EL(89)P/9
FPCL 11/89

DEPARTMENT OF HEALTH

To: Regional General Managers
District General Managers
General Managers of Special Health Authorities
for the London Postgraduate Teaching Hospitals
Administrators of Family Practitioner Committees) **for action**

Secretaries of Community Health Councils) **for information**

30 **January 1989**

Dear General Manager

REPORTS OF THE HEALTH SERVICE COMMISSIONER

This letter but not the 'epitomes' it encloses will be cancelled and deleted from the current communications index on 28 April 1989.

1. DA(83)30 informed health authorities that the Health Service Commissioner would be prefacing his six monthly periodic reports of selected cases with 'epitomes' of the reports included, and that the Department would be making a free distribution of these epitomes to authorities on a trial basis. The latest collection of epitomes covering the period April to October 1988 is enclosed for your information.

2. As indicated in DA(83)30, we believe there is value in giving this material wide circulation among staff of the authority and in arranging for its use, as appropriate, in training courses and seminars. The Commissioner's own leaflet on his functions may also be useful for training purposes[1].

3 There is no objection to authorities photocopying the epitomes if additional copies are required. Copies of the full periodic reports may be obtained for Her Majesty's Stationery Office (reference HC103 ISBN 010 210 3895, price £16.00)

Yours sincerely

M A HARRIS
Assistant Secretary

[1] **The Health Service Ombudsman for England, available on request from the Office of the Health Service Commissioner for England, Church House, Great Smith Street, London SW1P 3EW.**

From:

HSI Division
Room A410
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

Telephone: 01-407 5522 Ext 6682

Further copies of this letter may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

HEALTH SERVICE COMMISSIONER

FIRST REPORT TO PARLIAMENT FOR SESSION 1988-89 HC

EPITOMES OF SELECTED CASES FOR

THE PERIOD APRIL 1988 - OCTOBER 1988

1. ASPECTS OF NURSING CARE - W.764/85-86

Matters considered

Steps taken to prevent patient from falling and from developing bed sores - supervision of patient at meal times - level of physiotherapy provided - notification of patient's deteriorating condition to relative - delay in releasing body to undertakers - handling of complaint by Health Authority.

Summary of case

A woman complained about a range of matters associated with the care of her mother, who was a long-term patient on a hospital's geriatric unit. The woman complained that in approximately an eleven month period prior to her mother's death at the hospital, adequate steps were not taken to prevent her mother from falling or from developing bed sores; and that among various failures associated with her mother's supervision at meal times her meals were not always of a suitable consistency. The woman also complained that the physiotherapy provided for her mother was inadequate; that she was not informed by the hospital's staff of her mother's deteriorating condition before she died; and that there was a delay in releasing her mother's body to the undertakers. Finally the woman complained that although a registrar agreed to provide her with a written report concerning one of her mother's falls he had failed to do so.

Findings

It was not disputed that the woman's mother sustained three falls in an eight month period prior to her death; and I considered that as the mother had demonstrated an ability to escape from the restraining method used some safer method should have been considered at the time of the first two falls. I also believed that the woman had every right to be concerned when her mother fell for the third time; and I found that on this occasion, despite an entry in the nursing care plan specifying that she was at risk from falling and how she should be restrained, she had been left on a commode unattended and without a safety belt. I also found that on Christmas Day and probably on other occasions the woman's mother was offered inappropriate meals, and that despite an undertaking to do so the registrar had failed to respond to her request for a report concerning the third fall. I did not uphold the remaining complaints and indeed commended the hospital staff for the way in which generally they accepted the considerable demands placed on them by the woman.

Remedy

The Authority apologised for the shortcomings I had found and agreed to review the diets they provided for patients and take what steps they could to ensure that appropriate food was selected for those who could not choose for themselves.

2. CHILD'S ADMISSION TO HOSPITAL DURING CUSTODY DISPUTE - W.182/86-87

Matters considered

Place of safety order - involvement of paediatric sister - consultant's role and reasons for admitting the child - hospital's summoning of police.

Summary of case

A woman was in dispute with her husband and his family over the custody of their one year old daughter who was living with the husband's mother. Following a domestic incident the local social services department (the SSD) obtained a place of safety order but the next morning the child was admitted to hospital and later that same day a court awarded the mother-in-law custody of the child. The woman complained that her sister-in-law had misused her position as paediatric sister at the hospital to have the child admitted, and that a consultant paediatrician made the admission not for clinical reasons but as a way of keeping mother and child apart. The woman further complained that hospital staff caused unnecessary distress by calling the police and telling them that she and her parents had come to abduct the child.

