SPSO Scottish Public Services Ombudsman

4 Melville Street
Edinburgh
EH3 7NS
Tel 0800 377 7330
Fax 0800 377 7331
Web www.spso.org.uk

8 January 2013

Duncan McNeil MSP
Convener
Health and Sport Committee
The Scottish Parliament
EDINBURGH
EH99 1SP

Dear Convener,

I would like to thank the Committee for the opportunity to participate in their inquiry on the regulation of the care of older people in acute settings.

**Background**
It is one of the great success stories of our time that we are living longer. For many, there is the real prospect of a long, healthy older age that would have been unthinkable even a generation ago. As we live longer we can share the benefits of our experience for longer and even use the extra years to take interesting new directions. As with all good things, however, there are challenges. The rise in the number of older people also means a rise in the number of older people in hospital. This group is likely to enter hospital for acute care with a complex of pre-existing conditions. The reason for going to hospital may be a fall or a serious infection but the older person may also have cognitive impairment, hearing issues and/or failing sight.

This presents problems for hospitals and I see the problems in the cases that people bring to me. In these complaints, there are themes and repeated issues across the country. Notable among those I can mention are: failing to deal with dementia and cognitive impairment (which can lead to a loss of dignity); issues around communication with families and patients (which can lead to serious disagreement; anger and grief); and failings in what should be simple aspects of care – ensuring adequate nutrition; preventing falls; preventing bed sores. There is excellent and outstanding care in the NHS but we do also need to recognise that it does not always reach those standards.

In this letter, I would like to highlight two particular aspects of regulation that I think may be of particular benefit. These largely relate to the role of HIS who I know are also playing a role in this inquiry. It should be noted that HIS are a significant part, but only part, of the way that care in the NHS is scrutinised and assessed. Many bodies have a role including the professional bodies and the Royal Colleges. Indeed, when thinking about who is calling the NHS to account for its care, there is a fairly complex picture and I am coming to the conclusion that this may be too complex a picture and we may need to start thinking carefully

about how the many strands work together. On this point, I should say something about our role.

The Committee is looking at regulation. As the Committee will appreciate, our role is not that of a regulator. We respond to individual concerns and our legislation means we look at the impact of any failings on that person and their family. However, one of our most common recommendations is for systems changes and improvements. We think it is possible to see from an individual experience that there may be wider problems and, within our limitations, we try to address this. The Committee will be interested to know that we are seeking to find out how effective our recommendations are and how to make them more effective. We have been approached by, and are working with, university researchers and the NHS to put in place a possible impact study.

I will now turn to the two points on regulation that I wanted to highlight to you.

**The need to learn from mistakes and to ensure improvements are sustainable**

In 2012, HIS published a report on an NHS Lothian hospital which showed the need for improvements in 23 areas. This showed concerns about assessments, record-keeping, the use of information that was recorded and the way comfort and dignity was being maintained. In 2006, Anne Jarvie (former nursing adviser to SPSO) produced a report on elder care for NHS Lothian. She detailed a number of concerns and areas for improvement including concerns about pathways, clinical issues and record-keeping. The report also said:

*At the heart of the reported dissatisfaction by patients, their relatives and friends was the lack of respect offered by services and the impact this has on their personal dignity. Caring for older people means more than simply treating their illness or providing rehabilitation. It means recognising that their needs are likely to be broader than the immediate reason for treatment and seeking to meet these needs in an environment that maintains their dignity and respects them as individuals.*

I have to say that reviewing the two reports six years apart does not make pleasant reading. I do not intend to highlight NHS Lothian as being a particular problem. I know I could find evidence of failings in all the HIS reports that have been published to date and in reports on complaints about many boards that we have received over a number of years. In the appendix to this letter I include a note of relevant cases that we published in full from April to December last year. We publish only a handful of these full reports but also produce about 60 complaint outcome summaries each month. The appendix does not include all those cases – but does provide a useful if rather depressing overview of what we have seen recently. You will note that we do not uphold all complaints received. The ones we do uphold, however, bear out the information contained in the HIS summary – concerns that patients were not always treated with compassion, dignity and respect, as well as failings in assessment and care planning and in complying with national 'do not resuscitate' guidance.

