

SPSO NEWS

December 2015

Monthly news from the Scottish Public Services Ombudsman

This month we are laying four investigation reports about the NHS before the Scottish Parliament, and 81 decisions about all of the sectors under our remit. These can be read on our website at www.spsso.org.uk/our-findings.

Case numbers

Last month (in November), we received 427 complaints. We determined 447 complaints and of these we:

- gave advice on 210 complaints
- considered 163 complaints at our early resolution stage
- decided 74 complaints at our investigation stage

We made a total of 126 recommendations.

Ombudsman Overview

Complaints and professional conduct

I was interested to note earlier this month that a Nursing and Midwifery Council (NMC) panel found that poor complaints handling potentially put patients at risk. They found a nurse guilty of misconduct for failing to declare that she was a friend of a nurse involved in a complaint. They said that the nurse had ‘failed to acknowledge the potential harm that patients could have suffered when she failed to objectively decide if a complaint had any merit.’

The report went on to say: ‘Whilst there were no concerns relating to [her] clinical practice, the panel considered that not dealing with the complaints efficiently, effectively and in a timely manner had the potential to put patients at unwarranted risk of harm.’ [The NMC report can be read here.](#)

Two of today’s investigations (201404767 and 201404874) involve inadequate handling of complaints, as well as clinical failings and poor nursing practice relating to the care of elderly women with dementia. I found that the nursing care was unreasonable in many areas – personal care, skin care, eating and drinking,

assessment of falls risk, monitoring on the ward, care plans, record-keeping, communication with patients' families including where the family held welfare power of attorney, discussions of confidential patient information, compassion and end of life care. I would urge nursing leaders to look at these two reports and particularly at the recommendations made which aim to ensure learning and prevent recurrence. Among the recommendations, I ask the boards to review nursing care and leadership on the relevant wards and to carry out a significant event analysis. We can only improve if we look at what happened and why, asking ourselves what went wrong in the interaction between the procedures and the people responsible for implementing them, ie what were the human factors? Complaints are a vital part of that learning loop.

Saying sorry right

The two other reports highlight clinical failings. One investigation (201405155) concerns insufficient care taken to assess a woman's cardiac disease and blood loss. The other investigation (201406099) is into a man's complaint about the toxic reaction he suffered after a second cycle of chemotherapy. In both cases, among other recommendations, I require the boards to ensure that the health professionals concerned take the failings into account in their annual appraisals/educational supervision.

In all four of today's reports, as is often the case in NHS investigations, I ask the boards to apologise to the patients or their families. I would like to make the point that the apology should be made not for my benefit - and certainly not for the benefit of the media - but should be a sincere and heartfelt apology to the patient or their family. It must be genuine, focus on the harm caused to the people concerned, and say what the board is doing or has done to try to put things right.

Getting apology right is so important that we have published [guidance on apology which can be read here](#).

Promoting good practice through learning and improvement

Provisions in the Public Services Reform (Scotland) Act 2010 gave SPSO the duty of promoting of best practice in complaints handling. This explicitly includes monitoring practice, identifying trends in practice, promoting best practice, encouraging co-operation and sharing of best practice. This gives the Ombudsman the statutory authority to require relevant authorities to comply with any requirements the SPSO may make in relation to the promotion of best practice in complaints handling.

The model complaints handling procedures (CHPs) which were consulted on and developed in partnership with public authorities requires them to report and demonstrate learning from complaints. This is supported by the performance indicators which were developed in 2013/14. Among the requirements are that authorities show how they 'systematically review complaints performance reports to improve service delivery'. Local authorities were the first sector to implement the model CHP and all councils reported against the indicators in 2013/14. Many councils and other authorities in our remit are exemplars in reviewing complaints information effectively at a senior level (such as the appropriate scrutiny/ governance/ performance committees). To extend this best practice, we have asked authorities from across the main sectors in which we work to confirm that SPSO complaints are similarly reviewed at a senior level by returning a learning and improvement statement to us.

Another area of good practice which is already in existence in many authorities is good complaints file management. We routinely ask all authorities to provide all the information relating to a complaint at the start of our investigation (not on every complaint, only on the ones that we have established are appropriate to be taken forward by us). To support them in this, we have now developed a self-assessment complaints handling reflective learning form. This should not create any extra work, as these are complaints that the authorities have already completed. In response to feedback at our sounding boards, we also extended the deadline for providing the complete complaints file by 10 working days.

