



Ombudsman's Commentary

JULY 2008 REPORTS

I laid 23 investigation reports before the Scottish Parliament today. Seventeen were about the health sector, four about local government, one about a Scottish Government body and one about both a Council and a Scottish Government body.

Ombudsman's Overview

In this month's Overview, I am highlighting a recurring issue in health complaints – the care and dignity of people in hospital, and in particular communication with their families. I also draw attention again to the importance of good record keeping, a requirement of all staff in public bodies, and my examples are from the health and the local government sectors.

Relatives' grief over the death of a loved-one is naturally compounded when they feel their parent, partner, sibling or child has suffered unnecessarily or that their dignity was not maintained. In two investigations this month, relatives' distress about the circumstances of their loved-one's death formed a significant aspect of the complaint. In one case (Ref: 200601141) a woman believed that her husband was not treated with appropriate dignity and respect. Due to a lack of documentation, I was unable to make a finding on this particular aspect of the complaint. However, I did find evidence of inadequate clinical treatment, nursing care and record keeping, and I made several recommendations including improving communication between health professionals, patients and their relatives.

Another investigation (Ref: 200600942), about the nursing care of a 76-year old woman, found evidence of insufficient care including failure to supervise when going to the toilet and inadequate clinical records. The complaint details the family's distress in finding themselves using wet paper towels in an attempt to bring down their mother's

temperature, and the extremely distressing circumstances of the moments before her death. The Board's response to these latter complaints was to explain that their staff wish patients and their families to maintain their privacy, particularly when a patient is nearing death. Although I accept and support this wish, I was critical of the fact that no discussion took place between nursing staff and the family about who would provide what care. In this case, my report states, such a discussion would have helped the family feel supported, while at the same time allowing them to care for and spend time with the patient. In connection with this aspect, I recommended that the Board reflect on the complaint and consider staff guidance or training.

Poor record keeping was an issue in both the above complaints and in a number of other health complaints this month, including one about the cleanliness of a hospital room (Ref: 200603453). It also featured in a complaint about the handling of a formal complaints investigation (Ref: 200503340) by a Council. While I did not uphold the latter complaint, I did make a number of recommendations to the Council to improve their written records of investigations.

Professor Alice Brown, Ombudsman 23.07.2008

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case summaries

The reports are summarised below and the full reports are available on the SPSO website at <http://www.spsso.org.uk/reports/index.php>

Health

Communication, complaint handling

Scottish Ambulance Service (200600213)

Mrs C raised a number of concerns about the way the Service handled her enquiries and her complaints about their response to a request to take her husband to hospital. I upheld her complaint that the Service failed to arrange a meeting with Mrs C after having said this was in hand, and recommended that the Service remind all staff of the importance of ensuring the factual accuracy of communications. I did not uphold two other complaints relating to aspects of complaint handling, and made no finding on two further complaints about meetings, due to insufficient evidence.

Clinical treatment, communication

Lanarkshire NHS Board (200600725)

Mr C complained about the diagnosis and treatment of his late wife during two admissions to hospital. I partially upheld two complaints; firstly about the standard of clinical and nursing care (to the extent that his wife was not told that a surgical team would be unable to visit her as she had expected, after cancer was diagnosed) and secondly that internal communications were poor (to the extent that the need for an endoscopy was not given the appropriate degree of urgency). I recommended that the Board apologise to Mr C for the lack of information and for the inappropriate prioritisation of the endoscopy. I also recommended that the Board remind staff of the importance of keeping patients informed, and audit their referral processes to satisfy themselves that the urgency of a referral is clear.

I did not uphold complaints about misdiagnosis, inappropriate nutritional care, and record keeping, as these issues were dealt with appropriately by the Board in their handling of Mr C's complaint to them. Neither did I uphold Mr C's complaint about the appropriateness of the Board's actions in response to his concerns.

