



# Ombudsman's Commentary

SEPTEMBER 2006 REPORTS

**I laid twenty-three reports before the Scottish Parliament today. Thirteen relate to the health sector, seven to local government, two to housing and one to the Scottish Executive and devolved administration.**

## Ombudsman's overview

This month's focus is on health cases. I upheld or partially upheld nine of the thirteen health complaints, and made a number of recommendations to Boards. It is usually the case in health complaints that the complainant has been through a period of great emotional distress, and often has brought their complaint after a loved-one has died. I recognise that pursuing a complaint in such circumstances, first through the hospital or GP practice and then through my office, requires patience and courage. I hope that my investigations can at the very least provide clarity and closure in some of these cases. Most frequently, complainants express the wish that no-one else should experience what their loved-one and they have gone through, and, therefore, my recommendations aim to prevent a repeat of the cause of the complaint.

## Recommendations in health cases

The recommendations are made to individual Boards but they should be considered by Boards across Scotland. Four common themes – all of which I have highlighted in previous Commentaries – are once again present in this month's reports. They are:

- poor communication between nursing and medical staff;
- poor record keeping;
- poor communication with relatives; and
- poor complaint handling.

Two reports this month (about the pre and post-operative care of a cancer patient and the fall of an elderly man) are stark reminders of the serious consequences that can result from poor communication between nursing and medical staff and poor record keeping. Deficiencies in either of these areas can lead to the wrong assessment, diagnosis or treatment, and can have a critical impact on a patient's condition.

Deficiencies in communication with relatives is a feature of several reports, including the complaints about the fall of an elderly man; the death of a patient after cardiac surgery; assessment of suitability for a liver transplant; and the inappropriate delivery of a cancer diagnosis.

Poor complaint handling can add to relatives' feeling of a lack of concern on the part of medical staff for their views and feelings. I emphasise that full and timely explanations are important at all stages, but especially when a complaint has been made.

## The Value of a 'Meaningful Apology'

In recommending redress in several health cases, and also in some of the reports about local government and housing this month, I ask the bodies concerned to apologise to the complainant. I require an apology to be meaningful. Mindful of the complexities of interpreting the term 'meaningful apology', my office has produced guidance for bodies. It outlines what, in our experience, complainants want in an apology, the key elements of a meaningful apology, and direction on who the apology should come from. I acknowledge the helpful input from complainants and others in drawing up this guidance. It is available on request from our office and will soon be posted on our website.

# Ombudsman's Commentary

## SEPTEMBER 2006 REPORTS

### Health

I upheld or partially upheld nine of the complaints, and did not uphold or made no finding in four complaints in the health sector this month.

#### Pre and post-operative care:

Borders NHS Board

The complaint concerned the treatment provided to a patient, Mrs A, who had elective surgery for the removal of a cancer. The complaints from her daughter that were investigated were that staff:

- failed to take action pre-operatively when the patient became nauseated and in pain; and
- failed to take prompt action post-operatively when it was noted the patient's condition had started to deteriorate.

My investigation focussed on Mrs A's aversion to Picolax; the use of pre-operative antiembolic stockings; inadequate documentation in the clinical and nursing records; advice on the use of oxygen; and action taken by staff when Mrs A's condition deteriorated post-operatively. I found failures to make adequate assessments and a serious shortcoming in Mrs A's nursing care. I fully upheld the two complaints and recommended that the Board:

- consider a mechanism for explaining to patients and relatives the rationale for the use of heparin or antiembolic stockings to prevent pulmonary embolus or deep vein thrombosis;
- provide a specific action plan to monitor the standard of nursing documentation on the surgical wards;
- devise a protocol for the administration of oxygen therapy; and
- consider the need for a training requirement in communications between nursing and medical staff.