The HIS process is only six months old and I know they will follow up to check that action plans have been implemented. Following the Jarvie report, Anne Jarvie was appointed to be an Older People's Champion but stood down after a year because of improvements. Although these were clearly not sustained they do show that a concentrated focus can lead to change. Yet, I feel strongly that if patients, friends and family were being listened to effectively, regulators should not be highlighting problems months and years after complaints have been made on the same points. The need to learn from complaints was another key point in the Jarvie report.

In commenting on the statistics for the NHS complaints that I saw in 2011/2012, I highlighted the large percentage of complaints I upheld. I take independent clinical advice on the

complaints I investigate, but only in extremely rare cases do I find that I have access to information about the situation that was not already available to the Board. The key pieces of evidence are the views of the complainant and the clinical records. On occasion, Boards will disagree with me strongly. I accept this as a normal part of my role and listen to them carefully in the same way that I listen to complainants who disagree with me. However, more often Boards simply admit to problems when I point them out. In many of these situations, I consider that the problems could have been picked up by them and fixed before the complaint came to me. There also does seem, in some areas and on some occasions, to be a reluctance for Boards to accept criticisms of their own systems and staff. It can be difficult to work out what the cause for a specific failing is and there can be a complex mix of personalities, systems and resource decisions behind any issue. We will never have an NHS which never fails. However, defensiveness prevents the clear identification of problems and makes it more difficult to implement solutions.

I understand that HIS are looking at their methodology, and would strongly recommend that they consider more clearly how the areas they visit have responded to complaints and deal with feedback. This should include not only the matter of what enters the formal complaints process, but should look to discover how day to day issues are dealt with at ward level. This often reveals not only the attitude towards complaints but more generally how confident staff feel in supporting and communicating with individual patients and their families. Another option could be to carry out, as part of an inspection, a more focused study of the Board's reports on complaints, reports we have made and any relevant significant incident reviews. In particular, it is important to identify problems that the Board were aware of and could have taken action to fix *before* the inspection. If HIS find those problems remain, there has been a failure which may be an important sign of underlying issues in leadership and management. I note that, in the self-assessment Boards must undertake prior to inspection, HIS already ask Boards to consider an overview of complaints and the way they use and learn from patient experience. I am, therefore, suggesting strengthening this aspect of their methodology rather than introducing a radical change.

I would not like the Committee to take away the view that I am being overly negative. There is outstanding and excellent care, and there are areas of genuine improvement. This is noted in the six month HIS overview report alongside the problems they identified. It is, however, the case that the best and quickest feedback comes from patients, their friends and families. This is a free resource and is one we do not use as well as we should. Again, changes are on-going, the Patient Rights (Scotland) Act allows for more ways for patients, their friends and families to feedback and emphasises the importance of learning from this; and the Patients Experience programme is looking at ways we can embed learning from patients into the system. In fact, I am saying nothing that is not already being said within the NHS or is not at least part of the approach already being undertaken by HIS. Yet I have to say that, despite this, I remain concerned that we are continuing to fail to learn from experience and that this is increasingly a failing we can no longer afford.

**The need to follow the patient journey**

The Committee's review follows on from its previous work on the regulation of care for older people. The Committee made a number of recommendations relating to the need to improve complaints systems. This included noting the important role complaints can play in driving improvement. The Committee also encouraged close co-operation between HIS and the Care Inspectorate and the joint inspection of care pathways.

The Committee has already recognised that acute care does not stand alone. Failings in care provided in care settings may mean older people require acute care, or require longer term acute care, that they would not otherwise need. Conversely, good and positive communication and a patient-centred approach that seeks to make the journey between

primary care, social care and acute care seamless can help to ensure that mistakes do not happen and high quality care is provided throughout the patient's journey.

