings).

### Case numbers

Last month (in March), we received 500 complaints. In addition to the three full investigation reports we laid before Parliament, we determined 471 complaints and of these we:

- gave advice on 311 complaints
- considered 82 complaints at our early resolution stage
- decided 75 complaints at our investigation stage.

We made a total of 96 recommendations.

## Ombudsman's Overview



---

### Investigation reports

The five main reports I am laying today are about the NHS. Each investigation lays out in detail the failings we identified in care or treatment, and the recommendations I made to ensure that, as far as possible, the mistakes are not repeated. There is a wealth of learning in these investigations that all health boards should heed. I also have two specific points to make.

Something has gone badly wrong when in a Scottish hospital in the 21st century, a patient dies from poorly managed pressure sores (case ref: 201300690). This is not the first time I have raised the issue of poor management of pressure sores, which results in needless suffering and is quite simply an unacceptable and abject failure in care. It is a matter of great concern to me that an investigation has given me cause to draw this to boards' attention again.

My other point is about record-keeping (case ref: 201300063). I am very critical that a board was unable to provide me with a patient's medical and nursing notes. Boards must ensure that 1) staff make good records in the first place 2) the records are accessible in case they need to be referenced for clinical reasons or in the event of a complaint and 3) they are provided in full to my office when I ask for them for the purposes of an investigation. Good record-keeping is not a nice-to-have, it is an essential component of good care and good complaints handling.

## **PASC report**

Westminster's Public Administration Select Committee (PASC) published an interesting report this week on their inquiry into the UK Parliament's Ombudsman Service (the PHSO). The PHSO is the final stage for complaints about UK government departments and agencies and the NHS in England. Along with the ombudsmen for Wales and Northern Ireland, I gave evidence to the inquiry last December.

In many areas, the report acknowledges that the PHSO legislation is outdated – in its words, that the 'restrictive legislation governing the PHSO is unable to meet the standard set by Scotland, Wales, Northern Ireland and elsewhere'. In particular, the report calls for the abolition of the 'MP filter' (whereby for non NHS complaints, a member of the public must make their complaint via a member of the UK parliament) and for the PHSO to be able to receive complaints other than in writing.

In these and other significant areas, the report calls for models and initiatives in the devolved nations to be emulated. It recommends a consultation on the creation of a single public services ombudsman for England, and for the PHSO to investigate more complaints and provide more publicity about the outcomes of their cases.

The report also calls for new legislation that would give the PHSO the power to oversee complaints processes across its area of jurisdiction and a formal role in setting complaints standards and training in complaints handling. This would draw on the Scottish legislation that enabled me to set up the Complaints Standards Authority (CSA), a body that is unique among UK ombudsmen (and as far as I am aware is unique outside the UK as well). The CSA has brought about a sea change in how complaints are handled in Scotland, with clear benefits to the public and to public service providers. Detail about the legislative background to the CSA, and its current work streams, are on our dedicated complaints standards website [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk).

The report also calls for the PHSO to be given 'own-initiative' powers, to allow it to investigate areas of concern without having first received a complaint. This area has been debated in the Scottish context and I expect those discussions will continue. Finally, I also look forward to contributing to the debate about the report's recommendation for a consultation on proposals to deliver an effective ombudsman service for UK non-devolved matters.

The report 'Time for a People's Ombudsman service', is available on the PASC website at <http://www.publications.parliament.uk/pa/cm201314/cmselect/cmpubadm/655/65502.htm>

# Investigation Reports



Investigation report ref: 201300690

**Care of the elderly; clinical treatment; nursing care; policy/administration**

Lothian NHS Board

## SUMMARY

Mrs A, an elderly woman, was admitted to hospital following a fall at home. After a period of assessment, she was found to have a fractured left hip. She was later also found to also have a fracture of her sacrum (part of her pelvis). Mrs A went on to spend twelve weeks in three different hospitals before being discharged to a nursing home. While in the hospitals, Mrs A developed severe pressure ulcers (bed sores) on her heels and on her sacrum (at the base of her spine). One of these became very severe, and eventually became infected. This infection spread to Mrs A's bone and ultimately led to her death, six weeks after she was discharged.

