



Ombudsman's Commentary

MAY 2006 REPORTS

I laid 24 reports before the Scottish Parliament today. Fourteen relate to the health sector, one to a housing association, eight to local government and one to higher education.

The complaints that my office investigates are brought by members of the public who feel they have suffered hardship or injustice as a result of failings in a public service. When that service is the National Health Service, such failures can sometimes have devastating results.

This year marks the 10th anniversary of clinical investigation by the Ombudsman. It is disappointing that poor communication and inadequate record-keeping are still causes of confusion and anguish for patients and their relatives. The quality of available nursing care, especially for the most vulnerable members of society – the elderly, the infirm and those with mental health problems – remains an ongoing concern.

Several of the investigations outlined below involve bereavements. I acknowledge that in these cases, as with so many health complaints, the principal motivation of relatives is to prevent any other family experiencing a similar tragedy. That is why I seek through my reports not only answers for the complainants, but also assurances from those responsible that changes will be made to ensure that the likelihood of recurrence is as small as possible.

My role is also to ensure that the wider lessons from these reports are communicated to bodies in Scotland that have responsibility for the quality of treatment and care. In several of these reports, I have drawn specific aspects of complaints to the attention of the Scottish Executive Health Department (SEHD), NHS Quality Improvement Scotland (QIS) and the Scottish Health Council (SHC).

Health reports

Deep Vein Thrombosis (DVT): failures to diagnose condition

Lothian NHS Board; Argyll and Clyde NHS Board; a GP in the Argyll and Clyde NHS Board area

This report is one of two cases this month concerning the failure to diagnose and treat DVT. The complaint was brought by the parents of a young woman who died of a pulmonary embolism. Three separate services were involved in her treatment: the Royal Infirmary Edinburgh, the Royal Alexandria Hospital, Paisley, and a GP in the Argyll and Clyde NHS Board area. I have partially or fully upheld the complaints about the two hospitals, and have not upheld the complaints about the GP.

As a result of my investigation, I made specific recommendations about the DVT Management Protocol including guidance on communication to patients with continued or progressing symptoms and communication to discharged patients. I also recommended that the appropriate multi-disciplinary teams at each hospital discuss the limits of the available tests and what processes should be adopted when reaching a second opinion.

NHS Grampian

The complaint was that staff at Dr Gray's Hospital, Elgin, failed to diagnose DVT and carry out a scan before a patient's discharge from hospital. It also involved failure relating to the patient being declared fit for discharge; failure to provide the patient with appropriate accommodation when she was readmitted to the hospital; and failure in the handling of the complaint.

The complainant was the daughter of the patient who died of DVT. I upheld the first two and the last aspects of the complaint, and partially upheld the third.

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Health reports (continued)

I made specific recommendations to the Board about the DVT Management Protocol, the need to clarify responsibilities for patients awaiting discharge and their procedures for handling complaints. I also requested that the Board apologise to the complainant for the shortcomings identified in the Report and the manner in which her complaint had been handled.

In the light of these two sad deaths from DVT, I have requested that consideration be given to the need for Scotland-wide guidance on the management of suspected DVT, and that a Patient Information Leaflet be integrated into any such guidance. I note that although DVT is difficult to diagnose, it is not an uncommon condition and that these events are unlikely to be unique within NHS facilities in Scotland. I, therefore, urge all health boards to introduce or review their protocols for the management of suspected DVT.

Lack of dignity and privacy in care for the elderly

NHS Lanarkshire

I upheld three complaints about the nursing care of an elderly person with dementia in Hairmyres Hospital and a separate complaint about how the complaint was handled. Dignity and privacy are basic human rights and I am very concerned that they were denied by a public service to a vulnerable member of society.

I found that nursing staff failed to maintain the patient's personal hygiene and dignity, failed to ensure that his nutritional needs were met and responded poorly to family concerns. The inadequacies of the care were described by the complainant, Mrs C, who stated that: 'prior to the hospital admission her father had been relatively well and was mobile, talkative and continent. However, on the first visit to see him in hospital she found that he had visibly deteriorated and was very weak, barely able to speak, unable to feed himself, incontinent and his right arm was paralysed. At subsequent visits, the family would often find Mr C lying in bed soaked in urine and sweat with the constant struggle of trying to get up. They frequently had to ask for the linen to be changed before the visit could start. They often found him to be unshaven and on occasions lying in bed covered in nothing more than an incontinence pad.'

