SPSO NEWS

November 2015

Monthly news from the Scottish Public Services Ombudsman

This month we are laying three investigation reports about the health sector before the Scottish Parliament, and 68 decisions about all of the sectors under our remit. These can be read on our website at www.spso.org.uk/our-findings.

Case numbers

Last month (in October), we received 426 complaints. We determined 448 complaints and of these we:

- gave advice on 240 complaints
- considered 124 complaints at our early resolution stage
- decided 84 complaints at our investigation stage

We made a total of 140 recommendations.

Ombudsman Overview

Two of today's reports concern mental illness. The main recommendations I make are for reviews of a range of procedures, assessments and tools that in these two cases were not used properly by the health professionals involved. The investigations and findings provide wider learning, both for hospitals that specialise in psychiatric care and for A&E departments of general hospitals in their care for people presenting with mental as well as physical illness.

One complaint (case 201401377) was from the parents of a man who committed suicide after absconding from hospital. He had paranoid schizophrenia and a history of self-harming and attempting suicide. I found failings in the risk assessment carried out, and also criticised other aspects of his care and treatment at the hospital. I also found that the man's parents' needs were not examined. They played an essential role in supporting their son and were entitled to a carer's assessment. The assessment would have explored how much choice they had in their provision of care, and the impact on them, including their health, domestic needs and relationships.

The other investigation (case 201404087) was into delay in providing a psychiatric assessment of a woman who was taken to an A&E department after having a

psychotic episode. Her condition deteriorated during this delay and she was later restrained by the police and detained under mental health legislation. I found that the care and treatment provided in the hospital were inadequate, and also upheld the complaint about how the board handled the initial complaint.

In another investigation (case 201405009) I am critical of the standard of care provided to a man with lung cancer and several other conditions and who was terminally ill, after his admission to hospital. I obtained independent advice from a nursing adviser on this case, which identified a number of serious failings, amounting to unacceptable and poor practice. Nursing staff failed in their duty to appropriately assess, monitor and alleviate the man's pain, and my adviser also considered that written statements from the nurses concerned showed a lack of compassion for the man's situation and feelings. I made several recommendations, including a review of nursing in the ward to explore issues of leadership and culture.

Annual letters and annual report

In October we sent **annual letters** to all local authorities, health boards, the Scottish Prison Service and the water providers we receive complaints about. The letters contain statistics about complaints to us about each organisation in 2014-15, and show how the authority's rate of premature complaints and upheld investigations compared with the average for their sector. The SPSO complaints statistics and the learning from our recommendations are part of the detailed complaints picture that authorities are responsible for gathering, publishing and using to improve their services. **The letters are available on our website**.

We also laid our 2014-15 **Annual Report** before the Parliament. It charts another year of achievement for the SPSO. We handled a record number of complaints, and further improved our productivity and the quality of our service. The report also highlights our work on improving complaints handling across Scotland, and records my thanks to the many organisations and individuals who have helped us. **The Annual Report is available on our website (PDF, 528KB)**

SPSO sounding boards

Two of our three sounding boards met during the last month. These were the local authority and customer sounding boards, and both meetings involved constructive discussions on a wide range of issues, including the financial challenges councils and the third sector are facing; updates on Scottish Welfare Fund reviews; health and social care integration complaints; the Government's NHS complaints working group and research we are carrying out into financial redress. **Membership and minutes of previous meetings are available on our website.**

Finally, I would like to draw attention again to our two current consultations.

Scottish Welfare Funds review consultation

This will help inform the way we will approach and manage reviews about welfare fund decisions. **The full consultation can be found on our website,** and is open until 27 November.

SPSO Draft Strategic Plan consultation

This lays out the key challenges and opportunities we foresee over the next four years and how we are preparing for them. **The full consultation can be found on our website,** and is open until 18 December.