Both the reflective learning form and the learning and improvement statement should provide the authorities themselves, and us, with assurance that complaints file management is of a high standard and that the learning from complaints is reviewed at a senior level and used to drive improvement.

Scottish Welfare Fund

Our consultation about our proposed implementation of our new Scottish Welfare Fund role closed on November 27. We received 24 responses, with the majority from local government and a significant number from the third sector. The responses are now being analysed and we will publish our analysis with the responses in the new year. All the responses will also be considered carefully in the run up to the implementation and we would like to thank all of those who took the time to contribute. We remain keen to listen as much as possible over the next few months

and, while the formal consultation is now closed, are very happy to discuss the new role with anyone who has an interest.

Recruitment is underway for the welfare fund review team, which will be based in our Edinburgh offices. We are working closely with the Scottish Government and our two SWF sounding boards (made up of local authority and third sector representatives respectively) to ensure that we are on track to deliver the review service from 1 April. As well as developing the new guidance and process, we are expanding our website to include the new role. The site will host an online review function, and our new communications materials which we are preparing for user input in the new year. We will provide regular updates to stakeholders on our progress on the fund over the coming months.

If you have any questions meanwhile, please contact Paul Smith, SWF project lead, at paul.smith@spsso.org.uk or 0131 240 2969.

SPSO Draft Strategic Plan Consultation

We have received a number of responses to our Plan, which lays out the key challenges and opportunities we foresee over the next four years and how we are preparing for them. [The full consultation can be found on our website](#), and is open until 18 December.

Our **Complaints Standards Authority update** is below at p13.

Investigation Reports

Investigation report ref: 201405155

Clinical treatment; diagnosis

Lanarkshire NHS Board

Mrs A had a complex medical history, including heart problems and a low blood count. She fell ill, complaining of central chest pain, and an ambulance was called. The paramedics recommended that, due to the possibility of a heart attack, she was taken to Hairmyres Hospital because of the cardiac unit there. Mrs A was reviewed by a junior doctor in the emergency department, who diagnosed stable angina secondary to anaemia (chest pain due to the blood not carrying enough oxygen). Instead of the cardiac unit, she was transferred to Ward 2, the hospital's medical assessment unit. Within 48 hours she was transferred again to Ward 11, then moved to the high dependency unit and, finally, to a side room for palliative care (care provided solely to prevent or relieve suffering) where she died a few days later.

Mrs A's daughter (Mrs C) complained about the care and treatment Mrs A received when she was admitted to the emergency department at Hairmyres Hospital. In particular, she was concerned that staff did not check Mrs A's medical records to see what her anticoagulation level (INR - a measure of how long it takes blood to clot) should be, and that she was given a high dose of aspirin and other blood-thinning drugs, which seemed to cause major internal bleeding. She complained that Mrs A was not admitted to a cardiac ward and that she was moved from Ward 2 to Ward 11 when she was very ill. She also complained about a lack of communication and the junior doctor's failure to listen to Mrs A.

I obtained independent advice from a consultant physician. My adviser said that the doctors missed opportunities early in Mrs A's admission to identify the severity and complexity of her conditions, and to reduce the risk and extent of her internal bleeding. He considered that they failed to carry out the appropriate tests and was critical that, given her symptoms and abnormal blood tests, an early referral to cardiology was not made. My adviser said that Mrs A was incorrectly given her warfarin (a drug used to prevent blood clots) when it should have been withheld. As a result, her INR was raised to a high and dangerous level.

The advice I have received is that the staff caring for Mrs A should have considered the potential seriousness of her illness in more detail, and that they failed to properly

monitor her condition. I am concerned that advice from a cardiologist was not sought when Mrs A was admitted to the emergency department. It was also not sought at a time when, according to my adviser, signs were very suggestive that she had had a heart attack. I found that better care would have been provided to Mrs A if she had been transferred to the cardiac unit, as she would have received higher levels of monitoring and specialist care at an earlier stage. I am concerned Mrs A's condition was worsened by the care she received, particularly by continuing to administer warfarin when it should have been stopped. I am also concerned that Mrs A's medical history was not documented in enough detail and that the target INR level in her records was incorrect, despite it previously having been set at a lower level by board staff due to Mrs A's condition.