The events in this report preceded those investigated in my report of 3 August 2005 that also criticised nursing care at Hairmyres. In today's report I conclude:

'I am pleased to note, from the Board's recent response to my recommendation in another investigation – case number S.42/03-04, issued 3 August 2005 – that they have completed a review of nurse care planning, taking account of the 'Essence of Care' (a benchmarking tool), best practice standards and statements and SIGN (Scottish Intercollegiate Guidelines Network) guidelines.'

The standard of care received by Mr C was unacceptable and, while I acknowledge that the Board have given assurances that nursing care standards have improved, I shall be following up this evidently problematic area with the Board.

Neurosurgical treatment; meeting with consultant; complaint handling

NHS Lothian

The complaint centred on a mother's concerns about the care and treatment her daughter received at the Western General Hospital in Edinburgh. The core of Mrs C's complaint related back to a consultation and the interpretation of her daughter's CT scan by a consultant neurosurgeon. Mrs C believed the consultant had made an error of judgement and that he had given an over-optimistic interpretation of her daughter's condition.

After her daughter's death, Mrs C made a complaint which went to an Independent Review Panel (IRP). Dissatisfied with the handling and the outcome of that complaint, she came to my office. I partially or fully upheld most aspects of her complaint, and made the following recommendations:

- i. the consultant apologise to Mrs C for the shortcomings I have identified that relate to his comments during the consultation, and to his handling of a subsequent meeting with Mrs C and other members of the family;
- ii. the Board consider the issue of the availability of clinical notes in reviewing the lessons that can be learned from this complaint; and whether their system of electronic record keeping and reporting can be used to reduce the time between the writing and typing of clinical reports;
- iii. the Board apologise to Mrs C for the shortcomings identified; review their current process for arranging holiday leave to ensure there is sufficient cover to maintain the high quality of care and service; and reinforce the importance of the pre-clinic sessions when shared care is being provided and ensure that they take place;

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Health reports (continued)

- iv. the Board apologise to Mrs C for the failure of the Trust to write to her following receipt of the IRP report and for their failure to explain why they did not do so;
- v. the Board apologise to Mrs C for their failure to communicate her requests for a special meeting with the consultant, and for that meeting to be tape-recorded. I also recommend that the Board give further consideration to taping meetings that are likely to be highly sensitive and to issuing guidance to staff with regard to handling such meetings.

In conclusion I highlight the wider lessons that can be drawn from this particular complaint, and make reference again to the value I believe would be added by the introduction of legislation that would allow public bodies to apologise without fear of litigation.

'...if the team had met with Mrs C and had been more open and less defensive in providing an explanation and offering an apology it is likely that the complaint would not have arisen and escalated in the way that it did. The power of making an apology in such circumstances should not be under-estimated. It is evident that what had been a positive relationship between members of the team and Mrs C broke down when the difficulties arose and communication was poor.'

I have detailed the recommendations in this report because it highlights important issues to which I have drawn attention in previous complaints (see December 2005 commentary) relating to the continuum of care. When a patient's treatment is in the hands of a number of professionals and teams, it is vital that communication be timely and effective. In the report, I state:

'A further lesson that can be learned, which extends beyond this particular Board, relates to the issues surrounding joint care and who has overall responsibility for a patient at different points in the treatment provided. There are obvious advantages of a team approach to treatment and care and it is clear that, prior to the events of June 2001, Ms C very much benefited from this approach. This case has, however, highlighted an important point relating to minimising risks that can occur when different people are involved in the patient's journey. In such circumstances, good communication and record keeping are essential.'

It is now common for a patient's treatment to involve a number of different teams, supported by different professionals in often different facilities. This pattern of treatment places clear demands on all those involved in terms of record-keeping, decision-making and responsibility. I am reassured that these demands are now recognised by NHS Boards. Their challenge is to ensure that the proper processes and procedures are in place to manage the continuum of care.

Breast cancer diagnosis

A GP practice in Forth Valley area

The complaint was that the practice should have diagnosed breast cancer or referred the patient to a specialist or for a mammogram. While I did not uphold the complaint, I suggested that it may be timely for a review of the SIGN guidance on breast cancer in women. I have drawn this to the attention of NHS QIS.