Findings

As the sister-in-law was not on duty while the child was in hospital and did not initiate the admission I considered that her actions were made in her private capacity as the child's aunt. I did not criticise the consultant for offering to admit the child, but I considered that as he knew of the place of safety order yet effected the admission without securing the SSD's assent, he had put himself in a false position vis-a-vis both the SSD and the maternal relatives and I upheld the complaint. I took the view that there was a fundamental difference between an admission to hospital arranged with the approval of the SSD and an admission without such approval. In the former case the consultant would have been giving effect to a decision made by the SSD. In the other, as here, I found that he had been acting over the heads, and without the knowledge, of the SSD for the purpose of avoiding action which it was feared the SSD might take. I believed that the staff had good reason to fear unpleasantness once the woman and her parents arrived at the hospital but since they were there as a direct result of the consultant's actions I did not regard the Health Authority as wholly free of blame regarding the summoning of the police.

Remedy

The Health Authority asked me to convey their apologies for the shortcomings I found.

3. RESPONSIBILITY FOR OUT-PATIENTS' PRESCRIPTIONS - W.707/86-87

Matters considered

Failure to prescribe for a hospital out-patient - guidelines issued by the Department of Health and Social Security (DHSS) - misleading statement made by a consultant on hospital's prescribing policy.

Summary of case

A clinical assistant told an out-patient, whom he had been treating for infertility, that he should try a drug which would be prescribed by his family practitioner (the FP). The FP, however, refused to provide the initial prescription and complained that the clinical assistant's action placed her in a difficult and invidious position as she had no knowledge of the use of this drug for males. The FP also complained that the clinical assistant's actions were contrary to DHSS guidelines in that as at the material time he had had clinical responsibility for the patient's treatment, it was his duty, and not hers, to prescribe the drug initially. The FP also complained that a statement made by a consultant, to whom the clinical assistant was responsible, that the reason for the hospital not prescribing the drug was budgetary, could not be justified.

Findings

I found that muddle and faulty communication between the FP, her patient, the clinical assistant and the consultant, rather than a matter of principle, lay at the root of the complaint. The clinical assistant said that he was not aware of the DHSS guidelines and that although he could not remember why he had not prescribed the drug he would have had no objection to doing so. And he maintained that had he appreciated the nature of the FP's objection he would subsequently have given the prescription. I believed that if the clinical assistant had been aware of the existing DHSS guidelines he would have realised that it was up to him to provide at least the initial prescription. I upheld this aspect of complaint and I criticised the clinical assistant and the Health Authority for having failed to ensure that their staff were aware of DHSS guidance bearing on their work. I also found that the FP's erroneous belief that the reason for the clinical assistant not prescribing the drug was budgetary arose from a clear implication to that effect in a letter she had received from the consultant, whom I criticised in this regard.

Remedy

The Authority apologised to the FP for the shortcomings I identified and agree to ensure that their staff are made aware of, and adhere to, DHSS guidance on prescribing.

4. DELAY IN DEALING WITH A REQUEST FOR AN INDEPENDENT PROFESSIONAL REVIEW - W.717/86-87 - W.235/87-88

Matters considered

Delay in responding to a request for an independent professional review.

Summary of Case

The complainant was dissatisfied with treatment she received at a hospital's accident and emergency department and complained to the Health Authority. She found the Authority's response unsatisfactory and in March 1986 wrote to the regional medical officer (RMO) of the regional health authority (RHA) requesting an IPR under the National Health Service clinical complaints procedure. The regional postgraduate dean (RPD) considered the request on behalf of the RMO in accordance with the RHA's usual practice but it was not until March 1987 that the complainant received a substantive response informing her that there was to be an IPR. She found this delay unacceptable and complained to me.

Findings

I found that the RHA's system at that time for dealing with clinical complaints procedure was inadequate in a number of respects. I severely criticised their procedure which allowed a letter from the RPD requesting action and information from the Authority to go unmonitored for more than six months. And I found that despite receiving two interim letters from the RPD providing a substantive response 'shortly' the complainant had to wait exactly 12 months for a proper reply to her request for an IPR, which was eventually held in June 1987. I fully upheld the complaint.

Remedy

I was pleased to report that the RHA had already introduced a correspondence monitoring system and made other changes and improvements to their procedures for handling clinical complaints. I pointed to the need for the RHA or the district health authority concerned to ensure that complainants are kept fully informed about the progress of their clinical complaints. The RHA agreed to issue clarifying guidance on this. They and the Authority also unreservedly apologised for the shortcomings I had found.