As well as our usual **Complaints Standards Authority update**, there is information about **a new training course.**

Investigation Reports

Investigation report ref: 201401377

Risk assessment; record-keeping; care and treatment

Fife NHS Board

Mr C complained to the Ombudsman about the standard of care provided to his son (Mr A) in the community and in Stratheden Hospital, where he was taken by his parents in a moment of crisis. Mr A had been diagnosed several years previously with paranoid schizophrenia, and he had a history of self-harming and attempting suicide. Mr A was admitted to hospital, but absconded within hours and was found dead on a nearby railway line. Mr C believed that Mr A's suicide risk was not properly assessed on admission, and that actions were not taken that could have ensured his safety.

I obtained independent advice from a mental health nursing adviser and a consultant psychiatrist adviser. Both advisers noted the risk assessment in Mr A's medical records that was done when he was admitted to hospital. They said that the form was unsigned and that important sections were either left blank or completed without much detail. The form did, however, record Mr A's history of self-harm, suicide attempts and absconding behaviour. Both advisers said that the assessment should have been collaborative, including Mr A, his parents and all involved staff. It also should have assessed and discussed the many known factors that increased Mr A's risk of serious self-harm or suicide. As this was not the case, my advisers considered that this risk assessment was inadequate, and I agreed.

Further to this, on the day after admission, a doctor began the process to detain Mr A under a Short Term Detention Certificate. My adviser on mental health noted that this showed the doctor must have considered Mr A to be a significant risk to himself, yet did not ensure that Mr A was under constant observation from that time. Both advisers considered this to be unreasonable. They said that Mr A's detention was not recorded in his notes so it was not clear if nursing staff knew about the decision to detain him. My adviser on mental health was also concerned that Mr A was able to leave the ward and hospital without staff realising, which was unreasonable.

Given the advice received, I considered that the care and treatment provided to Mr A in the hospital was below a reasonable standard. I upheld the complaint and made several recommendations.

Mr C also complained about the medical care and treatment provided to Mr A in the community. The advice I received is that Mr A's care package was appropriately

planned and delivered, and his needs were met. However, the needs of his parents, who played an essential role in supporting him, were not examined. Mr C and his wife would have been entitled to a carer's assessment, which would have explored how much choice they had in their provision of care, and the impact on them, including their health, domestic needs and relationships. I considered this to be unreasonable. I therefore upheld the complaint and made recommendations.

Investigation report ref: 201404087

Psychiatric assessment; record-keeping; complaints handling

Lanarkshire NHS Board

Miss C, who had a previous history of mental illness, had a psychotic episode and was taken by ambulance in the early hours of the morning to the emergency department at Wishaw General Hospital. An initial mental health assessment was carried out identifying that she was seriously unwell and should be assessed by a doctor as soon as possible. However, she was not assessed for over three hours. A junior doctor examined her, took blood tests and contacted the on-call psychiatrist for advice. The psychiatrist said that out-patient follow-up may be the best option and that they would review Miss C after her blood tests were done. A couple of hours later, Miss C's parents were told that she was being admitted to the hospital for assessment. However, Miss C was agitated, received sedation and was restrained by the police. Later that morning her parents were told that she had been detained under mental health legislation. She was transferred to Monklands Hospital as there were no beds available.

Miss C’s mother (Mrs C) complained that if Miss C had initially been properly assessed by a psychiatrist and admitted to Wishaw General Hospital, then the police would not have become involved and she would not have been detained.

As part of my investigation of Mrs C's complaint, I obtained independent advice from advisers in emergency medicine and psychiatry. My adviser in emergency medicine considered that the triage nurse in the emergency department had appropriately assessed Miss C. He said that the delay in assessment by a doctor was not ideal but, unfortunately, was not unusual in a busy emergency department at night. My adviser found that the junior doctor's assessment was thorough and of a good standard, but that the junior doctor failed to recognise the severity of Miss C's illness. Due to a lack of detail in Miss C’s records, my emergency medicine adviser could not state definitively that she required hospital admission but, in his opinion, it was highly likely that she did. He said that the junior doctor should have questioned the advice of the on-call psychiatrist and insisted on an urgent psychiatric assessment in the emergency department, escalating this to a consultant if the request was refused. He also said that when Miss C's condition deteriorated and three doses of sedatives were required, she should have been thoroughly re-assessed.

