

Ombudsman's Commentary

APRIL 2009 REPORTS

Summaries of Investigation Reports

I laid eleven investigation reports before the Scottish Parliament today. Seven relate to the health sector, two to the local government sector, one to a housing association and one to the Scottish Government. As is often the case, some of the reports point up lessons which are relevant not only to the particular case but across a sector, or to providers of public services generally. Reports this month on health complaints identify issues relating to complaint handling which apply more generally and the report about a housing association picks up issues with wider application where complaints may involve insurance matters.

Case determinations

Investigation reports are public documents which we lay before the Parliament. These reports form only part of our overall work. The SPSO resolves on average 240 complaints each month. We aim to post annual statistics for the business year ending March 2009 on our website by the end of May.

Overview

Issues in health complaints

The investigations into health complaints this month touch on several issues which are recurring themes: poor nursing care and treatment, including post-operative management; inappropriate discharge from hospital; and poor communication with the family of a patient nearing the end of their life. Failings in these areas can have distressing impacts on individuals such as the patient who was left with no nutrition or fluids for 20 hours (Case ref: 200601436) and the woman who hoped to donate a kidney to her sister and received inadequate post-operative management (Case ref: 200800128).

We recognise that there are millions of NHS interactions where the care, treatment and communication are excellent. However, when things do go wrong the experience can be bewildering and frightening for patients and their relatives. Mistakes or miscommunications at a time when people are feeling vulnerable add to their distress.

People who complain are commonly motivated by a desire to seek explanations for what happened to them but also to try to stop the same thing happening to others. Most complaints to the NHS are resolved at that stage with timely, thorough and sympathetic responses. But where there are short-comings in complaint handling that compounds the distress people already feel. Reports this month illustrate several of the short-comings that can arise in complaint handling, not only in the NHS but in all areas: not having clear and up-to-date information available about how to complain (Case ref: 200800128); not having clear protocols in place for dealing with complaints made by relatives of service users (Case ref: 200600740); not obtaining information from staff involved before responding to a complaint and not addressing all issues raised (Case ref: 200602412); and not using clear and understandable language in a complaint response (Case ref: 200701701).

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overview

Housing – insurance claims

An investigation into a complaint about a Housing Association also contains wider lessons. The complainant, Mrs C, said that a faulty boiler caused soot damage requiring redecoration and the replacement of blinds and curtains. She complained that her landlord dismissed her claim for recovery of these expenses without adequately investigating the damage caused by the faulty boiler. She was also unhappy with the way her complaint had been handled. My investigation (Case ref: 200701713) partially upheld her complaint about the investigation of the damage, but not the complaint handling aspect.

I sought advice on good practice on the issue of investigating property damage claims from the Scottish Federation of Housing Associations (SFHA). I also asked them whether it was reasonable for an association to have a policy that required the tenant to prove an association's liability for damage caused before any

compensation could be paid. The SFHA advised me that there was no formal guidance or good practice on these issues. They suggested, however, that it may be prudent for housing associations to have a third party carry out independent inspections of appliances or damaged property as this would provide an impartial view. I agreed with this suggestion.

My report recommends that the Housing Association introduces a policy of seeking a determination by a third party of where liability lies in cases where a claim is for amounts higher than the Association's insurance policy excess, and for all claims that require an expert technical opinion. It also recommends that they consider asking their insurers to reinvestigate Mrs C's claim.

We receive a fair number of complaints about matters which organisations have, quite appropriately, referred to their insurers. It is important that in such cases complainants receive as full a response as they would have done if insurance issues did not arise.

case summaries

Health

Diagnosis; complaint handling

A Medical Practice (200600740) and Greater Glasgow and Clyde NHS Board (200701011)

Mrs C raised concerns about consultations her late husband had with GPs from his GP Practice and from Greater Glasgow and Clyde NHS Board's GP Out of Hours

Service. Mrs C was concerned that none of these GPs diagnosed that her husband might have had heart problems before his admission to hospital where he died following a heart attack. She was also unhappy with the way that the Practice handled her complaint to them. I did not uphold the complaints about diagnosis as I found that on each occasion the diagnosis was

reasonable given the symptoms described. I did, however, find that the Practice did not deal with Mrs C's complaint properly, and recommended that they apologise to her for this, reflect on their policy, review their complaints protocol and discuss how to respond to complaints from non-patients.