My investigation found that, given the severity of her illness, Mrs A's outcome may not have been different. However, better care of Mrs A might have increased her chances of survival. It might also have given her family the reassurance that this outcome was despite good medical care, rather than her chances of survival being reduced by poor medical care. In view of the failings identified, I upheld the complaint.

Investigation report ref: 201404874

Nursing care; clinical treatment; record-keeping; complaints handling

Highland NHS Board

Mrs A had a form of dementia and was being looked after at home by her family. When the family became unable to care for her at home, she was admitted to New Craigs Hospital, with the aim of assessing her mental health and finding appropriate medication to enable her to return home. Following falls in hospital, however, Mrs A's physical health deteriorated. She was transferred to Raigmore Hospital, where she was found to have a fractured pelvis and urine retention. Her daughter (Mrs C) made complaints about the admission process and the care and treatment Mrs A received at New Craigs Hospital.

As part of my investigation, I obtained independent advice from a psychiatric nurse, a psychiatrist and an elderly medicine specialist. Mrs C complained that the board should have admitted Mrs A to hospital for mental health assessment earlier. I was critical that, from the evidence available, the community mental health team did not provide enough information and advice about the waiting list and what to do if the situation deteriorated. However, the advice I received was that keeping Mrs A at home whilst waiting for a hospital bed was reasonable in the circumstances. I did not uphold this complaint.

Mrs C complained about various aspects of the nursing care provided to Mrs A in New Craigs Hospital. She was particularly concerned about the assessments of falls risk and of Mrs A's pain, the lack of referrals to doctors, the poor monitoring of Mrs A on the ward, and the use of a wheelchair to transfer Mrs A for an x-ray. The psychiatric nurse adviser was very critical of the nursing care Mrs A received, and concluded that it was disorganised, unsystematic and unreasonable. They noted the lack of a nursing care plan, poor evidence of falls assessments, and no evidence of proper monitoring of Mrs A's pain. The psychiatric nurse adviser found that nursing staff failed to bring Mrs A's first fall to the attention of medical staff until a day and a half later, despite clear evidence of bruising and changes in Mrs A's behaviour. They also commented that it was inappropriate to transport Mrs A in a wheelchair when it was suspected that she had a pelvic fracture. The advice I received clearly shows that Mrs A did not receive reasonable nursing care. In particular, I was concerned that nursing staff did not identify changes in Mrs A's behaviour, assess her falls risk,

monitor her pain, or ensure that doctors were aware of the situation, even though Mrs C was raising concerns. I upheld this complaint and recommended an internal review to identify changes.

Mrs C complained about several aspects of Mrs A's clinical treatment, including the way medical staff considered the evidence of her deterioration, and that not enough account was taken of her changing behaviour. She asked whether more scans should have been taken to investigate Mrs A's pain. Overall, Mrs C felt that Mrs A should have been transferred to a medical ward much sooner. The advisers noted that, on admission, Mrs A was mobile and active but, within 48 hours, she was in obvious pain and unable to bear weight. It is clear to me that when x-rays did not identify a fracture, doctors did not do enough to consider what was causing the pain, or causing changes in Mrs A's behaviour and continence. Additionally, I was concerned that doctors did not do enough to relieve her pain. I upheld this complaint.

Mrs C also raised concerns about the record-keeping of the board, particularly with regards to Mrs A's food and fluid intake, falls assessments, the use of hip protectors, and Mrs A's level of consciousness. My psychiatric nurse adviser found that, for all of these areas, the record-keeping was poor. Additionally, they were critical that there was no overall care plan so important issues were likely to be neglected, and that record-keeping was mostly retrospective. It was my opinion that poor record-keeping of Mrs A's care went hand-in-hand with poor care planning and provision, and both were well below reasonable standards. I upheld this complaint.

I also upheld Mrs C's complaint about the board's response to her complaint about Mrs A's care and treatment. I found that the response did not fully respond to Mrs C's questions, was overly defensive and lacking in empathy.