My psychiatric adviser considered that Miss C's psychiatric assessment was unduly delayed and that her condition was allowed to deteriorate during this delay. He said that it had been unreasonable for the on-call psychiatrist to say that out-patient

follow-up may be the best option for Miss C, and he also considered that the standard of note-keeping was inadequate. In view of all of these failings, I upheld this aspect of Mrs C's complaint and made recommendations.

Mrs C also complained that the board's handling of her complaint was inadequate. Having carefully considered their initial response to her complaint, I do not consider that it was an adequate response to the issues she had raised about Miss C's treatment, as they failed to show how these had been investigated. After this, Mrs C met staff from the board, then wrote to them. The board's response again did not acknowledge their failings or address all of Mrs C's concerns about Miss C's treatment in the emergency department. Therefore, I also upheld this aspect of the complaint.

Investigation report ref: 201405009

Nursing care; staff attitude; clinical treatment

Borders NHS Board

Mr A was admitted to Borders General Hospital with a heavy nose bleed and in considerable pain. He had lung cancer and several other medical conditions, and he was terminally ill. Mr A was initially admitted to the emergency department and then transferred to the medical assessment unit (MAU). Mr A's partner (Ms C) said that there were a number of failures in the care and treatment Mr A received in hospital. She complained that the bedside oxygen equipment did not work, that Mr A was not given adequate pain relief or his own medication, and that he was shown a lack of compassion by nursing staff. She said that Mr A discharged himself from hospital the day after his admission because of the poor care and treatment he had received, and so that he could receive the medication he needed. He died at home three days later.

I obtained independent advice from a nursing adviser and a medical adviser who is a hospital consultant in acute internal medicine. Ms C complained that the medical treatment Mr A received in hospital was unreasonable. My medical adviser noted that the failure of the oxygen equipment in the emergency department would have increased Mr A's feelings of distress. The board said they had already made changes to ensure that equipment was checked more often, so I asked to see evidence of this. I also asked to see evidence of the other positive action the board said they had made following Ms C's complaint. This was to make sure that patients arriving in the MAU were assessed within sixty minutes, whereas Mr A's medical review took place over two hours after arriving on the ward.

My medical adviser said that there was no record of a pain assessment in the emergency department though, on arrival in the MAU, Mr A was assessed as experiencing severe pain. My adviser considered that pain relief should have been provided earlier in the emergency department. There was also no record of pain assessment overnight in the MAU. The advice I have received is that Mr A, who was in acute pain and terminally ill, appears to have received inadequate pain control and was left in pain for considerable periods. I noted my medical adviser's comment that he could imagine Mr A's frustration at having been left in pain. In his view, this led Mr A to discharge himself from hospital, leaving his symptoms untreated and with no investigation into the cause of his pain. Therefore, he was potentially put at significant risk of harm or death. I upheld the complaint and made several recommendations.

The nursing advice I received identified a number of serious failings in Mr A's nursing care and found that, overall, the nursing care Mr A received in the MAU was unacceptable and poor practice. My nursing adviser found that nursing staff had failed in their duty to appropriately assess, monitor and alleviate Mr A's pain and did not appear to have followed Nursing and Midwifery Council Standards regarding the prescribing of pain relief medication to Mr A. My nursing adviser considered that Mr A must have been frustrated not to have had his severe pain relieved despite having his own pain relief medicines with him, which he should have been allowed to self-administer. My adviser also considered that written statements from the nurses involved in Mr A's care showed a lack of compassion for, or understanding of, his situation and feelings. I am critical of the board for these failings and the lack of compassion shown to Mr A. I am concerned that he had such a painful and distressing experience, and I also acknowledge the upset and distress this has caused to Ms C. I upheld this complaint and made the following recommendations.