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case summaries

Health

Care and treatment; complaint handling

Greater Glasgow and Clyde NHS Board (200800128)

Mrs C, who lived in England, was hoping to donate a kidney to her sister in Glasgow. Mr C, Mrs C's husband, raised a number of concerns about the treatment his wife received both before and after the planned nephrectomy (kidney removal). The nephrectomy was started but was not completed because when the clinicians involved saw the kidney they decided it was unsuitable for transplantation. Mr C complained that the process used before the operation to identify whether the kidney was suitable was inadequate, and meant that his wife underwent an unnecessary operation. Mr C also had concerns about Mrs C's post-operative care and the way the Board handled his complaints.

I did not uphold the complaint that the process was inadequate or that the decision to abort the nephrectomy was unreasonable. I did, however, note my adviser's concerns about the level of clinical information in Mrs C's medical records, and recommended that the clinicians involved reflect on this. I upheld Mr C's complaint about inadequate post-operative management. I recommended that they apologise for this, review their discharge arrangements for surgery of this type and take steps to ensure there is appropriate post-surgery discharge planning in each

case. I also upheld the complaint about complaint handling and recommended that the Board remind staff of their obligations to manage complaints in line with the NHS complaints procedure and take action to ensure that information held in hospitals and clinics about the NHS complaints procedure is up to date.

**Patient transport;
Accident and Emergency;
care and treatment**
*Shetland NHS Board
(200601436) and Scottish
Ambulance Service (200800094)*

Mrs C, who was paralysed as a result of a stroke, lived in a care home. She was unable to speak or swallow, and received food and liquids through a feeding tube. When Mrs C's feeding tube became blocked she had to attend hospital to have it cleared. Her husband, Mr C, complained about the transport arrangements made for her, and about the care and treatment she received at the local hospital.

In particular Mr C complained that the arrival of a Scottish Ambulance Service ambulance (to take Mrs C to hospital) was delayed, and that when it arrived it could not accommodate Mrs C in her powered wheelchair. I upheld this complaint to the extent that an ambulance could have been dispatched more quickly and the delay avoided and recommended that the Service apologise for these failings. The Service have already provided more tailored options for GPs to use when requesting

ambulance services and I asked them to demonstrate that this has improved responses and the appropriateness of responses.

I upheld all Mr C's complaints about the Board. The complaints related to Mrs C's care and treatment, in particular that she had no nutrition or fluids for 20 hours, and to several issues about travel arrangements. On one occasion no arrangements were made to take Mrs C home after she attended Accident and Emergency at the local hospital; on another she was sent alone to the wrong address in a taxi and finally, initial travel arrangements made for her to attend another hospital outwith the Board area were unreasonable. I recommended that the Board send me a copy of the results of their audit of record keeping in the Accident and Emergency Department and any action taken to improve practice. I also recommended that the Board audit the Patient Travel Service to ensure that they are now requesting sufficient information to allow them to make appropriate arrangements for all patients in the Board area who need to travel. Finally, I recommended that the Board apologise to Mr C for all the failings identified.

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case summaries

Palliative care; care and treatment; staff attitude; complaint handling

Forth Valley NHS Board
(200602412)

Mrs A was admitted to hospital with breathing difficulties, but did not respond to treatment. It was decided, with the agreement of Mrs A and her family, to pursue palliative care only. Mrs A's daughter, Mrs C, raised several concerns about the care and treatment provided to her mother after that decision was taken, and about the actions of some members of staff, particularly an inappropriate conversation initiated by bed managers in Mrs A's room.

I upheld all Mrs C's complaints. I recommended that the Board apologise to Mrs C for all the shortcomings identified in my report, and particularly for the actions of the bed managers; and that the incident is discussed with both bed managers at their annual appraisals. I found that a proposal to move Mrs A to a six-bedded bay where her family were unlikely to have unrestricted access to her was inappropriate. I recommended that the Board review the operation of the Palliative Care Manual in relation to the bed management of terminally ill patients. I also recommended that the Board review their pain management documentation and recording and remind staff of the importance of documenting concerns raised by patients and their families in the patient's clinical records.

I found the adequacy and delivery of medication and a failure to review medication to be inappropriate and made recommendations including conducting an audit in prescription

chart recording over a six month period, and ensuring that night staff recognise when there is a need to contact on call staff to review medication for patients in pain. Finally I found the Board's response to Mrs C's complaint to be inadequate and that specific staff directly involved in some of the incidents reported had not been approached. I recommended that in future the Board ensure that information is obtained from the staff involved to allow complaints to be investigated appropriately and that all issues raised in complaints are addressed.