Poor communication

NHS Forth Valley

My office investigated a complaint concerning a patient's diagnosis and treatment. I upheld only the aspect of poor communication, but I did recommend that the Board review the procedures for arranging scans to ensure that it is clear which test is being requested and that the patient's medical records contain sufficient details of tests arranged.

I did not uphold a complaint about a GP practice in the **Lothian NHS Board** area relating to failure to provide adequate pain relief.

Dental treatment

My office investigated three complaints about dentists.

General Dental Practice (GDP) in Greater Glasgow and Clyde Board area

I did not uphold the aspect of the complaint about bullying or aggressive behaviour by the dentist, but I partially upheld the complaint handling aspect. At the time of the issuing of the report, the dentist concerned has refused to apologise to the patient, as recommended in my report, nor has he accepted my recommendation about changes to complaint handling procedures. I am disappointed in the dentist's attitude and will take further steps to ensure compliance.

GDP in Greater Glasgow and Clyde Board area

A complaint about a different practice in the area was that the dentist had failed to advise the patient that treatment was private, and that the treatment he provided was inappropriate. I partially upheld only the first aspect of the complaint and recommended that the dentist act in accordance with the guidance from the General Dental Council (GDC) and provide patients with a written estimate and treatment plan where appropriate to avoid future misunderstandings. I also recommended that the dentist take note of the need to keep full, accurate and contemporaneous records.

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Health reports (continued)

Dental treatment

I did not uphold any aspects of the complaint about a GDP in **Lothian NHS Board** area concerning the fitting of a denture; the dentist's attitude; and alleged falsification of records.

Replacement of a 'single-handed' GP practice

NHS Lanarkshire

A patient group complained that NHS Lanarkshire had failed to properly manage and involve them in the retiral of a GP and the application process for his replacement. The complainants also complained about the quality of GP services they experienced while awaiting a replacement and during the time when patients were transferred to a new GP practice.

My investigation did not uphold the complainants' central complaints. The sequence of events leading to the complaint was unusual and the regulations surrounding the replacement of GPs were complex and changed during the period. However, I did find shortcomings in the Board's communication with the complainants which caused them injustice. In the light of that finding a need for action from the Board with respect to public involvement in the process was identified. This is relevant to the work of the Scottish Health Council (a national body established on 1 April 2005 with a responsibility to scrutinise how well NHS Boards are involving people) and I have drawn their attention to this complaint.

Scottish Executive Health Department

The same complainants also raised an issue about the SEHD's management of the above process. I did not uphold the complaint.

Resources

Orkney NHS Board

This complaint was about incorrect assessment of an x-ray; inadequate arrangements for reporting x-rays at the weekend; and the lack of appropriate equipment for patients requiring wheelchairs. I upheld the first and last complaints and did not uphold the second complaint. I recognise that the second complaint raises important issues of resourcing, as detailed below:

'The complainant, Mrs C, felt that, where there is no local orthopaedic expert available to immediately review x-rays of multiple breaks in joints, they should

be shown to an orthopaedic consultant at a major teaching hospital. My medical adviser has commented that an immediate review by an expert trauma and orthopaedic surgeon in Orkney may be impossible to achieve on the basis of the number of people on the island and the frequency with which such a person would be required.

However, with the transmission of x-rays electronically to Aberdeen, there may be a distinct possibility of arranging for orthopaedic specialist help when a radiologist sees a complex x-ray. Mrs C's x-rays would fall into that category and if an orthopaedic surgeon on the mainland had been alerted to this injury, maybe further problems could have been avoided. In view of the advice which I have received, I do not uphold this aspect of this complaint. I am, however, pleased that procedures have been amended so that x-rays are now sent electronically to Aberdeen for review by senior orthopaedic staff.'

I recommended that the Board:

- i. review its Risk Management and Clinical Governance Policies to reduce the likelihood of such a situation recurring;
- ii. ensure that appropriate strategies are in place to monitor and audit medical and nursing records and disseminate the results to staff;
- iii. review its policies and procedures on the use and maintenance of orthopaedic equipment, the provision of equipment on discharge, including out of hours, and the training of staff in the use of equipment and in the teaching/support of patients who will be using the equipment.

