

Table 1

## Lothian NHS Board Area

Complaints Received by Subject		A Dentist or Dental Practice	A GP or General Medical Practice	A Pharmacist or Pharmacy	Lothian NHS Board	Lothian NHS Board - Acute Division	Lothian NHS Board - Lothian University Hospitals Division	Lothian NHS Board - Royal Edinburgh and Associated Services Division	Lothian NHS Board - University Hospitals Division	Lothian NHS Board Area Total	Complaints as % of total	Sector Total	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	0	1	0	0	0	0	1	1%	15	2%
	Appliances, equipment & premises	0	0	0	0	0	0	0	0	0	0%	1	0%
	Appointments/admissions (delay, cancellation, waiting lists)	1	1	0	10	0	0	0	0	12	9%	48	6%
	Clinical treatment/diagnosis	9	14	1	36	10	5	1	1	77	59%	413	48%
	Communication, staff attitude, dignity, confidentiality	1	7	0	7	2	0	0	0	17	13%	91	11%
	Complaints by NHS staff	0	0	0	0	0	1	0	0	1	1%	2	0%
	Complaints handling	0	0	0	0	0	0	0	0	0	0%	20	2%
	Continuing care	0	0	0	1	0	0	0	0	1	1%	1	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0	0	0	0	0	0	0%	6	1%
	Hygiene, cleanliness & infection control	0	0	0	0	0	0	0	0	0	0%	6	1%
	Lists	0	2	0	0	0	0	0	0	2	2%	7	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0	0	0	0	0	0	0%	1	0%
	Nurses/nursing Care	0	0	0	0	0	0	0	0	0	0%	10	1%
	Other	0	0	0	1	0	0	0	0	1	1%	2	0%
	Policy/administration	0	2	0	12	2	0	0	0	16	12%	156	18%
	Record keeping	0	0	0	0	0	0	0	0	0	0%	7	1%
	Out of jurisdiction	0	0	0	0	0	0	0	0	0	0%	3	0%
	Subject unknown	0	0	0	2	1	0	0	0	3	2%	68	8%
	<b>Total</b>	<b>11</b>	<b>26</b>	<b>1</b>	<b>70</b>	<b>15</b>	<b>6</b>	<b>1</b>	<b>1</b>	<b>131</b>		<b>857</b>	
	2010-11	Admission, discharge & transfer procedures	0	0	0	0	0	0	0	0	0	0%	9
Appliances, equipment & premises		0	1	0	0	0	0	0	0	1	1%	5	1%
Appointments/Admissions (delay, cancellation, waiting lists)		0	3	0	3	0	0	0	1	7	6%	35	4%
Clinical treatment / Diagnosis		3	4	0	24	1	0	5	9	46	37%	402	45%
Communication, staff attitude, dignity, confidentiality		0	2	0	4	2	0	0	0	8	7%	64	7%
Complaints handling		0	0	0	4	1	0	0	0	5	4%	27	3%
Continuing care		0	0	0	1	0	0	0	0	1	1%	3	0%
Failure to send ambulance/delay in sending ambulance		0	0	0	0	0	0	0	0	0	0%	1	0%
Hotel services - food, laundry etc		0	0	0	2	0	0	0	0	2	2%	4	0%
Hygiene, cleanliness & infection control		0	0	0	0	0	0	0	0	0	0%	1	0%
Lists (incl difficulty registering and removal from lists)		0	5	0	1	0	0	0	0	6	5%	20	2%
Nurses / Nursing Care		0	0	0	0	1	0	0	0	1	1%	13	1%
Other		0	0	0	1	0	0	0	0	1	1%	8	1%
Policy/administration		0	2	0	14	3	0	1	3	23	19%	143	16%
Record Keeping		1	0	0	0	0	0	0	0	1	1%	10	1%
Out Of Jurisdiction		0	0	0	1	0	0	0	0	1	1%	1	0%
Subject Unknown		0	1	0	12	7	0	0	0	20	16%	142	16%
<b>Total</b>	<b>4</b>	<b>18</b>	<b>0</b>	<b>67</b>	<b>15</b>	<b>0</b>	<b>6</b>	<b>13</b>	<b>123</b>		<b>888</b>		