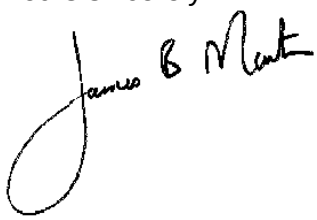
We strongly support a move to regulation which focuses on the individual experience over time, and the outcomes of that, alongside the more traditional snap-shot inspections. Unannounced and announced inspections that review the whole system and environment are beneficial and important. They can highlight urgent and significant problems. At present, given that the regime of inspection of acute care for older people is relatively new, this is a sensible starting point. However, in order to ensure maximum benefit for patients, this should be combined with a process that looks more closely at the patient journey. There are a number of ways this could be taken forward. We are not experts in regulation and there will be scope for innovation and creativity in approach. It may be possible to move towards this by using already available data such as significant incident reports, complaints, information from patient experience and feedback on websites such as Patient Opinion. It may also be possible to ask care providers to provide feedback when patients are returned to a care setting and, conversely, for acute providers to feed back any concerns or positive feedback they may have about the care provided before a patient enters the acute setting.

I am hopeful that the current system will lead to improvements in the general environment that will then allow regulators to start to look at different ways of inspection that may take longer but that will follow individuals through the system.

It is the case that the care of older people can be difficult and complex because, as we approach the end of our lives, we often have multiple care needs. Positively, if we can manage that process correctly, it should help us to work out how to support the care needs for all ages.

I hope Committee members find this summary useful. I look forward to discussing our work with you in more detail at the meeting.

Yours sincerely



Jim Martin
Ombudsman

Tel: 0131 240 8850 (Fiona Paterson, Personal Assistant)
Email: fpaterson@spso.org.uk

**Appendix – Summary of full investigation reports published between April and December which relate to care of the elderly.**

### Greater Glasgow and Clyde NHS Board

### SPSO report number 201102521 Report date 19/12/12

***Summary***
The complainant (Mrs C) raised a number of concerns against Greater Glasgow and Clyde NHS Board (the Board) that her late father (Mr A) had been inappropriately cared for by nursing staff in Dunrod F Ravenscraig Hospital (the Hospital) from 2 February 2011 up to his death on 24 April 2011.

***Specific complaints and conclusions***
The complaints which have been investigated are that:

- nursing staff unreasonably failed to monitor and maintain Mr A's fluid levels (*not upheld*);
- nursing staff unreasonably failed to deal with incontinence issues (*not upheld*);
- nursing staff unreasonably failed to maintain a reasonable level of hygiene for Mr A (*upheld*);
- there were inadequate transfer systems and documentation in place (*upheld*);
- there was poor communication from staff (*not upheld*);
- nursing staff unreasonably failed to pass on information to the relevant Social Work team when Mr A was transferred and this delayed the process of establishing a suitable nursing home for him to go to (*not upheld*);
- inadequate attention was paid to Mr A's dignity by ensuring that his clothing was appropriately attended to (*upheld*); and
- the investigation of Mrs C's complaint to the Board was inadequate (*upheld*).

***Redress and recommendations made***
The Ombudsman recommends that the Board:

- ensure that measures are taken to feed back the learning from this to nursing staff to avoid similar situations recurring;
- provide him with an update on the actions they have taken to ensure such an incident does not recur;
- ensure that communication between family members and staff are appropriately recorded;
- ensure that measures are taken to feed back the learning from this to complaints investigation staff to avoid similar situations recurring; and
- apologise to Mrs C for the failures identified in this report.

### Greater Glasgow and Clyde NHS Board - Acute Services Division

### SPSO Report Number: 201102830 Report Date: 21/11/2012

***Summary***
The complainant (Ms C) complained about the lack of communication with her family after her mother (Mrs A) was admitted to the Emergency Department in the Victoria Infirmary in Glasgow (the Hospital). Mrs A was 84 years old and had a history of dementia. The family were not told that Mrs A's condition in the Hospital had deteriorated. Mrs A subsequently died and Ms C considers that the family lost the opportunity of being with Mrs A at the end of her life.

***Specific complaint and conclusion***
The complaint which has been investigated is that the Board's lack of communication with the family just before Mrs A's death was unreasonable (*upheld*).

***Redress and recommendations made***
The Ombudsman recommends that the Board:

- issue a written apology to Ms C for the failure to inform her of the deterioration in her mother's condition; and
- provide him with an action plan and / or steps in place to ensure communication with relatives and carers is addressed within the Emergency Department.

**Forth Valley NHS Board**

**SPSO Report Number: 201102756 Report Date: 19/09/2012**

***Summary:***
The complainant, Mr C, raised a number of concerns about the care and treatment given to his father (Mr A) during the final days of his life.