Complaints Standards Authority (CSA)

NHS

We continue to work closely with the Scottish Government and NHS Scotland to plan for the development of the revised NHS model complaints handling procedure (CHP). A project steering group was formed with a supporting project and governance structure. Three sub-groups will lead the development work in key areas (drafting of a model CHP and associated documents; recording and reporting; and training and learning), with each sub-group reporting on progress to the steering group. All key stakeholders, including users, will be involved in this process. The current plan is for the NHS model CHP to be published in 2016 and implemented from April 2017.

Integration of Health and Social Care

Further to our previous update, we would remind readers that the Scottish Government is currently running a consultation to seek views on the draft Order to revise the procedures for complaints about social work. This consultation seeks views on the draft Order to amend the Scottish Public Services Ombudsman Act 2002 to allow the SPSO to investigate complaints in relation to the substance of social work decisions. The draft order also proposes to amend the Public Services Reform (Scotland) Act 2010 in relation to the sharing of information by the Care Inspectorate with the SPSO; and amend the Social Work (Scotland) Act 1968 to abolish the existing system of local authority social work complaints and allow a model complaints handling procedure prepared by the SPSO to be introduced. The consultation runs until 14 December.

Local Government

The local authority complaints handlers network met in October in Glasgow. The main theme was 'learning from complaints', with case studies being presented by three councils to demonstrate learning as a result of complaints.

The network also enjoyed a presentation from the Improvement Service communicating their early findings in relation to complaints handling performance across the sector in Scotland. Encouragingly, the complaints handling performance of councils is largely similar to the previous year, with improvements on performance being noted against some of the indicators. Key findings included 81% of complaints being closed at stage 1 of the CHP with improvements in the time taken to handle complaints being evident across the sector.

Further Education

The first phase of work to consider standardised complaints categories has been delivered by the City of Glasgow College. This takes account of feedback from colleges regarding the categories they currently use, and presents a proposed set of standardised categories for the complaints advisory group to consider. This proposal, together with work on customer satisfaction with the complaints procedure and the annual complaints performance of the sector, will be considered by the group.

Housing

The housing complaints handlers network hopes to meet in January where it will have the opportunity to consider the complaints handling performance over the previous two quarters.

Further information on the role of the network, including details of how you may join, can be obtained from anne.fitzsimons@tollcross-ha.org.uk.

For all previous updates, and for more information about CHPs, visit our dedicated website **www.valuingcomplaints.org.uk**.

SPSO Training Events

We have a new course available on **Managing Difficult Behaviour.**

Who should attend?

Staff who might receive negative feedback from the public or other stakeholders.

What does it cover?

- why people complain and what they want to achieve by complaining
- how people react in situations of conflict and how this can give rise to behaviours that cause problems
- ways to de-escalate potential complaints and look at what can go wrong when concerns are responded to badly
- how an unacceptable actions policy (or equivalent) can be helpful in dealing with situations which become difficult

Participants will be given an opportunity to assess their own conflict styles and develop ways of managing their own personal 'triggers'. We will consider a number of different theories and tools that can be helpful in managing conflict. The session will include a number of opportunities to put theory into practice, and participants will be able to discuss their own particular concerns.

For details on cost and location, and to apply for the course, please email training@spso.org.uk

We have more information about courses that we can offer to organisations in our flyer: **SPSO Training 2015 (PDF, 40KB)**

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.

Jim Martin, Ombudsman, 18 November 2015

The compendium of reports can be found on our website: http://www.spso.org.uk/our-findings

For further information please contact:
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The 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 for handling complaints about councils, housing associations, the National Health Service, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities.

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

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 complaints handling in bodies under our jurisdiction.

Communications team: T 0131 240 8849

SPSO website: www.spso.org.uk

Valuing Complaints website: www.valuingcomplaints.org.uk

Contact us: T 0800 377 7330 www.spso.org.uk/contact-us