Table 2

## Lothian NHS Board Area

Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	An Optician or Ophthalmic Services	A Pharmacy or Pharmacist	Lothian NHS Board	Lothian NHS Board - Acute Division	Lothian NHS Board - Royal Edinburgh and Associated Services Division	Lothian NHS Board - Lothian University Hospitals Division	Lothian NHS Board Area Total	Sector Total
2009-10	Discontinued before investigation	2	4	0	1	18	2	0	0	27	176
	Discretionary decision not to pursue	0	0	0	0	0	0	0	0	0	1
	Other	0	0	0	0	0	0	0	0	0	7
	Out of jurisdiction	1	2	0	0	6	1	0	0	10	60
	Premature	3	5	0	0	20	9	0	1	38	319
	Determined after detailed consideration	4	20	0	0	29	0	0	0	53	314
	Report issued: fully upheld	1	0	1	0	6	0	0	0	8	33
	Report issued: not upheld	0	0	0	0	0	0	0	0	0	9
	Report issued: partially upheld	0	1	0	0	4	0	0	0	5	32
	<b>Total</b>	<b>11</b>	<b>32</b>	<b>1</b>	<b>1</b>	<b>83</b>	<b>12</b>	<b>0</b>	<b>1</b>	<b>141</b>	<b>951</b>
2010-11	Premature	0	4	0	0	25	3	0	2	34	260
	Out of Jurisdiction	0	0	0	0	8	4	1	3	16	59
	Outcome Not Achievable	0	1	0	0	1	1	0	3	6	25
	No Decision Reached	2	3	0	0	16	5	2	0	28	268
	Fully Upheld	1	1	0	0	7	2	0	1	12	65
	Partly Upheld	2	0	0	0	6	0	0	2	10	50
	Not Upheld	2	6	0	0	4	1	1	7	21	113
	<b>Total</b>	<b>7</b>	<b>15</b>	<b>0</b>	<b>0</b>	<b>67</b>	<b>16</b>	<b>4</b>	<b>18</b>	<b>127</b>	<b>840</b>

Lothian NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
19/05/2010	200802971	(a) the ECG performed by the ambulance crew was not available to or checked by the Department doctor (upheld); and (b) apart from an ECG, no other investigations were undertaken on Mr A when he arrived at the Hospital and local protocols and Scottish Intercollegiate Guidelines Network guidelines for patients presenting with chest pain were not adequately followed (not upheld).	partially upheld	(i) review their current communication methods between ambulance staff and clinical staff (both verbally and documentary) in respect of patients who are admitted to the Department; (ii) remind clinical staff of the importance of ensuring that all ECGs are available for review by clinical staff for patients presenting with chest pain; that their findings are documented in the patient's clinical records; and the Board's audit procedures in relation to ECG sign off are followed; (i) remind staff of the importance of seeking details of any family history of heart problems from patients presenting with chest pain and documenting this in the clinical records; and (ii) apologise to Mrs C for the failings identified in this report.  The Board have accepted the recommendations and will act on them accordingly.
19/05/2010	200901774	(a) failed to prevent a male patient from entering Mrs A's room on a number of occasions (not upheld); (b) failed to explain what action they had taken to prevent a recurrence, when responding to the complaint (upheld); (c) inappropriately continued to barrier nurse Mrs A, despite a negative stool specimen being provided on 26 May 2009 (not upheld); and (d) stated, in response to Mrs A's complaint, that she was moved to Ward 17 for further assessment, whereas Mrs A had understood that she was simply being moved there because it was a safer environment (not upheld).	partially upheld	(i) ensure that, in future complaint responses, they provide complainants with information regarding the action they intend to take to prevent recurrence of any problems identified; and (ii) consider Adviser 1 and Adviser 2's comments at paragraph 18 and revise their action plan in order to ensure that it is comprehensive.
23/06/2010	200901758	(a) the Board's actions in relation to obtaining consent from Ms C for the removal of her left fallopian tube during a laparoscopic adhesiolysis and left salpingostomy were unsatisfactory (upheld); and (b) the Board delayed in responding to Ms C's complaints (upheld).	upheld	(i) apologise to Ms C for the decisions taken to carry out additional surgery without her clear understanding of the potential outcomes; (ii) ensure elective surgical consent forms are clearly set out and appropriately understood and signed by the patient or their representative; (iii) apologise to Ms C and her representative for the delays experienced in the handling of their complaint; and (iv) ensure the revised internal complaints procedure provides all the necessary components set out in the NHS complaints procedure to guarantee a consistent approach to complaint handling within the Board.  The Board have accepted the recommendations and will act on them accordingly.
23/06/2010	200901866	(a) there was a delay in Mr C receiving appropriate care following his initial assessment (not upheld); (b) child protection issues were not reported for a two week period, contrary to guidance, and that Mr C was not offered appropriate support (upheld); and (c) there was a delay in responding to Mr C's complaint (not upheld).	partially upheld	write to Mr C acknowledging that the Community Mental Health Nurse Therapist should have acted sooner on the issue of child protection and apologising to him for the delay in doing so.  The Board have accepted the recommendation and will act on it accordingly.
23/06/2010	200902581	(a) the decision to discharge Mr A was inappropriate (upheld); and (b) the complaints handling and information provided was inadequate (upheld).	upheld	(i) undertake an audit of the action plan and provide him with details of the outcome; (ii) satisfy themselves that the transfer of records between hospitals and Board areas is being carried out quickly and efficiently; (iii) review their complaints procedure and related guidance to staff, in order to ensure that complainants are provided with a full response supported by staff statements and records; (iv) ensure, when investigating complaints, that documentation is kept of interviews and key actions; and (v) apologise to Ms C and Ms D for the failings identified in this report.  The Board have accepted the recommendations and will act on them accordingly.
21/07/2010	200901871	(a) there was an unacceptable delay between referral for surgery and being offered an appointment (upheld); and (b) the Board failed to provide a clear and consistent explanation for the delayed appointment (upheld).	upheld	(i) write to Mr C to apologise for their failure to provide him with surgery within their own targets of 12 weeks from referral; (ii) write to Mr C to apologise for their failure to provide him with an explanation for the delay in offering him an accurate date for surgery within their target period and also their failure to adhere to their 'guaranteed' date for surgery of 18 September 2009; and (iii) review the way they carry out and monitor referrals for surgery.  The Board have accepted the recommendations and will act on them accordingly.