Psychiatry; discharge; care and treatment

Forth Valley NHS Board
(200603044) and A Medical Practice (200700888)

Mrs C raised a number of concerns about the psychiatric care and treatment of her late husband, Mr C, who suffered from bi-polar affective disorder. During the time of which she complained, Mr C became seriously ill and was admitted to hospital suffering from several health problems, including a toxic level of lithium in his body. I upheld Mrs C's complaint that the Board's psychiatric consultant inappropriately discharged Mr C from the Board's care. This is because I found that they did so without ensuring that Mr C was provided with the necessary support mechanisms. I recommended that the Board develop more effective and practical policies for dealing with a breakdown in doctor-patient relationships and for referring patients between services; and that they apologise to Mrs C for discharging Mr C without ensuring that necessary support mechanisms

were in place. I did not uphold complaints that Mr C's GP Practice failed to properly monitor his lithium levels, that the Board did not provide appropriate psychiatric care or that they failed to take account of Mrs C's input on Mr C's condition and requirements.

Care and treatment; complaint handling

Forth Valley NHS Board
(200701701)

Mr A was admitted to hospital after a fall. His son, Mr C, raised a number of concerns about Mr A's care and treatment between admission to the hospital and his death there several months later, and about the Board's complaint handling. I did not uphold the complaint that aspects of care and treatment fell below a reasonable standard. I did, however, find that the Board's handling of Mr C's complaint could have been better and upheld this complaint. I criticised the fact that the Board's replies used technical terms and jargon which could not be expected to mean much to Mr C. As, however the Board clearly took Mr C's complaints seriously, learned significant lessons from them and implemented a number of improvements as a result, I did not find it necessary to make any recommendations.

I did not uphold the following complaint about an NHS Board:

Failure to assess for NHS funded continuing care

Lanarkshire NHS Board
(200502797)

Relates to complaint 200600528 about the Scottish Government Health Directorates.

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Housing Associations

Liability for damage; complaints handling

Hillcrest Housing Association
(200701713)

Mrs C is the tenant of a house owned by the Association. She complained that a faulty boiler in her kitchen caused soot damage requiring redecoration and the replacement of blinds and curtains. She complained that the Association dismissed her claim for recovery of these expenses without adequately investigating the damage caused by the faulty boiler. She was also unhappy with the Association's complaints handling. I partially upheld her complaint about the investigation of the damage to the extent that the Association could have done more to investigate the source of the soot that had caused it. I recommended that the Association introduce a policy of seeking third party liability determination for compensation claims where the claim is for amounts higher than the insurance policy excess, and for all claims that require expert technical opinion; and that they consider asking their insurers to reinvestigate Mrs C's claim.

Local Government

Social Work: Complaints handling; policy/administration

West Dunbartonshire Council
(200700058)

Mr C raised a number of concerns with the Council's Social Work Department about the care provided to his uncle. Mr C pursued this through the Council's complaints procedure and, as he

remained unhappy, requested that a social work Complaints Review Committee (CRC) hear his complaint. He complained to me that the Council then delayed unreasonably in holding the CRC. I upheld his complaint as I found that it took a long time to actually achieve a meeting (ultimately it did not take place until more than eleven months after his original request). I recommended that the Council apologise to Mr C and ensure that, in future, any extension to the statutory time limits is agreed with the complainant(s). I also recommended that the Council review their procedures to ensure that in future CRC membership is kept up to date at all times; and as part of that review consider whether there is a need to provide specific literature on the complaints procedure to those complaining about social work issues.

Education: Access to services; complaints handling

West Lothian Council
(200601783)

Mr C's son, Child C, has special educational needs and attends a secondary school in the Council's area. Mr C raised concerns over the way the Council's Education Department (the Department) handled his grievance with the School about adjustments to Child C's second year timetable, and the Chief Executive's handling of his formal complaint. I did not uphold his complaint that the Department failed to intervene appropriately to resolve the issue of Child C's timetable choices. I partially upheld the complaint that they failed to tell Mr C that he was entitled to access mediation services, to the extent that information about how to

access these services was not readily and clearly accessible to him. I recommended that the Council review staff awareness of the Mediation Service and related leaflet and that they apologise to Mr C for not telling him about how to access the Mediation Service and for not expediting mediation when he requested it. I upheld the complaint about the Chief Executive's response, as I found that it was not comprehensive, and recommended that the Council also apologise for this.

Scottish Government and devolved administration

I did not uphold the following complaint:

Policy/administration; NHS funded continuing care

Scottish Government Health
Directorates (200600528)

Relates to complaint 200502797
about Lanarkshire NHS Board.

Compliance & 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.

Eric Drake, Acting Ombudsman
22 April 2009

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

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SPSO

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 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.

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