Investigation report ref: 201406099

Clinical treatment; diagnosis

Fife NHS Board

Mr C had surgery for bowel cancer and then started chemotherapy to reduce the risk of his cancer recurring. He suffered significant gastrointestinal side effects from the chemotherapy, including abdominal cramps and diarrhoea. He went to the emergency department at Victoria Hospital but his oncology consultants (cancer specialists) were not told about his visit. A week later, Mr C started to have regular sickness and diarrhoea and he visited his GP twice for treatment. Three days before his second cycle of chemotherapy, Mr C was reviewed by an associate specialist oncologist, who assessed Mr C's diarrhoea as grade 0 (on a scale of zero to five, where grade 5 is the most severe). The oncologist pre-authorized the administration of the drugs at a reduced dosage and made a note that Mr C's side effects should be observed closely. Mr C continued to experience diarrhoea and he reported this to the nurses at the chemotherapy unit when he went to receive the second cycle of chemotherapy. His condition deteriorated over the next few days and NHS 24 referred him to Victoria Hospital, where a scan showed evidence of severe chemotherapy-related inflammation, and possible perforation, of the colon. Mr C's chemotherapy was stopped and he had an operation on his colon, spending five weeks in hospital.

Mr C complained that his symptoms of chemotherapy toxicity were not recognised within a reasonable time and that he should not have been given another cycle of chemotherapy treatment.

I took independent advice from an adviser who specialises in oncology. The adviser said that the symptoms Mr C described amounted to grade 2 or 3 diarrhoea. The board's guidance stated that further treatment should not have been prescribed until the diarrhoea had settled to grade 1 or lower. The adviser found that the toxicity assessment by the associate specialist oncologist was inadequate and that further chemotherapy should not have been prescribed. He also said that when Mr C reported his on-going diarrhoea to nursing staff, they should have asked for medical advice before administering chemotherapy. The adviser said that Mr C should have been able to easily get advice about his problems, for example, from a 24-hour cancer treatment telephone helpline. He commented that the lack of access to a single point of advice about chemotherapy-related problems resulted in poor communication of these problems to the oncology team treating Mr C.

The advice I have received is that Mr C had considerable difficulty accessing medical advice when he developed problems. I found that there were failings at almost every contact Mr C had with health care professionals in relation to the second cycle of chemotherapy and that the system in place to ensure he was treated safely was inadequate. I found that better arrangements were needed to ensure that patients were properly assessed on the day of treatment at the chemotherapy unit, and that the nursing staff must raise any concerns with medical staff. In view of the failings identified, I upheld the complaint and made recommendations.

Investigation report ref: 201404767

Nursing care; record-keeping; communication; complaints handling

Borders NHS Board

Mrs A, who had dementia, was admitted to Borders General Hospital with sepsis (blood infection). She was discharged to her care home after a few weeks but was re-admitted two months later for end of life care. She died in hospital two days later. Her daughter (Mrs C) complained about several aspects of the care and treatment received by Mrs A during her admissions to the hospital. She said that, before her first admission to the hospital, Mrs A had been able to walk with the help of a walking stick and could feed herself. However, by the time of her discharge, she could neither stand nor eat without assistance. Mrs C said that Mrs A was not helped with personal care, her skin care was not attended to, and she was not helped with eating or drinking. She said that staff did not consider the needs of Mrs A as a person, despite the care home providing 'Getting to Know Me' documentation when she was admitted.

As part of my investigation I obtained independent advice from a nursing adviser. The adviser noted that the record-keeping, and particularly the nursing notes, about Mrs A's care was poor. Documents such as her care plan were not completed properly and other documents that my adviser expected to see (such as a wound chart, and food and fluid charts) were missing entirely. This meant that there was no evidence to show that reasonable nursing care was provided to Mrs A. The adviser said it was very poor that relevant personal information about Mrs A was lacking from her notes as this information was vital to ensure her care plan was person-centred. I was advised that Mrs A's care lacked any knowledge of dementia, and I am concerned that her needs and preferences were not taken into account. I concluded that Mrs A did not receive adequate care during this admission.