5. SUPERVISION OF A BABY IN HOSPITAL - W.6/87-88

Matters considered

Incorrect completion of infant feed chart - lack of nursing care - misleading statement by Health Authority - circumstances in which parents were told of their baby's death.

Summary of case

An eight week old baby girl was admitted to a hospital with a respiratory infection and died at around 8.10 pm the same evening. The parents complained that the nursing staff had incorrectly completed an infant feed chart in respect of their daughter's noon and 4.00 pm feeds. They also complained that when they returned to the ward in the late afternoon they had found that their daughter had been left to cry and was sobbing. They further complained that when a student nurse, who had been allocated to care for their baby, could not carry out observations due at 8.00 pm because she was occupied with another child other staff were not instructed to attend their daughter; and they disputed the accuracy of a statement in a letter from the Authority that nursing staff had been with their daughter for much of the time in the two hour period prior to 8.00 pm. Finally, they complained that the hospital staff showed insensitivity in informing them of their daughter's death in a room where there had been a Christmas party atmosphere with food and alcoholic drink remnants visible.

Findings

I partly upheld the complaint about the feed chart as I found that the record keeping in respect of the noon feed was unacceptably lax and that as a result incorrect information was recorded on it. I found no evidence that any member of staff had attended the baby between about 7.00 and 8.10 pm and I criticised the Authority for the seriously misleading and inaccurate statement in their letter. I also upheld the complaint that the parents were told of their daughter's death in entirely inappropriate surroundings; and it was evident that this was due to a complete lack of forethought and preparation by the ward sister. I did not uphold the remaining complaints but criticised and drew attention to disturbing deficiences in the observation arrangements which were highlighted by this case.

Remedy

The Authority unreservedly apologised to the parents for the shortcomings I identified. In accordance with my recommendations they agreed to ensure that nursing staff were given precise instructions about how and when infant feed charts should be completed, and to issue, as a matter of priority, guidelines on the placement and supervision of babies on the ward to try to prevent a recurrence of the most unfortunate event in this case.

6. SUPERVISION AND CARE OF PATIENT ON A LABOUR WARD - W.10/87-88

Matters considered

Failure to provide information about induction procedure - failures in nursing care - supervision of student midwife - monitoring equipment not functioning - inaccuracy of records of birth - attitude of consultant - handling of complaint.

Summary of case

The complainant, who was 39 weeks pregnant, was admitted to an ante-natal ward of a hospital and four days later was taken to a labour ward where a hormone drip was started in order to induce delivery of her baby who was born later that evening. The woman complained that she was not given any information about the induction procedure; that a student midwife (the student) failed to bring a pillowcase so that she had to use a gown to cover the plastic-covered pillow; that there was a failure to provide the pain relief she requested and that on one occasion a midwifery sister (the second sister) ignored her complaint of excessive pain; that the monitoring machines were not functioning properly; and that there was inadequate supervision of the student when she administered the hormone. She also complained that the records of the birth, particularly in respect of the administration of the hormone, were inaccurate. The complainant and her husband met the consultant obstetrician five months later to discuss their complaint and found him unhelpful and hostile, and they were also dissatisfied with the Health Authority's subsequent handling of their complaint.

Findings

While I was satisfied that a registrar probably explained the use of pessaries as one method of induction, I was not persuaded that the complainant and her husband were given sufficient detail of the hormone procedure and I upheld this complaint. I also upheld the complaint about the pillowcase. I found that while the possibility of an epidural anaesthetic to provide pain relief was discussed between the first midwifery sister (the first sister) and the complainant, no note had been made in the relevant records and in the event no epidural was given, and I upheld this complaint. I found no reason to question the judgment of the first sister and of a nursing officer (the NO) that the student did not require supervision. I was not persuaded that the second sister was sufficiently aware of the complainant's needs as to offer her encouragement and to help her relax, with the result that the complainant believed her cry of pain had been ignored and I upheld this complaint. I did not find made out the complaint that the monitoring machines were not functioning properly. I regarded the allegations about the accuracy of the records, which suggested that some had been falsified, as extremely serious. I noted however that there were variations in the accounts given by the complainant and her husband and I did not uphold the major part of this complaint although, because there were some relatively minor discrepancies, I could understand how the complainant and her husband were caused uncertainty by the records. I upheld the complaint about the consultant's attitude. I criticised the NO for her initial handling of the complaint in that she should have ensured

that a written reply was received rather than by responding informally as she had done through the complainant's family practitioner. I found that while the district general manager and senior officers individually made diligent attempts to deal with the complaint subsequently, a co-ordinated response would have been better.