***Specific complaints and conclusions***
The complaints which have been investigated are that:

- nursing staff at Bannockburn Hospital (Hospital 1) failed to recognise that Mr A's condition was such that he required appropriate medical assistance (not upheld);
- two out-of-hours doctors who separately attended Mr A assessed and treated him inappropriately. In particular, they failed to recognise his poor condition and arrange for a transfer to Stirling Royal Infirmary (*upheld*);
- the decision making, care and communication of nursing staff in relation to the provision of palliative care for Mr A was inappropriate (*upheld*);
- nursing staff inappropriately refused to provide even the most basic of medical records to a medically qualified relative, despite him having Mr C's consent as next of kin with welfare power of attorney (*not upheld*);
- a staff nurse refused to allow a medically qualified relative to speak to Mr A's on call consultant and the on call consultant failed to recognise the importance of having this conversation (*not upheld*);
- an inappropriate care and treatment plan was agreed between the staff nurse and the on call consultant pending the arrival of an out-of-hours doctor (*not upheld*);
- during his stay in Hospital 1, Mr A's consultant failed to make himself available to meet with Mr C, who was next of kin with welfare power of attorney. This was despite Mr C's best efforts (*not upheld*); and
- during Mr A's stay in Hospital 1 there was an unacceptable level of care with regard to his possessions, which resulted in the unacceptable loss of his spectacles for some weeks and his hearing aid which was never recovered (*not upheld*).

***Redress and recommendations made***
The Ombudsman recommends that Forth Valley NHS Board:

- complete a critical incident review regarding this situation, if they have not done so already;
- consider the practicality of having routine discussions regarding care escalation for patients admitted to Hospital 1 and other similar units;
- consider the means by which it can be ensured that severe illness is promptly recognised in such units, by use of a Scottish Early Warning Score or similar scoring system;

- consider a strategy for determining the appropriate limits of care as soon as a patient in Hospital 1 or similar unit becomes acutely unwell and where there has been no anticipatory care discussion;
- emphasise to staff in Hospital 1 the importance of keeping full and proper records, including notes of conversations and telephone conversations; and
- remind Hospital 1 staff of the Do Not Attempt Cardiopulmonary Resuscitation Policy and provide evidence that they have done so.

**Greater Glasgow and Clyde NHS Board**

**SPSO Report Number: 201100402 Report Date: 23/05/2012**

***Summary*** The complainant (Mrs C) raised a number of concerns regarding the nursing care provided to her late mother (Mrs A) during an admission to the Royal Alexandra Hospital in Paisley (the Hospital) from 12 October 2010 until her death on 16 October 2010.

***Specific complaint and conclusion***
The complaint which has been investigated is that there were several unacceptable shortcomings in care during Mrs A's admission to the Hospital in October 2010 (*upheld*).

***Redress and recommendations***
The Ombudsman recommends that Greater Glasgow and Clyde NHS Board (the Board):

- provide him with an update regarding their implementation of the introduction of the Liverpool Care Pathway;
- consider the Adviser's comments on the several failings in Mrs A's end of life nursing care and draw up and implement an action plan to address these failings;
- conduct a significant events review of this case; and
- apologise to Mrs C for the failures identified in this report.

**Lanarkshire NHS Board**

**SPSO Report Number: 201004658 Report Date: 25/04/2012**

***Summary***
The complainant (Mrs C) raised a number of concerns about the treatment her late husband (Mr C) received whilst a patient at Hairmyres Hospital (the Hospital) in March 2010, after he was admitted on 10 March 2010 with shortness of breath. He developed pneumonia and MRSA, and Mrs C felt the Hospital were not caring for him adequately, in particular that staff did not properly recognise his needs (Mr C suffered from dementia). Mr C discharged himself against medical advice on 23 March 2010 and died at home on 2 April 2010.
***Specific complaint and conclusion***
The complaint which has been investigated is that during Mr C's admission to hospital in March 2010, there were unreasonable failings in his medical and nursing care and treatment in relation to pneumonia and medication (upheld).