#### Care and treatment of the elderly:

Greater Glasgow and Clyde NHS Board

The complaint concerned the circumstances that led the complainant, Mrs C's, 74-year-old husband, Mr C, to fall after he had been sitting in a chair. The specific complaints which were investigated were:

- that Mr C should not have been sitting out of bed;
- that there was inadequate communication with Mr C's family regarding the fall;

- whether it was appropriate to put Mr C back to bed following the fall; and
- whether the nursing assessment, care planning and documentation was inadequate.

I upheld all the complaints, and recommended that the Board:

- remind staff of their responsibilities to assess patients who have fallen for potential injuries, before moving them to an appropriate and safe place;
- audit the use and effectiveness of the Cannard Risk Assessment Form and Falls Care Plan; and
- review the nursing documentation within the Generic Integrated Care Pathway (ICP) for the Older Person, to ensure that nursing assessments and care plans are visible and reflect the requirements of the NMC Code of Professional Conduct.

#### Concerns following death of patient after cardiac surgery:

Greater Glasgow and Clyde NHS Board

The complainant, Ms C, was concerned that her mother had not been referred for cardiac surgery earlier when she was stronger and better able to tolerate the operation. Ms C was also concerned about her mother's post-operative care, which she felt did not allow her to recover from the surgery. The specific complaints which were investigated were that:

- her mother was not referred earlier for surgery;
- there were problems in providing post-operative nutrition and that these were inadequately explained;
- a ventilator was not operated properly; and
- septicaemia was not diagnosed properly or early enough.

I partially upheld the second and third aspects of the complaint, and did not uphold the other two. I recommended that:

- the Board apologise to Ms C; and
- that staff are reminded of the importance of proper and full explanations as part of the response to complaints.

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### Health

#### Assessment of need for liver transplant; complaint handling:

Greater Glasgow and Clyde NHS Board and Lothian NHS Board

The complainant, Mr C, was concerned about the assessment of his nephew's, Mr A's, need for a liver transplant. The specific complaints which were investigated were that:

- the liver transplant unit did not properly assess Mr A for transplant;
- the hospital failed to provide proper care for Mr A or arrange a timely review of his eligibility for transplant following his unsuccessful assessment; and
- the Board to which he directed his initial complaint failed to respond to his complaint in a timely manner.

I partially upheld the first and second aspects of the complaint, and fully upheld the third. Those parts of the complaints that I upheld did not concern clinical decisions, but the appropriateness in some cases of seeking a second opinion, and poor communication with the family. I recognise the national shortage of donor organs and the resultant stringent protocol for assessment of patients for liver transplant. I state:

*'The evidence shows that Mr A's assessment was clinically appropriate. However, I concluded that the lack of family involvement was not properly recorded and contributed to the delay which prevented Mr A obtaining a second opinion. I have also concluded that the hospital provided appropriate treatment but failed to provide timely planning for Mr A following his negative assessment by the liver transplant unit.'*

In the light of my findings, I recommended that the liver transplant unit:

- provide evidence of a common understanding amongst all staff of the guidance and its practical application with respect to family involvement;
- revise their discharge procedures for patients not admitted to the transplant list to include information on the right to a second opinion and what such a process might entail and provide evidence of this change;

and that the Board:

- ensure that the new process for obtaining an appropriate second opinion for patients negatively assessed for liver transplant is made known to the relevant clinical staff; and
- provide Mr C with a written apology for the acknowledged delay in responding to his complaint.

#### Diagnosis and care of cancer patient; inappropriate communication of diagnosis:

Lanarkshire NHS Board

The complainant, Ms C, was concerned that her father's cancer had not been diagnosed during an earlier hospital admission. She also raised a number of concerns about the care provided during his stay and was aggrieved that he was told he had cancer in an inappropriate manner and in direct contravention of previously expressed wishes. I did not uphold the first two aspects of the complaint, but I did uphold the last, and I recommended that:

- the Board apologise to Ms C and her family for the distress caused by the way in which the diagnosis was communicated to Mr C and subsequently to her; and
- the initial audits into the effectiveness of new nursing documentation be shared with my office.