Mrs A's son (Mr C) raised concerns about his late mother's care and treatment. My investigation found that the board failed to take reasonable steps to prevent Mrs A developing pressure ulcers and that they failed to adequately manage these.

In investigating this case, I obtained independent advice from a consultant geriatrician and a nursing adviser. My investigation found that when Mrs A transferred from the first to the second hospital, there was insufficient information for staff in the second hospital to know what care and assessment had taken place in relation to her skin. They then failed to take full consideration of a number of critical issues which would have contributed to her high risk of developing pressure ulcers.

When Mrs A's skin started to break down, staff should have acted promptly to ensure that her mobility was appropriately assessed and that her nutrition was maintained. An incident should have been logged and, later, a formal incident investigation should have been completed. From the evidence I saw, this did not happen. There was also an excessive delay in a specialist nurse reviewing Mrs A's pressure ulcers. Mrs A waited 28 days for this review and during this time her skin deteriorated significantly.

In making my recommendations, I took into account the findings of a previous report (case ref: 201103459) that I published in May 2013 about a previous failure by the board to prevent pressure ulcers; and the findings of a Healthcare Improvement Scotland (HIS) unannounced inspection report (on the care of older people in acute hospitals) in one of the hospitals concerned. I made four recommendations, including that the board provide an update on the action they have taken to implement recent recommendations from HIS and my office on the care and treatment of patients in relation to the risk and treatment of pressure ulcers. I also asked them to conduct a peer review of the prevention, care and management of pressure ulcers in the particular ward concerned, and to develop an action plan for improvements identified through that review, including education and training, and share this with my office. Finally, I said that the board should apologise to Mr C for the failures identified in my report in relation to Mrs A's care and treatment, for the pain and suffering experienced by Mrs A and for inaccurate information provided to Mr C in their initial response to his complaint.

# Investigation Reports



Investigation report ref: 201300063

**Clinical treatment; nursing care; communication; record-keeping**

Lothian NHS Board

## SUMMARY

Mr C was diagnosed with lung cancer. He was also diabetic and had heart disease. Mr C and his wife (Mrs C) agreed to chemotherapy treatment, believing this would give him up to a year of life. However, Mr C deteriorated significantly after the first course of chemotherapy and later had several admissions to the hospital.

During one of his admissions, Mr C was taken to an assessment ward, where he waited on a trolley for a bed. After seven to eight hours, Mrs C became very concerned because no diabetes medication or food was provided and so she approached staff a number of times asking for insulin and some bread. Mrs C said that staff told her they did not have any food or insulin and there were no beds. Eventually, staff provided some insulin.

After being on the trolley for around 11 hours, Mr C was given a room in another assessment ward, which was cold and had no heating. He was eventually moved to an oncology ward. Shortly before Mr C's discharge a few days later, his consultant oncologist (cancer specialist) told Mr and Mrs C that Mr C had around two weeks to live. Mr C went home to the care of his medical practice that day, and died a little over a week later.

Mrs C raised a number of concerns with us. In my investigation, I obtained independent professional advice from specialists in oncology and nursing. I upheld Mrs C's complaints and was highly critical of the board in a number of respects.

My nursing adviser said it was totally unacceptable that Mr C, who had lung cancer and insulin-dependent diabetes, was left on a trolley for such a long time. Moreover, he was not given food or insulin within a reasonable time. This was not just a failure to meet expected standards, but also a failure to show care to Mr and Mrs C and to treat Mr C with respect and dignity.

This exacerbated what was already a very distressing situation, given Mr C's serious and deteriorating condition, and I was very critical of this. I was also very critical of the fact that the board have been unable to provide me with Mr C's medical and nursing notes.

On the matter of communication, while I was satisfied that the risks of treatment and prognosis were explained, I took the view that healthcare professionals did not take sufficient care to ensure that Mr and Mrs C not only heard what they were saying, but that they fully understood. This led to a personal injustice to Mr and Mrs C, in that they were shocked and extremely distressed when the oncologist told them that Mr C only had weeks left to live.