Mrs C also complained about communication from staff during Mrs A's first hospital admission. Despite the family holding welfare power of attorney for Mrs A, she said staff never approached them to discuss treatment or the care plan. She said the family, who made daily enquiries, were often given misleading information, and she complained that the staff discussed Mrs A with them in the corridor. The adviser said that they would have expected more information in Mrs A's notes about communication with her family, and that the standard of communication was

generally poor. They considered confidential discussions taking place in hospital corridors to be totally unacceptable practice. I found that the welfare power of attorney should have been identified and reflected in Mrs A's care plan, and the family should have been updated regularly. An inspection in 2012 by Healthcare Improvement Scotland (HIS) alerted the board to instances where staff failed to satisfy themselves that a welfare power of attorney was in place, and also instances where staff discussed confidential patient information in corridors. I was concerned that this was still occurring.

Mrs C was also unhappy about the care Mrs A received when she was re-admitted to Borders General Hospital for end of life care, and about the attitude and communication of nursing staff at that time. She said that Mrs A, who was close to death, and her grieving family were left alone for two and a half hours. She said the staff showed no care or compassion and seemed uninterested. The adviser said the nursing role is to care and support both the patient and their relatives, and that they would have expected staff to assess and provide care to a dying patient at least every two hours. However, there were long gaps between entries in the nursing records, which I found concerning. The family's needs were clearly not met and I conclude that the level of support provided was unreasonable.

Mrs C complained about the board's handling of her complaints, one of which they did not acknowledge within the correct timescale or automatically treat as an official complaint. The board also failed to send Mrs C a written follow-up or apology after their meeting with members of the family. Mrs C considered that the board's investigation missed serious failings and, in particular, a breach in procedures that were put in place after the HIS inspection. I found that Mrs C's letter was clearly a complaint and should automatically have been dealt with as such, and that it would have been good practice to summarise the key points of the meeting for Mrs C. I considered that the board's learning from the complaints was vague, and I agreed with Mrs C that the board's action plan was insufficient. I upheld all of the complaints and made several recommendations.

Complaints Standards Authority (CSA)

NHS

Our work to develop a revised NHS model complaints handling procedure (CHP) continues to make progress. We have worked closely with the Scottish Government and NHS stakeholders to form a project steering group which provides overall programme governance for the project. Three distinct sub groups are leading on the development of: the revised model CHP and associated information; an agreed and consistent approach to recording and reporting of performance; and a training and awareness programme. The next meeting of the steering group will be held in January where each sub group will report on the progress made to date.

The current plan is for the NHS model CHP to be published during 2016 with implementation by NHS Boards from April 2017.

Social work complaints

The Scottish Government's consultation on social work complaints closed on 14 December. The draft order proposes to revise procedures for complaints about social work in line with the SPSO model CHP and seeks views on amending the SPSO's role to allow it to investigate complaints about professional judgement elements of social work decisions. Subject to the outcome of the consultation, including the Scottish Government's response, we will aim to work with relevant stakeholders to develop the model CHP together with preparing for any new functions transferred to this office.

Local Government

The local authority complaints handlers network last met in October 2015 in Glasgow and considered local authority performance against the SPSO performance indicators for 2014/15 and reporting and learning from complaints. Local authority performance was analysed and presented by the Improvement Service and demonstrated a continuation of positive performance from the previous year. The next meeting of the network will be in January.

Further education

The further education complaints advisory group met in December. Topics discussed included the work of the short life working group to develop standardised complaints categories for the sector, and planning for the next further education complaints handlers benchmarking workshop, which is likely to be held in April.

Housing

The next meeting of the housing complaints handlers network is scheduled for January. The network will consider complaints handling performance over the first half of the year, together with learning from complaints and good practice in complaints handling. There will also be the opportunity for complaints handlers to share knowledge and expertise through the complaints surgery.

Further information on the role of the network, including details of how you may join, can be obtained from anne.fitzsimons@tollcross-ha.org.uk.

For all previous updates, and for more information about CHPs, visit our dedicated website www.valuingcomplaints.org.uk.

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 December 2015

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.

Communications team: T 0131 240 8849

SPSO website: www.spsso.org.uk

Valuing Complaints website: www.valuingcomplaints.org.uk

Contact us: T 0800 377 7330 www.spsso.org.uk/contact-us