Lothian NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
18/08/2010	200900395	(a) Miss C's pain was managed inappropriately (upheld); and (b) the standard of record-keeping was inadequate (upheld).	upheld	(i) review their systems for ensuring that patients' pain is properly assessed in Accident and Emergency and on the gynaecology ward and that patients' needs are met with timely pain management, and provide copies of audits regarding pain assessment and management. The review should consider triage arrangements for patients directly referred by their GP and also initiatives for meeting patients' needs if medical staff are not readily available to prescribe pain relief; (ii) ensure that, when handling complaints, all complainants' concerns are addressed and that responses refer to relevant standards and guidelines where appropriate; (iii) apologise to Miss C for their failure to manage her pain appropriately and for not fully addressing this issue when responding to her complaint. The apology should also acknowledge the inappropriate reference to Miss C using her mobile telephone; and (iv) provide evidence that appropriate strategies are in place to ensure that all nursing records meet the standards outlined by the Nursing and Midwifery Council.  The Board have accepted the recommendations and will act on them accordingly.
22/09/2010	200901459	(a) the diagnosis provided by the Board was not reasonable (upheld); and (b) the care provided in Hospital 1 was inadequate (upheld).	upheld	(i) should give consideration to implementing the Ottawa knee decision rules when assessing A&E patients if these are not already in place; (ii) should apologise for the shortcomings in the care provided which are highlighted in this report; and (iii) devise/review their pain management guidelines and ensure that all A&E clinical staff are aware of the guidelines.  The Board have accepted the recommendations and will act on them accordingly.
22/12/2010	200904074	the Board failed to: (a) provide Mr A with proper nutrition (upheld); (b) provide Mr A with general personal care (upheld); (c) take action to prevent bedsores (not upheld); (d) provide any form of stimulus to Mr A as a patient suffering from Alzheimer's disease (upheld); and, (e) communicate adequately with the family (upheld).	partially upheld	(i) make a written apology to Ms C for their failures with regard to Mr A and for the misinformation given; (ii) emphasise to staff in the Care Home the necessity of following adopted procedures and the proper completion of standardised forms; (iii) monitor procedures in the Care Home for a period of four months; (iv) provide an apology to Ms C, taking into account that they failed to offer Mr A stimulation and also to reflect the misinformation they gave; (v) provide evidence to the Ombudsman of the range of structured recreational or diversional activity now available to residents in the Care Home and emphasise to staff the importance of such; (vi) emphasise to their staff the benefit to all parties of clear communication; and (vii) ensure that, on each new admission, the Care Home take steps to discuss and record the level and means of communication required with families; and provide evidence to the Ombudsman that this is happening.  The Board have accepted the recommendations and will act on them accordingly.

Lothian NHS Board (Dentist)

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
23/06/2010	200901763	(a) failed to fit Mrs C with correctly sized dentures (not upheld); and (b) failed to detail treatment charges prior to treatment (upheld).	partially upheld	introduces a policy of discussing the full treatment plan and costs with her patients prior to the commencement of treatment and that a note of this discussion is recorded in the clinical records.  The Dentist has accepted the recommendation and will act on it accordingly.
23/06/2010	200903339	(a) the examination of Ms C's mouth was inadequate (upheld); and (b) the record-keeping was inadequate (upheld).	upheld	(i) apologises to Ms C for the shortcomings identified; (ii) ensures adequate investigation of patients with toothache; and (iii) improves his record-keeping to the standard described in this report.  The Dentist has accepted the recommendations and will act on them accordingly.