

# Ombudsman's Commentary

## FEBRUARY 2011 REPORTS

The SPSO laid two investigation reports before the Scottish Parliament today. They both relate to the health sector.

### Case numbers

Last month, January 2011, in addition to the three investigation reports laid before the Parliament, we **determined 292 complaints and handled 57 enquiries**. Taking complaints alone, we:

- gave advice on 205 complaints
- resolved 69 in our early resolution team
- resolved 15 by detailed consideration
- made a total of 23 recommendations in decision letters (some of these are listed at the end of this Commentary).

### Ombudsman's Overview

There are two health reports laid today. I hope that the people who brought the complaints can take some comfort from the knowledge that their concerns have been thoroughly investigated and that they have got some of the answers they sought. The health boards concerned have accepted my recommendations, which aim to ensure that there is no recurrence of the problems that caused such distress and pain.

I made twelve recommendations to one board following my investigation into the care of a man who died after absconding from an intensive psychiatric care unit. The recommendations covered a wide range of areas including the transfer of patients under a Compulsory Treatment Order; decisions taken about patients' leave and escort arrangements, and nursing care. The most critical of the failings I identified in relation to the man's care and treatment after he returned to the unit was that nursing staff failed to undertake even the most basic of observations in terms of taking and charting respirations, vital signs, level of consciousness and vital stimuli. As I state in the report 'I believe it is imperative that the Board and all those involved in Mr A's care that night consider carefully the failures to ensure that a similar situation does not recur'.

### Service improvements

As part of our ongoing commitment to improving our service, we have reviewed two SPSO policies that relate to how people use our complaints process. The reviews build on work we have already undertaken to improve our communication and accessibility, including gaining the Crystal Mark 'Plain English' standard on our website and many SPSO leaflets. We are also working to ensure that our written communication to complainants and service providers is of a consistently high quality. To this end, all our investigative staff will have refresher training in 'Plain English' over the next several weeks. The two recent reviews are detailed below.

**Service standards:** our commitment is that we will do our best to follow the seven principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership). These are sometimes referred to as the 'Nolan principles'. Based on these, we make commitments about how we will treat people who use our service; how we will stay in contact with them and communicate with them; and how we will meet their accessibility needs. For more information, visit <http://www.spsso.org.uk/about-us/our-service-standards>.

**Unacceptable actions policy (UAP):** we want to deal with the people who use our service professionally, with respect and in line with our service standards. We also expect users of our service to treat our staff and the service we provide with respect. Our UAP explains how we manage unacceptable behaviour against our staff. The aim of this policy is to make our service as accessible as possible whilst protecting and supporting staff, and helping them to identify and manage unacceptable behaviour or actions proportionately and effectively. We have made some changes to our UAP, and these are explained in full at <http://www.spsso.org.uk/media-centre/news-releases/spsso-unacceptable-actions-policy-reviewed>.

For a copy of the UAP, or of our service standards leaflet, call our Freephone advice line number: 0800 377 7330.

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case reports

## Health

### Hospital transfer; clinical treatment; nursing care; policy/administration

Tayside NHS Board (200900775)

Mr A, who had mental health problems, was a patient in an Intensive Psychiatric Care Unit (IPCU). He had been transferred there, against his mother's wishes, from a unit in another city, where he was being treated under a Compulsory Treatment Order (CTO). Mrs C (Mr A's mother and his 'named person') was unhappy about the transfer and had expressed to the Board her concern that as the IPCU was closer to home, the transfer carried an increased risk of access by Mr A to people and situations that could involve illicit substances, and an increased risk that he might abscond.

She also complained that, when in the IPCU, Mr A was granted a period of escorted leave within the vicinity of the building, from where he was able to abscond. When Mr A returned to the IPCU that same evening, he admitted taking drugs and was medically examined. Staff were told to monitor him overnight. Mr A was, however, found dead in the early hours of the morning. It was found that he had concealed a bag of heroin within his body, and that the bag had burst. Mrs C complained that the physical care and treatment provided to her son on his return to the IPCU was inadequate.

I upheld all of Mrs C's complaints. I found that the Board's decision making processes to transfer Mr A from the Unit to the IPCU were unclear and that the decision to allow him escorted leave from the IPCU was inappropriate. I also found that Mr A's physical care and treatment was inadequate on his return to the IPCU. I recommended that the Board

apologise to Mrs C for the failures identified in my report. I also recommended that they carry out an urgent review of procedures for transfer of patients under a CTO, ensure that where there is a statutory right of appeal against a transfer decision, the appropriate people are told about that right, and that every consideration is given to allow the named person's views to be formally considered and recorded.