Diagnosis, clinical treatment, record keeping

Greater Glasgow and Clyde NHS Board (200702258)

Following Miss C's mother's, Mrs A, death in hospital, Miss C had a number of concerns. She complained that an earlier decision to discharge Mrs A was taken without an appropriate scan taking place, that aspirin was prescribed inappropriately and that there was a delay in the Board telling Mrs A's family that she had contracted MRSA while in hospital. After taking clinical advice, I did not uphold the first two complaints, but I did uphold the complaint about delay. I recommended that the Board apologise to Ms C, and that they emphasise to staff the importance of good communication, comprehensive note taking and record keeping.

Communication, record keeping

Tayside NHS Board (200602439)

Mrs C's husband, Mr C, was diagnosed with Type 1 diabetes. Mrs C complained that staff failed to provide adequate advice and support in respect of Mr C's condition after his diagnosis. I found that record keeping was incomplete – this appeared to have led to specific communication problems, and, therefore, I partially upheld the complaint. I recommended that the Board write to Mr and Mrs C apologising for the record keeping deficiencies and lack of clarity in communication, and consider introducing a relevant protocol for the post-discharge care of patients with diabetes.

Clinical treatment, complaint handling

Forth Valley NHS Board (200503366)

Ms C underwent a rectal examination at one of the Board's hospitals which she found very uncomfortable. She complained that it was inappropriately carried out and that the Board failed to deal properly with her original complaint. I did not uphold the complaint about the examination itself, as when Ms C complained to the Board they investigated, partly upheld the complaint

and apologised appropriately. They also produced new guidelines as a result of the complaint. I did, however, uphold Ms C's complaint about the Board's handling of her concerns, as the investigation was not as thorough as it could have been, particularly in relation to a lack of evidence from two significant witnesses. I recommended that the Board send Ms C a further apology for this failing, reflect on how they obtain evidence in future and send me information about any further changes to guidance or procedure.

Diagnosis, care and treatment, communication, record keeping

Ayrshire and Arran NHS Board (200601141)

Mr C had urological problems and was eventually diagnosed with a kidney condition not long before his death. His wife, Mrs C, complained of delay in diagnosing this condition, and that Mr C was not told of this diagnosis at the appropriate time. She also complained about the care and treatment he received in hospital on the last few days of his life, in particular her concerns about withdrawal of medication, inadequate nursing care and a lack of respect for Mr C.

Investigation of the complaint about diagnosis and information showed that there had been significant failures, including inaccurate provision of information to Mr C's GP and delays in taking action on abnormal test results. Medical and nursing records were also inadequate and complaint responses were unclear. As a result, I made a number of recommendations including: further apologies to Mrs C; that the Board consider lessons learned from Mr C's case (from both the medical and complaint handling perspectives); and that they should review or audit relevant results, procedures, letters and records, sharing some of these results with me. I also recommended that the Consultant involved discuss this case with his appraiser at his annual review and reflect on how his approach may be perceived. I did not uphold the complaint about withdrawal of medication and made no finding on the complaint about the dignity and respect afforded to Mr C.

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I did not uphold a linked complaint about the Medical Practice (Case ref: 200603770) because of evidence that the GPs acted reasonably on the information and advice provided by the hospital, albeit that, as described above, this information was inaccurate.

Diagnosis, care and treatment, record keeping

Lothian NHS Board (200501277)

Ms C complained that she was given conflicting information about her diagnosis and the treatment she received for gallstones. I upheld her complaint.

The medical records showed that there was some confusion about whether or not gallstones were present and what treatment was required, but the Board's replies to Ms C's concerns did not clarify the position for her, and she remained concerned about her condition. I, therefore, upheld the complaint and recommended that the Board apologise for this, offer Ms C a further clinical assessment, and share my report with the Consultant originally involved in her care.