Remedy

The Authority apologised for the shortcomings I found.

7. NURSING CARE AND COMMUNICATION - W.38/87-88

Matters considered

Failures in nursing care - attitude of a ward sister - failure to accede to relative's request regarding ward allocation - inaccurate response to complaint by Health Authority.

Summary of case

A man was admitted to hospital with severe chest pains. He was discharged approximately two weeks later at his wife's request but was readmitted the following day suffering from pneumonia and died at the hospital a few days later. The wife complained that prior to her husband's discharge the nursing staff failed to notice the state of his sore mouth and his inability to eat or drink as a consequence of which he became dehydrated. She also complained that the ward sister had made derogatory remarks about her husband and had also threatened that if he took his own discharge various community services would not be provided and the hospital would neither liaise with his family practitioner (the FP) nor readmit him. The wife also complained that although she had asked the FP to arrange for her husband to be readmitted to a different ward and was told that this had been agreed, in the event he was returned to his original ward. She further complained that on one occasion following his readmission he was left on a commode chair wearing only a pyjama jacket, and as the curtains were not fully down round his bed he was exposed to the full view of visitors to the ward. Finally the woman complained that a response to her complaint she received from the Authority included inaccuracies.

Findings

Although I believed that on one occasion the sister had used words to express her view that the husband was much more capable of helping himself than his wife believed, I did not think that she had intended to disparage him or give offence. Also I did not believe that the sister had threatened the withdrawal of care for the husband but rather that she had pointed out the adverse consequences to his care if he took his own discharge before adequate arrangements at home could be made for him. The only complaint I upheld was that the husband was not properly screened when on the commode. I found it difficult to accept that such an incident could not have occurred and I had no reason to doubt the wife's account that on the occasion in question the curtain was not completely drawn and that this caused unnecessary distress to her husband. But this aside, my investigation convinced me that the staff were fully aware of the husband's difficulties and that they did all they could for him.

Remedy

The Authority apologised for the shortcoming I found.

8. SUPERVISION OF A PSYCHIATRIC PATIENT - W.114/87-88

Matters considered

Supervision of a patient expressing suicidal intentions - communication between medical and nursing staff - delay in informing next-of-kin and police of patient's absence from hospital.

Summary of case

Following a suicide attempt a 27 year old man was readmitted to a hospital as an informal patient. Five days later he left the hospital without permission and travelled to his previous place of employment where at about 9.40 am he jumped to his death. His mother complained that, despite the fact that both she and another son had stressed to the hospital's doctors that he had suicidal feelings, he had been allowed to leave the ward on the day before his death to buy a newspaper, and that on the morning of his death his absence had gone unnoticed for about an hour. She also complained that on that morning she was not informed immediately when her son was discovered to be missing at 8.55 am, and that the police were not contacted until 10.15 am.

Findings

I found that the decision to allow the son to leave the ward to buy a newspaper was taken by a charge nurse in the exercise of his clinical judgment, which I could not question. However, I discovered that this decision was contrary to what a senior house officer (SHO) had intended in his instructions to the ward staff. I accepted that they had been open to misinterpretation, criticised the SHO for failing adequately to communicate his wishes and upheld this aspect of the complaint. As to the morning of the suicide, I could not establish with certainty when the son left the hospital, but I believed that it was rather later than 8.15 am, the time alleged by the complainant. Although in strict terms I could not find made out the complaint that the son had been missing for an hour before his absence was noticed, I upheld the complaint to the extent that the supervision provided was not sufficient to prevent him absconding. And I expressed concern that it had been all too easy for him to leave the ward, which I suspected had been due to a combination of its layout, the number of exits and the level of observation or supervision. I also upheld the complaints that the police should have been notified of the missing patient before 10.15 am, and that the mother should also have been told of it earlier than she was.

Remedy

The Health Authority apologised to the mother for the shortcomings I identified. As a consequence of my recommendations the Authority have reminded medical staff of the need for clear and precise instructions to nursing staff; agreed to establish a monitoring system for patients with a tendency to suicide or self-harm and to adjust the existing arrangements for the management of such patients as circumstances dictate; and the ward in question has been moved to what they consider to be a more appropriate location for the management of acutely ill patients.