Finally, I was critical of the board's response to Mrs C's complaint. It refers in considerable detail to technical and medical terms and much of it was likely to be difficult for a lay person to understand. This, together with the lack of any statement of condolences, makes the response appear uncaring. This was inappropriate and insensitive in light of the nature of the complaint.

I recommended that the board:

- (i) provide a plan detailing the changes they have made to: prevent a recurrence of failing to store medical records securely and meet Scottish Government emergency department targets;
- (ii) confirm the learning gained as a consequence of this complaint and provide details of how this has been passed to and considered by relevant staff;
- (iii) provide a plan detailing the changes they have made to prevent a recurrence of failings in their communication with Mr and Mrs C regarding chemotherapy treatment;
- (iv) ensure their responses to complaints are meaningful and appropriate in tone, use of language etc; and
- (v) further apologise to Mrs C for the failures identified and offer to meet her to discuss in more detail the response she received to her complaint.

# Investigation Reports



Investigation report ref: 201105263

## Care of the elderly; diagnosis; consent Forth Valley NHS Board

### SUMMARY

Mrs A was 84 and lived in a care home. She had a medical history that included recurrent urinary tract infections (UTIs). After falling at her care home, Mrs A was taken to hospital where she was assessed as needing surgery to repair a fractured wrist. Her surgery was at first cancelled because of concerns about her condition, but Mrs A was taken back to theatre the day after. She initially became very unwell during the anaesthetic, but was successfully resuscitated, and the fracture was manipulated into position. Mrs A then had a cardiac arrest and died in theatre.

Mrs A's daughter (Mrs C) complained to me about her mother's care and treatment. I upheld all her complaints, the first of which was that staff failed to explain how they diagnosed Mrs A with dementia. I found that staff incorrectly diagnosed Mrs A with dementia rather than delirium. The consultant geriatrician from whom I obtained independent advice said that this error was very important, as it affected the judgement of clinicians and staff's view of Mrs A's confusion.

The misdiagnosis led to a consultant signing a certificate of incapacity to obtain consent for the operation on the basis that Mrs A had dementia and did not have the capacity to do so for herself. In signing the certificate, the consultant was stating that they had observed the principles set out in the relevant legislation (the Adults with Incapacity (Scotland) Act 2000). In my report, the adviser explains that the principles of the Act were not appropriately observed and also says that there was no specific assessment of Mrs A's capacity before the certificate was completed.

I was also critical of other aspects of how Mrs A was treated in hospital. The care home and Mrs C told hospital staff that Mrs A had a history of frequent UTIs. Mrs C also said that her mother's behaviour in the hospital was not normal for her, and could be explained by her having a UTI. A neighbouring health board, that carried out an external review into the medical aspects of Mrs A's care, said that Mrs A had several indicators of severe urinary sepsis (infection) and that treating this should have been a clinical priority. The report also said that failure to recognise and treat this was a major factor in Mrs A's subsequent cardiac arrest. I concluded that hospital staff failed to consider all the obviously abnormal clinical indicators together.

I also upheld a complaint that the board failed to accept that there were clinical failings or to offer an apology, despite the findings of the external review. The board commissioned the review but, in their response to it, they only accepted the positive comments and rejected the critical ones.

I made five recommendations to the board, including that they apologise to Mrs C for the poor standard of care provided to Mrs A, and for incorrectly diagnosing Mrs A with dementia, and incorrectly completing a certificate of incapacity to obtain consent for the operation. I also recommended that they review their provision of specialist care for patients like Mrs A, who present with fractures but have other medical conditions that need to be managed in an orthopaedic ward. Finally, I recommended that the board apologise to Mrs C for their handling of her complaint, in particular their failure to accept the findings of the external review they commissioned; and carry out a significant event analysis of the care and treatment provided to Mrs A, the handling of Mrs C's complaint, and their response to the external review they commissioned.

