SPSO NEWS

JUNE 2014

Monthly news from the Scottish Public Services Ombudsman

We laid two detailed investigation reports before the Scottish Parliament today, both about the NHS. We also laid a report on 59 decisions about all of the sectors under our remit. All the reports can be read on our website at **www.spso.org.uk/our-findings**.

Case numbers

Last month (in May), we received 439 complaints. In addition to the two detailed investigation reports we laid before Parliament, we determined 445 complaints and of these we:

- gave advice on 300 complaints
- considered 63 complaints at our early resolution stage
- decided 82 complaints at our investigation stage.

We made a total of 115 recommendations.

Ombudsman's Overview

Investigation reports

Today's detailed investigation reports highlight two areas that involve a significant degree of judgement – risk assessment and seeking consent for medical procedures. One case (201301359) was about a woman who attempted to take her life in hospital. Her husband complained that the hospital did not remove objects from his wife that she could have used to self-harm, and also that she was not under the appropriate level of observation. The other complaint (201300380) was from the wife of a man who died during an operation that she says he would not have consented to had he been fully aware of the risks involved.

The first case highlights the need for health professionals to maintain the fine balance between ensuring patients' safety on the one hand while not being overly controlling on the other. The second case underlines how important it is to provide sufficient specific detail to allow people to make informed decisions and to record those discussions. Every patient has the right to make an informed choice and in this case we found that the explanations were not tailored enough to meet the individual's needs and understanding.

We take great care in assessing the way clinical judgement has been exercised in difficult situations such as these. We sift and weigh the available evidence, including any independent specialist advice that we obtain, and consider relevant guidance. We then make a judgement about whether the action taken or not taken was right in the circumstances at the time. What is essential is that clinicians can satisfy themselves – and can demonstrate to others – that they have used the tools available (such as guidance, policies and procedures, risk screening tools and so on) in making their decisions. Where it is clear that these tools have not been used properly or have not been considered at all, or where this is not evidenced in the written records, we will uphold the complaint.

Investigation Reports

Investigation report ref: 201301359

Psychiatry: Risk assessment; clinical treatment

Grampian NHS Board

SUMMARY

Following an urgent GP referral, Mrs C was admitted to hospital as a voluntary patient. She was noted on admission as having borderline personality disorder and depression. It was noted that she had suicidal thoughts, and was planning and preparing to take her life. She also had a history of rheumatoid arthritis of some six years standing. Mrs C was given medication to help her sleep and to manage her anxiety. She was also seen by a consultant psychiatrist. A few days after admission, she tried to strangle herself. After being assessed in A&E Mrs C was returned to the hospital, where she remained for approximately six weeks before she was discharged.

Her husband (Mr C) raised several concerns about his wife's care and treatment. He said that, as Mrs C was experiencing suicidal thoughts, any medication and sharp objects should have been taken from her immediately, and she should have been properly sedated. He also said that his wife should have been on special observation and that had she been listened to and looked after appropriately with proper medication, she would not have attempted to take her life.

In their response to Mr C's complaint to them, the board said that their usual operating procedure on the ward was that on admission, a member of staff would check whether patients had any money, valuables, medication or items that could be used for self-harm. They said that on the day of Mrs C's admission the ward had been very busy and so it may not have been possible for all aspects of the admission procedure to have been undertaken as timeously as usual. The board had acknowledged Mr C's concern and apologised.

My investigation found no evidence to confirm when the procedure had been undertaken or to confirm what had been removed from Mrs C's possession. While I noted the apology already made to Mr C, I made a recommendation requiring the board to emphasise to the staff on the ward that when suicidal intent has been indicated they must take action to mitigate the risk. I also asked them to ensure that their action is properly documented and timed.

On the complaint about the level of observation of Mrs C, I obtained independent advice from two specialists, a consultant psychiatric adviser and a senior mental health nurse adviser. They commented in detail on what happened in the ward and what should have happened. One adviser said that he could see no evidence in the records of a structured approach to Mrs C's risk assessment. Neither the initial assessment carried out on admission nor the consultant's review adequately covered historical factors related to the risk of suicide. The same adviser added that, in considering risk factors, the presence of feelings of hopelessness, low self-esteem and impulsive personality traits, all of which Mrs C disclosed to nursing staff, had not been addressed.