9. HANDLING OF A COMPLAINT UNDER THE FAMILY PRACTITIONER COMMITTEE (FPC) INFORMAL PROCEDURE - W.117/87-88

Matters considered

Failure to respond promptly to the complainant's letters - delay in arranging a meeting with conciliator - subsequent delays in resolving the complaint.

Summary of case

The complainant wrote to the FPC expressing dissatisfaction with the treatment he had received from his family practitioner (the FP). The FPC sought to resolve his complaint by means of their office informal procedure involving an exchange of correspondence with the FP. But this was not successful and, almost a year after the complainant's first letter to the FPC, the matter was referred to a conciliator. After a further delay the conciliator had a meeting with the complainant and asked for his permission to contact a hospital which had carried out investigations. Although such permission was not granted it was not until nine months later that the complaint was put forward by the FPC for consideration under the formal complaints procedure.

Findings

I found that there were no acceptable reasons for the long delays both in dealing with the complainant's correspondence and in referring the complaint to the conciliator. I noted that the FPC had introduced a system for monitoring the progress of complaints but I did not consider that these procedures had been followed with sufficient vigour. I accepted that the conciliator was not to blame for the delay in arranging a meeting with the complainant but I considered she should have put his complaint forward for consideration under the formal procedure as soon as it became apparent her efforts to resolve his concerns had failed.

Remedy

The FPC apologised for the delays which had occurred and agreed to take further action to ensure that their monitoring system was followed with a sense of greater urgency. They also agreed to review their use of the office informal procedure and to consider whether letters of complaint should continue to be sent to doctors without complainants' consent.

10. FAILURE BY FAMILY PRACTITIONER COMMITTEE (FPC) TO MAKE PAYMENTS TIMEOUSLY UNDER THE ESSENTIAL SMALL PHARMACIES SCHEME (ESPS) - W.141/87-88

Matters considered

Action taken by the FPC to ensure ESPS payments were made during a period of industrial action by the FPC administrator.

Summary of case

When the complainant applied to be included in the ESPS for 1987-88 he was told that his application could not be dealt with as the introduction of the new pharmaceutical contract was the subject of an industrial dispute. He was later informed that an advance towards each ESPS monthly payment would be made based on calculations relating to the previous year. The complainant sought payment in full and was told first that the matter would be referred to the FPC chairman and later that it would be considered by the FPC at their next meeting. Meanwhile when the next payment became due the complainant again received an advance only and it was not until the industrial dispute was settled that all moneys due to his company were paid.

Findings

I found that the income of the complainant's company was significantly reduced as a result of the FPC's failure to make the payments to which the company was entitled on the due dates. I criticised the FPC for their failure to inform themselves fully of the implications of the industrial action, and the FPC chairman for his failure to seek advice from the Department of Health and Social Security (DHSS). But despite these criticisms I concluded in the particular circumstances of the case that the FPC's failure to make payments on the due dates did not constitute maladministration. I did not therefore uphold the complaint.

Remedy

The FPC agreed to apologise for the shortcomings I identified and, subject to DHSS approval, to reimburse the complainant for any additional bank charges he incurred as a result of the delay in making payments to him.

11. DISCHARGE FROM HOSPITAL TO A PRIVATE NURSING HOME - W.155/87-88

Matters considered

Arrangements for discharge - alleged pressure put on patient's wife - communication with wife.

Summary of case

A man who had been an invalid for many years and had been cared for at home by his wife with the assistance of the community nursing service was admitted to hospital for a stay of 48 hours while his wife had a minor operation. However the wife's illness proved to be more serious than had been anticipated and she remained unable to care for her husband at home. The man stayed in hospital for just over six months before he was discharged and transferred to a private nursing home. His brother complained that, despite the man's continuing need for constant medical care, undue pressure was put upon his wife to remove him to a private nursing home at a time when she herself was seriously ill and least able to resist such pressure.

Findings

The consultant under whose care the man was admitted believed he did not require hospital care, and I considered that he formed this view solely in

the exercise of clinical judgment which I could not question. However it was clear that despite his opinion the consultant had been quite prepared to allow the man an extended stay in hospital when it was found that the wife's condition was far more serious than had been anticipated. I concurred with the view expressed by others that the eventual duration of the man's stay in hospital demonstrated the flexibility and sympathy of the consultant and hospital staff. Apart from what I considered to be a routine offer of help from a hospital social worker I found no evidence to suggest that any approach was made to the wife about the man's discharge until he had been in hospital for almost four months. The consultant then had a meeting with the wife which concluded with her agreeing to look at available accommodation in private nursing homes. Thereafter the consultant wished to be kept aware of what progress was being made towards the man's eventual discharge and this led to various members of the nursing staff repeatedly questioning the wife on the subject. I did not think it was unreasonable that the wife should be asked about progress, but, as the staff were aware of the reasons for her indecision and of her fears and worries, I thought that approaches to her by different members of staff did not help the situation. I believed that a better approach might have been to nominate one member of staff to liaise with her and I upheld the complaint to the extent that I thought the matter could have been better handled.