# Investigation Reports



Investigation report ref: 201300629

## Delay in diagnosis

A Medical Practice in the Lothian NHS Board area

### SUMMARY

Mr C, who was in his early twenties, visited his practice several times over a period of a few months with a lump and pain in his right testicle. He saw three different GPs at the practice over this period and was initially prescribed antibiotics. On the third visit he explained he now also had pain in his back. He was prescribed painkillers but no further investigations were undertaken. It was not until his fourth visit to the practice that he was referred for a 'routine' ultrasound scan.

Just over a week before the scan was due take place, Mr C attended the practice again due to the pain he was experiencing, and was referred to hospital. Initial investigations suggested testicular cancer, and this was later confirmed with a diagnosis of Stage 2B testicular cancer which had spread to the residual lymph nodes in his abdomen. Following initial surgery, Mr C underwent chemotherapy and further surgery.

I upheld Mr C's complaint that his GPs failed to take appropriate steps to diagnose his testicular cancer promptly. National guidance in this area (SIGN 124) says that patients presenting with a testicular lump that does not resolve within three to four weeks should be referred urgently for assessment. The independent advice of my medical adviser, who is an experienced GP, was that any GP presented with a history of a persistent testicular lump should be aware that an urgent referral for a scan was needed, regardless of whether or not they were aware of the specific SIGN guidance.

In upholding the complaint I was, however, pleased to note that the GPs involved have acknowledged that their practice was not in line with the guidance and that the outcome of a significant event analysis they held had been shared with their colleagues in the practice. I made two recommendations – that the practice apologise to Mr C for the failings identified in my report, and that two of the GPs should reflect on their practice in relation to these events and discuss any learning points at their next appraisal.

# Investigation Reports

Investigation report ref: 201204071

## Clinical treatment

Grampian NHS Board

### SUMMARY

Mrs C's husband was in hospital for a hip replacement operation. During surgery, the cement gun used to apply the joint cement broke. The surgeon removed the cement from Mr C's hip and sourced a replacement cement gun before attempting the procedure again. At the second attempt, the surgeon found that the cement began to harden more quickly than it normally would. He opted to proceed with setting the joint in place. This, however, caused a fracture in Mr C's femur, which was repaired during the same operation.

Following surgery, Mr C developed delirium. Although his condition improved with time, his severe confusion and disorientation meant he had to stay in hospital for a long time after the operation. At the time of writing my report, Mr C had been a hospital in-patient for more than ten months, due to mobility problems.

I upheld Mrs C's complaint that hospital staff failed to conduct the operation reasonably and appropriately. In the course of my investigation, I took independent advice from a consultant orthopaedic surgeon and a consultant in acute medicine for older people and general medicine. I reviewed the board's investigation including their interviews with key staff involved in the operation, and the findings of the manufacturer's investigation into the failed cement gun and the batch numbers of the cement used.

My report acknowledges that the surgeon was in a difficult position with very little time to make a decision about how to proceed when the cement hardened more quickly than usual. His statement indicated that he considered the options available to him and reached a decision that he considered to be in Mr C's best interests. While I was satisfied that the surgeon exercised his clinical judgement in a reasonable way, the fact remains that his decision led directly to Mr C's fracture.

I found that the surgical team reacted promptly to the cement gun's failure. In terms of replacing the equipment and repairing Mr C's fracture, I found their actions to be entirely reasonable. However, the absence of certain instruments and the decision to force the prosthesis through the rapidly hardening cement led to significant complications for Mr C, and protracted post-operative problems for him. I was, however, satisfied that Mr C's delirium was managed appropriately. I was also pleased to learn of the steps taken by the anaesthetist to review his, and the board's, working practices as a result of Mr C's experiences.

I recommended that the board conduct a review of the equipment in operating theatres, to ensure that their surgical teams have access to any instruments which might be required in the course of an operation. I also recommended that the board discuss my findings with surgical staff at a suitable learning forum, with particular reference to the appropriateness of the decisions made during Mr C's operation.

