Ombudsman's Commentary

AUGUST 2007 REPORTS

I laid 30 investigation reports before the Scottish Parliament today. Sixteen relate to the health sector, 11 to local government, two to the Scottish Executive and devolved administration and one to housing associations. The Reports are summarised below and the full Reports are available on the SPSO website at www.spso.org.uk/reports/index.php

Ombudsman's Overview

In this month's Overview I am highlighting a number of themes that recur in the health complaints that we receive. Enquiries and complaints about NHS services constitute approximately a quarter of our caseload, and cover a wide range of aspects including diagnosis, treatment, nursing care, provision of services and complaint handling. Investigating these complaints can take longer than complaints about other sectors since we usually have to obtain medical records, and often, to consult internal or external clinical advisers.

We published sixteen Reports today about the health sector. Several of them contain references to themes highlighted in previous Reports – the quality of nursing care (which can be affected by poor record-keeping); obtaining consent; and poor communication with patients and especially with relatives of patients.

I am distressed that there are still patients, especially the elderly and those with mental health problems, who are not receiving nursing care of a sufficiently high standard. For example, I upheld the aspect of a complaint (*Case ref: 200500132*) that a 92-year-old patient was left alone without adequate clothing and bedding in a cold room and that the cause of gashes in her legs was not adequately communicated to relatives. There was also no proper assessment of her nursing needs on admission to the Hospital and problems with the transfer of medical records. In another complaint (*Case ref: 200600459*) I concluded that there was a failure to ensure documentation was correctly completed and regular assessments taken on an elderly patient's condition; a failure to communicate with the patient and her family about her condition or to document this; and a failure to document the provision of specialist meals.

Poor communication was a major issue in a particularly distressing case (*Case ref: 200502750*) reported on this month. The complaint focussed on the cremation of a baby without the consent of the parents, Mr and Mrs C; the Board's failure to provide adequate evidence that the baby had been cremated entire; and also the manner in which the parents' complaints were handled by the Board. My investigation found that the initial communication breakdown between the undertakers, midwives and perhaps other staff at the Hospital led to the parents not being present at the cremation as they had wished.
The Report goes on to state:

'had the Board made every effort to deal effectively and efficiently with this very serious and tragic mistake, I do not believe Mr and Mrs C's complaint would have escalated to this office and more importantly, the suffering experienced by Mr and Mrs C would have been minimised. I feel that it is important to note that throughout the complaint, the midwifery staff have expressed what I believe to be a genuine regret for the distress caused by the communication breakdown.'

This case is sadly typical of poor communication issues, where early recognition of mistakes and good handling of complaints can help prevent escalation, and perhaps, reduce suffering. My Report goes on to state:

'I believe that the failures were unintentional on the part of staff, but a result of the extremely difficult and sensitive nature of this very rare type of case.'... 'I must draw attention to the fact that the Board have, in my view, taken effective and efficient measures in their work to identify what went wrong and have taken steps to ensure, to the best of their ability, that this kind of situation does not arise again. The Board's management and response to the process issues involved in this case have been, in my view, excellent. However, the management of, and communication with, Mr and Mrs C during the complaint was on the whole unacceptable.'

These and other health complaints are summarised on the subsequent pages.

Ombudsman's Commentary

AUGUST 2007 REPORTS

Health

Nursing care, communication, record-keeping, complaint handling
Greater Glasgow and Clyde NHS Board (200500132)

I upheld the complaints made by Mr C about the treatment and care his 92-year-old mother, Mrs A, received in hospital. I partially upheld the complaint about delay by the Board in handling his complaint to them. I made several recommendations to the Board, including an apology for the failings in nursing and medical care; audit of care planning documents; and changes to the recording of a patient's transfer.

Clinical treatment
Greater Glasgow and Clyde NHS Board (200500732)

I upheld the aspect of the complaint that related to the process for obtaining full consent and did not uphold the other aspects of the complaint. I made two recommendations to the Board, relating to training and audit of the Board's new policy on consent, and to responding to complaints.

Waiting-list administration
Greater Glasgow and Clyde NHS Board (200503576)

The complainant, Mrs C, complained that errors by the Board had resulted in an unreasonable delay in her referral for treatment in the NHS and that consequently she felt it necessary to obtain treatment privately. Mrs C sought reimbursement of the costs directly incurred by her in having her surgery performed outwith the NHS. I fully upheld her complaint and recommended that the Board reimburse Mrs C's treatment costs.