#### Delay in provision of medicine following hospital discharge; staff attitude:

Greater Glasgow and Clyde NHS Board

The complainant, Dr C, complained about delays in providing medicines when his wife was discharged from hospital. He also complained about staff attitude and said that they had failed to provide a referral. I upheld the first aspect of the complaint, but did not uphold the other two aspects. I recommended that the hospital:

- review the practical operation of their Discharge Policy ; and
- offer a more fulsome apology to Dr C for the circumstances relating to the delay and collection by him of Mrs C's discharge medication.

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### Health

#### Care and treatment in A & E; communication; post-mortem procedures:

Lanarkshire NHS Board

The complaint concerned the care and treatment of a patient, Mrs A, who died three days after her hospital admission. The specific aspects that were investigated were that:

- care provided by the Accident and Emergency doctor was inadequate;
- care provided by the out-of-hours doctor was inadequate;
- pain relief provided to Mrs A during her hospital admission was inadequate;
- communication between health professionals and Mrs A's family was inadequate; and
- procedures for arranging the post-mortem were inadequate.

I upheld the first, third and fifth aspects, and did not uphold the other two complaints. However, I did not make any recommendations in connection with this complaint because I concluded that appropriate action had already been taken by the Board. I am satisfied that the failures identified were attributable to individual errors which have been addressed and do not indicate a wider problem.

#### Care and treatment by GP; complaint handling:

Lothian NHS Board

I did not uphold the complaint about care and treatment but I did find that the GP practice failed to properly handle the complaint and did not properly follow the NHS complaints procedure. Therefore, I recommended that the practice apologise to the complainant for the lengthy delays in responding to her complaint.

#### Breach of confidentiality; attitude; complaint handling:

Tayside NHS Board

The complainant raised concerns about his session with a counsellor, including an alleged breach of confidentiality, racism and the handling of his complaint. I upheld only the complaint handling aspect and made no recommendation.

#### Other health complaints investigated and not upheld or where I made no finding related to the following issues:

- inaccurate information passed to social worker (GP in **Highlands and Islands** region)
- care received from a mental health and learning disabilities service (**Highland NHS Board**)

Although I did not uphold, or made no finding on, aspects of this complaint, I did invite the Board to consider whether the service might be able to take a more proactive approach to reassure patients on confidentiality issues.

- inappropriate feeding of a baby; staff attitude (**Greater Glasgow and Clyde NHS Board**)

Although I did not uphold, or made no finding on, aspects of this complaint, I did make recommendations to the Board, namely that they ensure that:

- there is a method of ensuring that all relevant information pertaining to the care of a baby is accurately entered into the clinical notes;
- any discussion with a staff member relating to a complaint made is documented and that additional support to the staff member through education and training is offered; and
- each newly qualified staff member in a specialised unit such as the neonatal unit, as well as having clinical competencies to achieve, be assessed on their skills in managing stress and difficulties within the family unit to ensure full support is available from the unit team.
- delay in informing patient's GP of patient's death; appointment card sent after patient's death (**Tayside NHS Board**)

Neither aspect of the above complaint was upheld because the Board had already taken appropriate action before I received the complaint. If I am satisfied that a complaint has been resolved by a body before the matter is raised with my office, technically the complaint is not upheld. I may, however, make recommendations and in regard to this complaint I recommended that the Board:

- monitor the policy they have introduced to notify GP practices of the death of patients to ensure effectiveness; and
- until all systems are interfaced with the Community Health Index for Scotland, remind staff of the need to access this system before sending out appointment cards and to reinforce the training given at regular intervals.

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### Local Government

Of the seven reports about local government, one was upheld in full, two were partially upheld and four were not upheld or I made no finding.

#### Failure to report on costs:

North Lanarkshire Council

The complainant was aggrieved about the abolition of discounted rate swimming for pensioners when the council introduced a new leisure access card. The specific complaint that I investigated and upheld was that the council had not fulfilled a remit given to them to report back on the costs associated with the introduction of a policy of providing free swimming for pensioners. I recommended that the council issue an apology to the complainant.