NHS Lothian

I did not uphold a complaint about lack of administrative support (relating to a change in the appointment system) for the Board's podiatry service. I noted the need to prioritise use of finite resources.

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Housing reports

Registered Social Landlord

I did not uphold a complaint about the failure of the landlord, **Almond Housing Association**, to redecorate the complainant's property after the installation of a new central heating system. I found that the complainant had been advised of the association's procedures at an early stage.

Local Government reports

Five of the eight complaints about local government related to tenancy issues. The others concerned a councillor's alleged interference in a planning application; alleged assaults at a primary school; and a council tax review.

Penalising of housing application

East Ayrshire Council

I did not uphold the complaint. I commended the council for the fact that in the course of the investigation they accepted that actions taken by the housing department may have had a detrimental effect on the complainant's health. I am pleased to note that they apologised to her about this and also returned her to the position she was in before the complaint arose in terms of her 'points' allocation.

Landlord's refusal to replace or repair fence

Stirling Council

I found no evidence of service failure or maladministration in the way the council reached their decision and consequently I did not uphold this complaint.

Noisy pipes

Fife Council

The complainant claimed undue delay by the council in researching and resolving a problem of noisy pipes which was preventing her from sleeping. After he was notified of the complaint to my office, the council's Chief Executive reviewed the circumstances of the complaint. I am pleased to note that the Chief Executive accepted that the complaint was justified, apologised to the complainant and made a substantial payment to her for the poor service she had received. I commend the Chief Executive for his open acceptance that the case carries important lessons for customer care and have asked him to inform me of the outcome of discussions with staff on how to avoid a recurrence of this situation.

Vehicular access and increase in size of garden

Fife Council

I did not uphold the complaints from an MSP on behalf of a constituent, that the council had dealt improperly with the constituent's requests to buy land to allow him to create a vehicular access and also to increase the size of his garden.

Release of personal information; council misled tenant into accepting housing transfer

Fife Council

My investigation did not uphold the first complaint but upheld the second. I accepted the complainant's allegation that he was misled into accepting a housing transfer, that incorrect information was given to him and that, as a consequence, he lost his original Right to Buy discount. I recommended that the council reinstate the complainant's discount to what it would have been, had he not transferred his tenancy and had he not been given the incorrect/conflicting information. I also recommended that Fife Council take steps to ensure that their staff pass on accurate information to their tenants, by confirming their Right to Buy in writing at the point of offer.

Handling of complaint about perceived interference by councillor in planning application

Fife Council

This complaint concerned the council's handling of a complaint about a councillor's perceived interference in a planning application. I upheld the complaint that the complainant had not received a reply to an email he claimed he had sent and recommended that the council apologise for their failure to properly investigate his complaint. I also recommended that council staff be made aware that complaints about the conduct or actions of elected members should be referred to the Standards Commission for Scotland.

Alleged assaults at a primary school

Argyll and Bute Council

I did not uphold the core complaint, but I did find that the school was remiss in its complaints handling process and recommended that the council apologise to the complainants for their failure to advise them of their right to complain to my office and revisit the information contained in their Education Complaints framework.

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Local Government reports *(continued)*

Council Tax review

Dumfries and Galloway

This complaint concerned the way the council dealt with a council tax review. While I did not uphold the core aspects of the complaint, I found that the council should have offered the complainant the assistance of a Benefits Assessor. I recommended that the council clarify and publicise the role of the Benefits Assessor and make it more widely known to the public.

Further and Higher Education reports

My remit was expanded in October 2005 to include complaints about higher and further education and today I am publishing the first investigation report in this sector.

The complainant claimed that the University of Glasgow had failed to provide her with appropriate supervision and that as a consequence her PhD had been disadvantaged. I did not uphold the complaint.

Compliance and Follow-up

In each complaint, apart from that of a dentist from a GDP in Greater Glasgow and Clyde Board area, all the bodies complained about have accepted my recommendations. In line with SPSO statutory responsibilities and practice, my office will follow up with bodies to ensure that they implement the actions to which they have agreed.



Alice Brown. 30.05.2006

The compendium of reports can be found on our website, www.spsso.org.uk

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Commentary