# Complaints Standards Authority update



---

## Local authorities

The local authority complaints handling network, hosted by Glasgow City Council, met on 28 March 2014. 41 stakeholders attended, with 26 of Scotland's 32 councils represented. The purpose of the meeting was to consider benchmarking of complaints handling performance, and the journey towards service improvement. The group heard guest presentations, including from Police Scotland about how complaints about the police are used to assess performance and public confidence, and from the Scottish Fire and Rescue Service who explained their approach to recording complaints, analysing performance and identifying opportunities for improvement. The Improvement Service (IS) also presented three benchmarking options to the network, with an assessment outlining the pros and cons of each.

North Lanarkshire Council facilitated a workshop to establish how the network wished to progress with benchmarking. It was agreed that benchmarking will take place as part of the Local Government Benchmarking Framework and that the IS will provide the lead role. This is in keeping with the CSA's discussions with the IS about the analysis and benchmarking of SPSO complaints performance indicators, and the potential to include these within the wider SOLACE (Society of Local Authority Chief Executives and Senior Managers) benchmarking indicators, which would include IS involvement in collecting and analysing information.

The network also considered how best to demonstrate 'Learning from Complaints'. Members agreed to look at what happens locally to them and share these examples with network colleagues with a view to working together to develop a good practice guide for the sector.

This network is run by the sector for the sector and those who regularly attend recognise the value that it provides for them and for their council. The network is open to all complaints handlers, managers and senior managers across the sector. If you are interested in becoming involved, please contact the CSA team at [csa@spsso.org.uk](mailto:csa@spsso.org.uk).

---

## Further education

At the request of New College Lanarkshire, the CSA team delivered an awareness session on complaints handling and the requirements of the model CHP to approximately 50 senior staff and complaints handlers from across the different college campuses. The event covered the background to the work of the CSA; the operational requirements of the model complaints handling procedure (CHP); examples of complaints, requests for service and appeals; the roles and responsibilities in managing complaints; recording, reporting and publicising complaints performance; SPSO performance indicators; learning from complaints and the ongoing support that the CSA can provide for organisations.

Following the successful launch of the new further education complaints handling advisory group, the group are working on detailed terms of reference for the Quality Development Network Steering Group to agree. The group will meet again to discuss the way forward and the key deliverables they can work towards.

Again, this advisory group is run by the sector for the sector with SPSO as equal members. We encourage any sector representatives who are keen to join, or to learn more about the work of the group, to contact the CSA team at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)



# Complaints Standards Authority update



---

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

The Scottish Government, Scottish Parliament and all associated public authorities in Scotland are now required to have implemented, and be handling complaints within, the requirements of the model CHP. All organisations within this sector have intimated that they were on target to achieve a successful implementation of the model CHP, and throughout the implementation phase we provided advice, guidance and support to organisations who requested our support.

We would like to remind organisations that the CSA team continue to be available to them for advice, and to respond to any operational queries that may arise during the early phases of operating the model CHP. In this circumstance, or where organisations find they have a need for additional support, we encourage them to contact the CSA at [csa@spsso.org.uk](mailto:csa@spsso.org.uk)

---

## **NHS review of complaints handling**

The Scottish Health Council's review of NHS complaints handling (commissioned by the Scottish Government) is due to report shortly. The review involved visits to all NHS Boards to meet senior management teams and those responsible for complaints and also sought patients' views on the operation of the feedback and complaints arrangements. The CSA was consulted on potential areas for improvement. We look forward to working with the NHS, the Scottish Health Council, Health Improvement Scotland, the Scottish Government and other stakeholders to help take forward areas of improvement and share good practice identified in the review.

## 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, 30 April 2014**

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

For further information please contact:

**Emma Gray**

**Communications Team**

Tel: **0131 240 2974**

Email: [egray@spsso.org.uk](mailto:egray@spsso.org.uk)

## 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.



**COMMUNICATIONS TEAM**

T **0131 240 8849**



**SPSO WEBSITE**

W [www.spsso.org.uk](http://www.spsso.org.uk)



**CONTACT US**

T **0800 377 7330**

W [www.spsso.org.uk/contact-us](http://www.spsso.org.uk/contact-us)

**VALUING COMPLAINTS WEBSITE**

W [www.valuingcomplaints.org.uk](http://www.valuingcomplaints.org.uk)