Clinical treatment
Greater Glasgow and Clyde NHS Board (200600011)

I fully upheld the complaints that the Board failed to provide a correct biopsy in the first instance; arrange timely follow-up; and report the biopsy results in a timely manner. I recommended that the Board apologise to the complainant for the specific errors in her care and treatment and the additional distress this caused her.

Diagnosis, clinical treatment, communication
Greater Glasgow and Clyde NHS Board (200600459)

I upheld the complaint that there had been a delay in the initial diagnosis of the patient, Mrs C's, condition and that there were significant failures of communication concerning her treatment and care, both to Mrs C and her family and between the hospital staff. I partially upheld the complaint that the treatment given to Mrs C was inappropriate. I made several recommendations to the Board, including apologies to Mrs C's husband and family for the many failings identified, and that the Board review their pain assessment and management procedures and provide evidence of improvements in standards of communication.

Ambulance transport, communication, delays
Scottish Ambulance Service (200500917)

The complainant, Mrs C, raised a number of concerns about the care provided to her husband, Mr C, by ambulance staff during his discharge home from hospital. Mr C was terminally ill with advanced cancer at the time. I upheld the complaint that the ambulance crew had failed to take adequate care in carrying Mr C from the ambulance to his home, but made no finding on, or did not uphold, two other aspects of the complaint. I recommended that the Ambulance Service apologise to Mrs C for the distress and anxiety caused and ensure that staff have adequate training. I also recommended that they consider other recommendations from my Specialist Adviser.

Midwifery: communication, complaint handling
Forth Valley NHS Board (200502750)

As reported above, two parents complained that the Board denied them the opportunity to attend their baby's cremation; failed to provide adequate evidence that the baby was cremated entire; failed to carry out a thorough investigation of their complaint; and treated them with disregard for their emotional state. I fully upheld the first three aspects and partially upheld the last aspect.

In recommending redress, my Report states: *'I have considered whether or not the Board should contact Mr and Mrs C directly with an apology, however, Mr and Mrs C have expressed to me that they do not feel they could interpret any further apologies as sincere given their experiences regarding this case. The Board and Mr and Mrs C have entered into discussion regarding appropriate alternative redress and I am satisfied with this approach. Given the sensitivity and nature of this case, I have decided that the final redress arrangements should remain private to both parties.'*

Diagnosis, record-keeping
Tayside NHS Board (200500717)

I upheld the complaint that a clinician had not taken into account all of the complainant's conditions and symptoms, but did not uphold the complaint that the notes taken at consultation were inaccurate and of poor quality.

Treatment, nursing care, communication
Grampian NHS Board (200500810)

This complaint concerned the care and treatment provided to an elderly man, Mr A, with a long history of manic depressive illness. I upheld his sister's complaints that Mr A's weight loss was not dealt with appropriately and that the response to his falls was poor. I did not uphold or made no finding in two other aspects of the complaint. I made several recommendations to the Board, including that they review how eating and drinking/weight problems are dealt with; review care planning in the Hospital; implement their new policy on patient falls if they have not already done so; develop and implement a policy on the use of restraints at the Hospital in line with Mental Welfare Commission guidelines; and take steps to ensure that the Hospital follow the guidelines on pressure sore prevention.

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Health

Clinical treatment/diagnosis, record-keeping, delays
Tayside NHS Board (200501038)

I upheld aspects of this complaint relating to incorrect clinical records, delay in diagnosis, inappropriate use of restraint and unexpected delay in hospital transfer in relation to the care of a 90-year-old man. I did not uphold three other aspects of the complaint. I made several recommendations to the Board relating to record-keeping, clinical treatment and training in patient and family communication. I also recommended that the Board develop and implement a policy on the use of restraints at the hospital in line with Mental Welfare Commission guidelines, and apologise to the complainant for the failures identified.

Complaint handling
Grampian NHS Board (200501257)

I partially upheld the complaint and recommended that the Board apologise to the complainant and take steps to ensure no repetition of the failures that prompted it.

Care of the elderly: clinical treatment, nursing care
Tayside NHS Board (200503444)

The complainant, Mrs C, raised a number of concerns about the nursing care and also the amount of medication given to her father, Mr A. I did not uphold three of the complaints, but I did uphold the complaint that management of Mr A's catheter was poor. I recommended that the Board apologise to Mrs C and for this failing and for the distress which this caused.