***Redress and recommendations***
The Ombudsman recommends that the Lanarkshire NHS Board (the Board):

- provide evidence on the implementation of Scotland's National Dementia Strategy and the Dementia Resource folder, including relevant action plans, in order to ensure: ongoing education and training for staff in the Hospital; and good communication with dementia patients and their families, involving family members in care when appropriate; and

- carry out a ward audit to ensure compliance with the Nursing and Midwifery Council's Standards for medicine management and record-keeping.

**Greater Glasgow and Clyde NHS Board - Acute Services Division**

**SPSO Report Number: 201101255 Report Date: 25/04/2012**

***Summary***
The complainant (Mr C) complained about the care his late father (Mr A) received at the Southern General Hospital (the Hospital) in February 2011. Mr C was concerned that the staff involved in Mr A's care had failed to consider and assess his cognitive function, or communicate with Mr C in relation to the plans for discharge, resulting in Mr A being inappropriately discharged. Mr A fell and was injured two days after being discharged home, and was re-admitted to the Hospital.

***Specific complaints and conclusions***
The complaints which have been investigated are that Greater Glasgow and Clyde NHS Board (the Board):

- did not provide reasonable care and treatment to Mr A during his admission to the Hospital between 10 and 24 February 2011 (*upheld*);
- did not reasonably consider whether Mr A was fit for discharge on 24 February 2011 (*upheld*);
- did not dress Mr A in the outdoor clothes that had been provided for his journey home on 24 February 2011 (*upheld*); and
- did not provide a reasonable response to Mr C's complaint (*upheld*).

***Redress and recommendations***
The Ombudsman recommends that the Board:

- provide evidence to the Ombudsman of the implementation of a policy for the assessment of cognitive function of elderly patients, which should include documenting whether or not clinical staff find a patient has capacity to participate in decision making;
- provide the Ombudsman with a copy of the new discharge policy to demonstrate it states that relatives and carers must be engaged with during the planning for discharge process;
- ensure that their discharge policy and checklist contains a reminder that patients are dressed appropriately upon discharge;
- provide a full apology to Mr C for all of the failings identified within this report; and
- review and clarify their policy in relation to the review of hip fracture patients by the DOME.

**Fife NHS Board**

**SPSO Report Number: 201100109 Report Date: 25/04/2012**

***Summary***
The complainant (Mrs C) raised a number of concerns about the care, treatment and subsequent discharge of her husband (Mr C), who has dementia, following his admittance to the Accident and Emergency Department (the Department) of Victoria Hospital (the Hospital) on 6 January 2011.

***Specific complaints and conclusions***
The complaints which have been investigated are that:

- the care and treatment of Mr C in the Department on 6 January 2011 was not reasonable (*upheld*);
- the arrangements for Mrs C to deal with Mr C's personal hygiene in the Department were unreasonable (*upheld*);
- the time taken to admit Mr C to a ward from the Department was unreasonable (*upheld*);
- the responses to Mrs C's telephone calls to the Department for information about Mr C were unreasonable (*upheld*);
- the arrangements for Mr C's discharge on 7 January 2011 were unreasonable (*upheld*);
- Mrs C was not provided with reasonable information upon Mr C's discharge (*upheld*); and
- Mr C's mental health condition and Mrs C's role as his carer, next of kin and holder of power of attorney over him were not reasonably taken into account during his admission (*upheld*).

***Redress and recommendations***
The Ombudsman recommends that the Board:

- remind nursing staff within the Department of their responsibilities with regards to patients' personal hygiene and that it is not appropriate to rely on visitors to undertake this for them;
- provide evidence to the Ombudsman that staff within the Department have undergone training in relation to the importance of good communication with patients and their families;
- review their policy in relation to ensuring appropriate discharge arrangements for patients, taking into account any vulnerabilities and risk factors;
- remind nursing staff of the importance of treating patients with dignity at all times;
- review their policy in relation to providing discharge information to patients with dementia and their relatives and carers as part of the implementation of Scotland's National Dementia Strategy;
- provide evidence that, as part of the implementation of Scotland's National Dementia Strategy, staff within the Department and the Ward are given ongoing training in relation to the importance of acknowledging dementia and recognising the role of carers and next of kin; and
- provide a full formal apology to Mr and Mrs C for all of the failings identified within this report.