Given the evidence and advice presented to me, I upheld this complaint. My report underlines that the board have a responsibility, as far as possible, to maintain the safety of their patient. They have procedures to help them do so. In this case they were not followed. I asked the board to make a formal apology to Mr and Mrs C for their failures in this matter. It had been my intention to make a recommendation about the application of the board's observation policy but during my investigation they told me that they had introduced an updated version and intend to formally review it in May 2015. In these circumstances, I made no further recommendation about this. Nevertheless, I did recommend that the board take steps to ensure that their processes of risk assessment and risk assessment planning are robust and transparent.

I also upheld the complaint that the board failed to ensure that Mrs C had an adequate supply of medication. When Mrs C transferred between wards, the hospital ran out of the drugs she needed. Both my advisers said that this was unacceptable and showed a lack of forward planning. While the board have already apologised for this, I asked them to improve their procedures so that patients in future will receive any required medication without undue delay.

Investigation Reports

Investigation report ref: 201300380

Communication; consent; record-keeping

Lothian NHS Board

SUMMARY

Mrs C complained that her late husband (Mr C) had not been given enough information before he gave his consent to open-heart surgery. Mr C died during the operation, and Mrs C said that, if they had been fully aware of the risks involved, Mr C would not have chosen to go ahead with the operation.

Mr C had undergone open-heart surgery two years and eight months previously. When his symptoms returned, he agreed to have repeat surgery. Mrs C said that she and her husband were not informed of the increased risks involved in repeat open-heart surgery, and specifically were not told of the risk that his heart might have adhered to his breastbone after the first operation. Mr C died of complications resulting from this.

My investigation examined the relevant documentation, including Mr C's medical records, guidance from the General Medical Council (GMC) on consent and the Society of Cardiothoracic Surgeons' 'Good Practice Guide' on consent. I also considered the board's response to Mrs C's complaint and obtained independent advice from a medical adviser who is a consultant in adult cardiothoracic surgery. I concluded that the consent process was not properly carried out, in that the board unreasonably failed to provide sufficient information about the potential complication of Mr C's heart being attached to the back of the breastbone.

The evidence indicated that the way in which Mr C gave consent for his second operation fell far short of the GMC Guidance and the Good Practice Guide. There was no contemporaneous evidence that Mr and Mrs C were given sufficient information to provide informed consent, that the discussions responded to any questions raised by Mr and Mrs C, or that they were offered any written information. My report is particularly critical of the limited recording of any discussions about the consenting process. The surgeon's operation notes also failed to include reference to the fact that a colleague joined him towards the end of the procedure.

The advice that I received clearly stated that CT scans should be used to aid decision-making in relation to repeat open-heart surgery. This could have provided important information to help the surgeon identify risks ahead of the surgery. The surgeon has since said that he will be carrying out CT scans for all subsequent patients undergoing repeat open-heart surgery.

It is clear that the board failed to ensure that Mr C gave appropriate, informed consent for his operation. In this case, however, my concern extended beyond the consenting process. There was a substantial delay in the board's audit meeting following Mr C's death (it took place over a year later). This meeting also appeared to have been held only in response to our investigations. The reason given for this was that Mr C's notes were missing (which may have been due to their use in responding to Mrs C's complaint). However, the fact that Mrs C was expressing concern and formally complaining should have made it all the more important for this meeting to have been held as early as possible, to provide Mrs C with as much information as possible, both about what happened and about what action the board was proposing to take to ensure this did not happen again. The board's practice is to hold these meetings once a month, with the expectation that cases are discussed as close to the event as possible. Clearly this did not happen here, and the evidence would suggest that Mr C's case would not have been discussed at all if Mrs C had not brought her complaint to us.