I did not uphold four other complaints in the health sector about the following issues and bodies:

Treatment, nursing care, communication
Greater Glasgow and Clyde NHS Board (200600419)

Clinical treatment, nursing care
Greater Glasgow and Clyde NHS Board (200601272)

Clinical treatment
A GP Practice, Lothian NHS Board (200601828)

Diagnosis
A GP Practice, Ayrshire and Arran NHS Board (200503522)

Housing Associations (RSLs)

Policy/administration
North Glasgow Housing Association Ltd (200601391)

The one Report laid today about a Housing Association was not upheld. The complaint which was investigated was that the Association unfairly excluded the complainant, Mr C, from their offices, in response to a community website being set up by residents to highlight the lack of support they felt they received from their landlord. Although I did not uphold the complaint, I did recommend that the Association carry out a further review of their Customer Care Policy to ensure that it sets out the types of behaviour that are considered to be unacceptable and that, prior to deciding to restrict contact with a customer, those who are considered to be behaving inappropriately are explicitly warned of the consequences of continued inappropriate behaviour under the Customer Care Policy.

Local government

Land and property: sales and leases
North Lanarkshire Council (200600243)

The complainant, Mr C, raised concerns about the Council's disposal to a charitable trust by means of excambion (exchange) the land on which his lock-up garage was located. I upheld the complaint that the Council failed to inform Mr C and his neighbours about the transfer of ownership, and I recommended that the Council apologise to them for this failure. I did not uphold a separate complaint by Mr C that he and other users of the land were not given the opportunity to purchase or to lease the land with access rights.

Land and property: acquisition, complaint handling
Comhairle nan Eilean Siar (200502985)

The complainant, Mr C, complained about the sale of Council-owned land on which he had a loom shed. I partially upheld his complaint that the sale of the land was not carried out appropriately, but did not uphold the complaint that he should not have been served with notice to demolish the loom shed. I upheld the aspect relating to complaint handling, and recommended that the Council clarify aspects of their complaints process. I also recommended that they apologise to Mr C for the failings identified and review their procedures about land sales with reference to notification and consultation.

Housing: anti-social behaviour
Midlothian Council (200500239)

The complainant claimed that the Council failed to take appropriate action in response to complaints made by him and his wife regarding the anti-social behaviour of two local residents including the consideration of witness statements and video evidence. I partially upheld the complaint and recommended that the Council make an apology to the complainants; ensure any future complaints from the couple are dealt with in accordance with current procedural requirements; and ensure that staff involved with complaints of the same or similar type are adequately trained in current Council procedures.

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Local government

Policy/administration
The City of Edinburgh Council (200600152)

I upheld the complaint that the Council unfairly excluded the complainant, Mr C, from their offices following a discussion about his council tax account, and made no finding on another aspect of his complaint. I made a recommendation relating to Council policy for dealing with alleged incidents of inappropriate behaviour. I also recommended that the Council apologise to Mr C for the unfair manner in which he was excluded from their offices and for failing to provide him with an adequate and detailed explanation regarding the grounds for his exclusion.

Planning: enforcement action
North Ayrshire Council (200500902)

The complainant complained about the Council's handling of a planning matter relating to a site adjacent to his property where unauthorised works had been carried out. I upheld the complaint that the Council delayed in taking action against the contractor, but not the complaint that they delayed in taking action following the decision to serve an enforcement notice. I recommended that the Council apologise to the complainant, and produce internal guidance on good practice in Planning Enforcement with specific advice on maintaining good documentation.

Finance: council tax and housing benefit, complaint handling
Dumfries and Galloway Council (200501957)

I did not uphold or made no finding on the aspects of this complaint relating to council tax and housing benefit, but I did find that the Council had delayed unduly in responding to the complainant's letter of complaint.

I did not uphold five other complaints in the local government sector about the following issues and bodies:

Roads: policy/administration
East Ayrshire Council (200601461)

Housing: letting and repairs
The City of Edinburgh Council (200601258)

Planning: local plans
Fife Council (200600024)

Handling of planning application
South Ayrshire Council (200601080)

Council Tax
East Dunbartonshire Council (200502814)

Scottish Executive and devolved administration

Policy/administration
The Scottish Commission for the Regulation of Care (200502898)

I did not uphold this complaint, which concerned the Commission's handling of the inspection of nursery premises. I did, however, recommend that the Commission, in order to avoid confusion, when making recommendations to service providers, ensure that they are clear, specific and measurable.

Policy/administration
The Scottish Commission for the Regulation of Care (200600745)

The complainant claimed that during the review of their investigation into her complaint against a care home, the Commission failed to take account of all relevant evidence and they used witness statements out of context. I did not uphold the complaint, but I did recommend that the Commission offer the complainant an apology for their failure to confirm, during both their initial investigation and the review, that the documentary evidence which she provided had indeed been considered.

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.

Professor Alice Brown
22.08.2007

The compendium of Reports can be found on our website, **www.spso.org.uk**

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