Ms C also had concerns about the way in which she was treated when she attended an Accident and Emergency Department. The records of Ms C's attendance were unavailable when the investigation began, but were later found. From these records, there was no evidence that Ms C was improperly treated, but I was concerned about the fact that the records were mislaid for some time. I recommended that the Board apologise to Ms C and review their procedures within the Department to ensure that such records are readily available in future.

Care and treatment, consent, communication, record keeping

Lothian NHS Board (200402209)

Mr C complained about several aspects of the care and treatment he received after suffering a brain haemorrhage. In particular he raised concerns about an embolisation procedure during which a catheter ruptured and fluid leaked, as a result of which he suffered a stroke. I upheld the complaints that Mr C was not informed of alternative treatments available to him, or a cooling off period to allow him to make his decision,

and partially upheld his complaint that the risk involved in the procedure was not fully disclosed to him. I recommended that the Board apologise to Mr C and provide me with details of reviews of their consent policy and their Incident Reporting and Investigation procedure. I did not uphold complaints about the way in which the procedure was carried out, or the Board's recording and investigation of the incident. I was unable to reach a finding on a complaint that explanations were inadequate, as there was insufficient information in the medical records. As a result I made a further recommendation that such explanations should be properly recorded.

Care and treatment

Tayside NHS Board (200603211)

Ms C raised a number of concerns about the care and treatment of her late brother, Mr A, who died unexpectedly in hospital after a knee replacement operation. I upheld one complaint – that staff failed to properly monitor Mr A's fluid levels and to properly administer an intravenous drip, and recommended that the Board apologise to Ms C for these failures. I found that the care and treatment provided was otherwise reasonable and appropriate, and I, therefore, did not uphold complaints about administration of laxatives and treatment for gastroenteritis; about the results of the post-mortem examination, an x-ray, and monitoring of Mr A; or that the Board used insensitive language in responding to Ms C's complaints.

Cleanliness, record keeping

Lothian NHS Board (200603453)

Mr C complained that while he was in hospital his room was not properly cleaned. My investigation found that although the procedure included template pages on which to record action taken, no cleaning records were available for the period of Mr C's stay, and evidence obtained in the Board's investigation did not refer to such records. I, therefore, partially upheld this complaint in the absence of these records and recommended that the Board remind the contractor of the importance of good record keeping and that in future the Board obtain all relevant information when investigating a complaint, including questioning or requiring evidence to support statements provided.

Care and treatment, record keeping

Lanarkshire NHS Board (200600942)

Mrs C raised a large number of concerns about her mother's care and treatment in hospital where she died two and half months after admission. I upheld or partially upheld complaints that the Board failed to:

- supervise Mrs A when she visited the toilet, or do enough to prevent falls
- ensure the correct drugs were taken
- provide sufficient nursing care to Mrs A
- put in place fluid charts or record observations adequately for Mrs A

I did not uphold complaints that Mrs A was not admitted when she was first referred to hospital or that doctors were rude to Mrs A since I was satisfied that the Board investigated her complaints to them adequately, upheld them and took appropriate action. I did not uphold a number of other complaints where I considered that the care, treatment and decisions in respect of these was, in the circumstances, reasonable.

I recommended that the Board:

- emphasise to staff the importance of adjusting care plans appropriately and take action to ensure that records are appropriately kept
- ensure staff understand the importance of and procedure for incident reporting
- monitor compliance with the Medicines Code of Practice
- reflect on the complaint to consider what may be done to ensure that patients' families feel appropriately supported.

Ward closure

Fife NHS Board (200700114)

Mrs C complained that the closure of a ward in which her niece was resident was poorly handled and that the Board's response to her complaint was inadequate. I upheld both complaints and recommended that the Board apologise for this, and that they draw on this experience to review any future similar plans and the documentation of such decisions.