I made four recommendations for redress and improvement, including that the board:

- ensure that staff refer to the GMC guidance on consent when agreeing and recording consent and risk for cardiac surgical procedures;
- ensure that unacceptable delays between patients' deaths and subsequent audit meetings do not occur in the future;
- ensure that the surgeon is reminded of the importance of record-keeping in all elements of care and treatment; and
- apologise to Mrs C for the failure to inform her and her husband adequately of the risks involved in his operation, and for the suffering that Mrs C has endured as a result of this failure.

Complaints Standards Authority update

Local government

The local authority complaints handlers network met on 20 June. The theme of the day was 'Benchmarking – the next steps', with an emphasis on service improvement and good practice. The Improvement Service gave a presentation, and a workshop followed at which some early baseline information from councils was considered.

The next session was 'Learning from Complaints', followed by a complaints surgery where topics of discussion included the arrangements for elected members using the complaints procedure, the development of case studies to support e-learning investigations training and the Scottish Government's consultation to support the Public Bodies (Joint Working) (Scotland) Act (on Health and Social Care Integration).

The network is run by the sector for the sector and provides a valuable forum within which to share knowledge and experience in managing complaints. Membership 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 directly at **CSA@spso.org.uk**.

We would like to remind local authorities that they are required to report on their performance in handling complaints annually, in line with SPSO requirements. It is for them to decide the most appropriate way of meeting this requirement, which may be online and/or by including the information in their annual report.

Further Education

The second meeting of the Complaints Handling Advisory Group for the further education sector took place on 10 June at The College Development Network in Stirling. The meeting agreed a remit for the group and its membership. Issues discussed included the provision of a webinar for colleges during the new term, performance indicators against which to measure and report performance in complaints handling, and learning from complaints. The meeting also agreed the value of holding a regular 'complaints surgery' to share knowledge and learning as a standing item on the group's agenda.

The Complaints Handling Advisory Group is run by the sector for the sector. Although still early in its development it is clear that it provides an excellent forum for FE complaints practitioners, managers and senior managers to share knowledge and develop sector wide solutions to shared issues. We encourage any sector representatives who are keen to join, or to learn more about the group to contact the CSA team directly at **CSA@spso.org.uk**.

Housing

The requirements for registered social landlords to report on their performance in handling complaints are set out in the *SPSO complaints self-assessment indicators for the housing sector*, developed in partnership with HouseMark, the Scottish Housing Best Value Network and the Chartered Institute of Housing. We would reiterate the need for RSLs to publicise this information for the year 2013/2014. The information they publish will help to facilitate continuous improvement in complaints handling and benchmarking between RSLs.

The next meeting of the network is planned for later this month and we will shortly send members an update with details. As with the local authority complaints handling network, the housing network is run by the sector for the sector and we would encourage those who may be interested in attending to contact the CSA team directly at **CSA@spso.org.uk**.

Complaints Standards Authority update

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

We continue to work closely with organisations that need support, advice or guidance in relation to their implementation and operation of the model complaints handling procedure for the sector. We will continue to monitor compliance both through the complaints that we are asked to consider and through the activities of the CSA. If and where there is a need for additional support we encourage organisations to contact us directly at **csa@spso.org.uk**.

Health and Social Care Integration

The Scottish Government have published for consultation regulations to support the Public Bodies (Joint Working) (Scotland) Act (on Health and Social Care Integration). In our response to the consultation we will be mindful of the need to ensure suitable complaints arrangements to address the requirements of different statutory processes.

NHS complaints procedures

As we reported last month, the Scottish Health Council's report *Listening and Learning – How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland* recommended that the CSA should lead on the development of a more succinctly modelled, standardised and person-centred complaints process for NHS Scotland.

We met recently with one NHS Board to learn about the challenges it faces in dealing with complaints, and we will continue to liaise directly with Scottish Government and NHS stakeholders as we take this work forward.

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, 25 June 2014

The compendium of reports can be found on our website: **http://www.spso.org.uk/our-findings**

For further information please contact:

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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.