#### Housing allocation:

Perth and Kinross Council

The complainant raised a number of concerns about the way in which her housing allocation had been handled by the council. The specific complaints that were investigated were that:

- council officers provided incorrect information in connection with medical advice relating to the appropriateness of a property;
- the council delayed acting when informed of the unsuitability of a property; and
- the council failed to comply with the time limits of its complaints procedure.

I did not uphold the first or second aspects of the complaint and I did uphold the third. I recommended that the council remind staff of the council's commitment to answering complaints within the timescale specified in its complaints process and, furthermore, that complainants should not be referred to this office before they have exhausted the council's own complaints process.

#### Recovery of alleged overpayment of housing benefit payments:

Renfrewshire Council

The complainant, Mr C, who runs a property letting company, said that he was being unjustly pursued for a debt for which he was not responsible and that his business was suffering as a consequence of the council's pursuit of recovery of alleged overpayment of housing benefit payments. The specific complaints that were investigated were that:

- overpayments were made to the tenant's previous landlord but were recovered from Mr C;
- Mr C was not advised that overpayments had been made when the tenancy commenced and money was taken from him without consultation;
- there was delay between the overpayments being made and the money being recovered; and
- the council failed to advise Mr C of their complaints procedure.

I upheld the first and fourth aspects of the complaints; did not uphold the second; and made no finding on the third. I recommended that the council:

- offer Mr C appropriate apologies, reinforced by a payment in recognition of his time and trouble in pursuing the situation with regard to overpayments; and
- clarify procedures in relation to representations made by landlords where housing benefit payments are concerned.

#### Other complaints investigated and not upheld or on which there was no finding related to the following issues:

- Changes to housing allocations policy (**Stirling Council**)
- Anti-social behaviour (**South Ayrshire Council**)
- Noise nuisance from kennels (**Inverclyde Council**)

Although I did not uphold this complaint, I recommended that the council, as a matter of good practice, record any site visits undertaken and produce clear guidelines to ensure consistency in the practice of writing to/copying in third parties. I am pleased that the council has already advised me on the steps they are taking to address these matters.

- Breach of confidentiality; failure to reply to correspondence (**City of Edinburgh Council**)

Although I did not uphold the first and made no finding on the second aspect of this complaint, I did recommend that the council take action urgently to minimise the risk of council files being misplaced.

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## Housing

I partially upheld one of the two housing complaints, and did not uphold the other.

### Right to Buy; failure to carry out repairs; release of personal information:

Scottish Borders Housing Association Ltd

I did not uphold the complainant's, Mr C's, concerns that the Association had failed to progress his house sale and that they had released personal information to a third party without his permission. I did, however, uphold his complaint that the Association had failed to carry out essential repairs in a timely fashion and, therefore, I recommended that the Association:

- apologise to Mr C for their failure to carry out the repairs in a timely fashion; and
- reinforce this apology with an appropriate payment to recognise the injustice caused to Mr C as a consequence.

I did not uphold a complaint about **Bridgewater Housing Association Ltd** relating to estate management.

## Scottish Executive and devolved administration

### Dissatisfaction with handling of applications for transfer to an open prison and for a compassionate visit:

Scottish Prison Service (SPS)

This complaint concerned a prisoner's dissatisfaction with the SPS' handling of his application to transfer to an open prison. In a subsequent complaint about the SPS, he complained of delay and other administrative shortcomings in the handling of his compassionate visit application. I did not uphold either aspect of the complaint.

## Compliance and Follow-up

All the organisations complained about have accepted my recommendations. In line with SPSO statutory responsibilities and practice, my office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



**Alice Brown.** 26.09.2006

The compendium of reports can be found on our website, [www.spsso.org.uk](http://www.spsso.org.uk)

For further information please contact:  
**SPSO**, 4 Melville Street, Edinburgh EH3 7NS  
[ask@spsso.org.uk](mailto:ask@spsso.org.uk)