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Health

I did not uphold the following complaints about NHS Boards:

Clinical treatment, communication

Greater Glasgow and Clyde NHS Board (200502857)

Care and treatment, communication

Tayside NHS Board (200502959)

Diagnosis, complaint handling

Ayrshire and Arran NHS Board (200502012)

Diagnosis, communication

A Medical Practice, Ayrshire and Arran NHS Board (200603770)

Delay in treatment

Tayside NHS Board (200700903)

Mr C complained about a long wait that he experienced while waiting for surgery. I did not uphold the complaint, but I did recommend to the Board that they consider Mr C's overall treatment plan, and the time taken up by administration, when reviewing their procedures in line with the Scottish Government's revised waiting time targets.

Local government

Social Work:

Complaint handling

The Moray Council (200601167)

Mr C applied to the Council for funding for a service that his voluntary organisation wished to provide. He raised concerns about the Council's responses about the failed application, as these stated that he had not provided information about projected users and numbers. I upheld this complaint because there was no evidence from the records that the Council had directly asked Mr C for this information. I recommended that the Council apologise to Mr C for the failings identified in my report.

Planning

Fife Council (200603329)

Mr C lived next to a hotel where an extension was being built, accessed by a private road maintained by residents. During

construction, Mr C raised concerns with the Council about contractors' site access and possible damage to the road. He was given some reassurances but then complained that these were not adhered to. I upheld his complaints that the Council did not adequately monitor access to the site, and did not adequately communicate with Mr C. I recommended that they apologise to Mr C for added stress and inconvenience and for the communications shortcomings.

I did not uphold the following complaints in the local government sector:

Communication

The Highland Council (200600176)

Ms C complained that the Council misinformed her about the status of a language qualification that she had achieved, and delayed providing her with the relevant certificate. She also complained that a Council staff member behaved inappropriately when visiting her, and that the Council did not handle her complaint well. I did not uphold the complaints about information provided, delay and complaint handling. Clearly things had gone wrong, but the Council had already taken action to deal with this prior to the complaint being made to the SPSO. I could reach no finding on the complaint about the behaviour of the staff member, as there was no independent evidence available to corroborate what happened during the visit.

Complaint handling

Glasgow City Council (200503340)

Ms C, the mother of Ms A, complained that the Head Teacher at Ms A's school did not adequately respond to a complaint about failure in the School's duty of care, and that the Council then failed to follow their complaints procedure. Although I did not uphold either complaint, I did recommend that in future the Council ensure that documents obtained as part of a formal investigation are dated and include appropriate detail and are appropriately retained, and that they consider including this in the School's Pastoral Care Policy.

Local Government / Scottish Government and devolved administration

I did not uphold the following complaint:

Planning

The Highland Council (200402220) and the Directorate of Planning and Environmental Appeals (200500649)

Scottish Government and devolved administration

Policy/administration

Scottish Prison Service (200503484)

Mr A is a patient in The State Hospital. His brother, who at the time the complaint was made was in the custody of the Scottish Prison Service, visited him accompanied by staff of Reliance Custodial Services (RCS). Mr A complained that during a visit RCS used excessive security by insisting that his brother remain handcuffed to a guard in what he claimed was already a secure environment. I partially upheld the complaint to the extent that it was clear that RCS had not carried out the required Risk Assessment. I recommended that the Scottish Prison Service ask RCS to apologise to Mr A for not conducting this assessment.

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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.

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

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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 in handling complaints about councils, housing associations, the National Health Service, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, colleges and universities and most Scottish public authorities.

We normally consider complaints only after they have been through the formal complaints process of the organisation concerned. Members of the public can then bring a complaint to us by visiting our office, calling or texting us, writing to us, or filling out our online complaint form.

The Scottish Public Services Ombudsman was set up in 2002, replacing three previous offices – the Scottish Parliamentary and Health Service Ombudsman, the Local Government Ombudsman for Scotland and the Housing Association Ombudsman for Scotland. Our role was also extended to include other bodies delivering public services.

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 complaint handling in bodies under our jurisdiction.

Further details on our website at: www.spsso.org.uk

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