I further recommended that decisions about approved leave are recorded and properly explained to the patient and their relatives; that the Board review escort arrangements and that they consider introducing a system in the IPCU to quickly alert staff within the building when a patient absconds. Finally I made a number of recommendations relating to Mr A's care and treatment. These included that the Board provide training to ensure adequate medical examination, nursing observation and assessment of vital signs within the IPCU, when managing a patient recently having consumed an illicit substance; and that they review the procedure for referring a patient to the local Accident and Emergency Department in these circumstances. I also recommended that the Board conduct an audit of assessment tools, remind all staff of their professional responsibilities towards the care and treatment of a patient, and ensure that my report is shared with all staff involved in Mr A's care on the night he died, so that they can learn from its findings.

### Clinical treatment

Grampian NHS Board (201001566)

Mrs C had been diagnosed with lung cancer and was attending hospital as a day patient for chemotherapy treatment. While there, she fell and hurt her hip. She was examined immediately and an x-ray taken. The on-call doctor who examined the x-ray said there was no sign of fracture and she was discharged home. Four days later, the consultant oncologist called Mrs C and said that he had reviewed the x-ray and had identified a fracture. She was admitted to hospital that day but her condition deteriorated and she died four days later. Her husband, Mr C, complained that the care and treatment of Mrs C was inadequate. He felt that the fracture contributed to his wife's death and that staff had been negligent in allowing her home in the circumstances. After taking advice from two of my professional medical advisers, I upheld Mr C's complaint. I found that, although the care pathway and treatment for cancer was exemplary, the x-ray showed a fracture that could and should have been diagnosed from it. The result was that Mrs C was sent home in pain which caused unnecessary distress to her and her family. I recommended that the Board bring this report to the attention of the on-call doctor's clinical supervisor and determine whether there is a training requirement for the interpreting of x-rays. I further recommended that the Board formally apologise to Mr C for the on-call doctor's failure to correctly interpret the x-ray.

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## Recommendations made in decision letters in January 2011

### Recommendations to Councils

- that a Council take steps to ensure staff are made aware of the Council's complaints procedure and, in particular, of the expected time to deal with correspondence at each stage of the complaints process and the importance of providing updates
- that a Council remind staff within their Revenue and Benefits Department of the importance of recognising, recording and responding to letters of grievance
- that a Council incorporate into any guidance on collecting outstanding council tax that, where an error on the Council's part has led to an outstanding amount, they consider the individual circumstances of the case and, if necessary, be flexible with their normal practice
- that a Council make an ex-gratia payment to a complainant to recognise the time, effort and trouble to which they were put in getting problems with a council tax account addressed
- that a Council apologise to a complainant for unacceptable delays in progressing planning enforcement action, and for failing to follow their own procedures or national guidance, in response to complaints of alleged breaches of planning control
- that a Council review their planning enforcement procedure and include:
  - indicative timescales in the "Acting on breaches of planning control" section,
  - clear definition of the stages of the procedure,
  - the need for clear recording of progress at each stage and decisions reached, and
  - the need to communicate these decisions to relevant interested parties
- that a Council identify all outstanding issues in a complainant's case, and set and adhere to a reasonable timescale for responding
- that a Council consider developing a procedure for escalating operational matters when it becomes clear that deadlines may not be met

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### Recommendations to Health Boards

- that a Board ensure that clinicians complete incident reporting forms when there is an example of unexpected behaviour which may be referred to in any correspondence or clinical notation
- that a Board send the SPSO a copy of their fall and fracture prevention policy when it has been introduced
- that a Board remind nursing staff at a hospital that insertion of hearing aids should be normal practice
- that a Practice devise and implement a system to ensure that referrals and other actions decided by locum GPs are undertaken
- that a Practice apologise to a complainant that their response to his complaint was not reasonable
- that a Practice review their complaints procedure to ensure that responses provide a full, proportionate and clear response that represents their definitive position, and consider including a requirement to ensure they understand the complaint
- that a Practice put in place a regular review of their complaints handling to ensure responses have provided a full, honest, proportionate and clear response that represents their definitive position

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### Recommendations to Housing Associations

- that a Housing Association apologise to a complainant for failing to provide a full response to her enquiry
- that a Housing Association put procedures in place for staff to follow when considering whether there may have been a breach of tenancy

# Ombudsman's Commentary

## 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.

**Jim Martin, Ombudsman, 16 February 2011**

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**

Head of Policy and External Communications: **Emma Gray**

Tel: **0131 240 2974** Email: [egray@spsso.org.uk](mailto:egray@spsso.org.uk)



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, prisons, 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](http://www.spsso.org.uk)

Contact us at:

<b>SPSO</b>	Tel: <b>0800 377 7330</b>
<b>4 Melville Street</b>	Fax: <b>0800 377 7331</b>
<b>Edinburgh EH3 7NS</b>	Text: <b>0790 049 4372</b>