Remedy

The Health Authority apologised that the matter was not better handled and for any distress this caused the man's wife.

12. LOSS OF PROPERTY IN A HOSPITAL - W.197/87-88

Matters considered

Failure to check and record a patient's property on admission - failure adequately to search for reported missing property - attitude of a ward sister (the sister).

Summary of case

A 65 year old woman was admitted to a hospital on 29 December 1986 and was discharged on 20 January 1987 during which period her engagement ring and handbag were reported missing by her family. The handbag was eventually found in her locker on 15 January but the ring remained missing. Her daughter complained that ward staff had failed to check and record her mother's property on admission as required by the hospital's admission procedure; and had also failed to carry out adequate searches for either the handbag or the ring when they were reported missing. The daughter further complained that when the handbag was found the sister was not apologetic and blamed the daughter and her husband for not going to the hospital and looking for it themselves.

Findings

I found that the nurse who admitted the woman to the ward failed to follow the hospital's procedure for advising, checking and recording patient's

valuables. I was left in some doubt as to whether prior to 15 January the daughter and her husband had made specific enquiries of the ward staff regarding the ring. But I was satisfied that in response to enquiries about the handbag the staff failed to carry out adequate searches, because if they had done so it would have been quickly located in the locker. I also considered that when the handbag was found the sister should have made more effort to adopt a sympathetic and concerned approach. I was dismayed by the apparent discord and communication difficulties between the ward staff which had probably contributed to the failures I found. I also criticised the Health Authority for failing to take statements from the staff involved during their investigation into the loss of this property.

Remedy

The Authority apologised for the failures I had identified. They agreed to my recommendation that they should remind their staff of the procedure which should be followed concerning the recording of patients' property, especially when a patient was confused. And they also agreed to my suggestion to contact the complainant with a view to making an act of grace payment on the basis of an independent valuation in respect of the missing ring which, on the balance of probabilities, I felt had been lost in hospital.

13. DISCLOSURE OF CONFIDENTIAL INFORMATION - W.205/87-88

Matters considered

Alleged disclosure of confidential information - failure by Health Authority to investigate the complaint satisfactorily.

Summary of case

While a patient in a hospital the complainant had been responsible for damaging hospital property. Following his discharge he had been surprised to learn from a neighbour that the latter was aware of this, having allegedly been informed about it by a community psychiatric nurse (the CPN). The complainant subsequently brought the alleged breach of confidence to the attention of the Authority and complained that their subsequent investigation amounted to a 'cover up'.

Findings

I found that the neighbour had obtained access to the information, that what he had heard was substantially true, and that he had discussed the matter with the complainant, attributing the information as having come from the CPN. The CPN denied having discussed the matter with the neighbour and maintained that he himself had not become aware of the incident at the hospital until after the date on which it was alleged he had disclosed confidential information to the neighbour. I could find no evidence to support the neighbour's

allegation that the information had originated from the CPN and therefore I did not find the complaint that the CPN had divulged confidential information made out. With regard to the complainant's belief that the investigation which the Authority had conducted into the complaint amounted to a 'cover-up', I found that the Authority had in fact taken his allegations very seriously and had made a sustained and commendable effort to resolve the matter.

Remedy

Although I did not uphold either complaint I noted that the Authority had written to the complainant during the course of their investigation expressing regret for the evident distress which he had suffered and I hoped that this, together with the additional information which I was able to provide in my report, would restore in some measure the complainant's confidence in the services provided by the Authority's mental health services unit.

14. DELAY IN UNDERTAKING ORTHOPAEDIC SURGERY - W.242/87-88

Matters considered

Cancelled admissions - failure to undertake planned surgery - unsatisfactory response by Health Authority.

Summary of Case

After waiting five months for admission to hospital for a bunionectomy the complainant was told that a bed had been reserved for her, but when she telephoned the ward on the appointed morning she was told that she could not be admitted because the ward was full. She was later given a new admission date but when she contacted the ward on that morning she was once again told that no bed was available. After protesting she was asked to come to the ward later that day in the expectation that a planned discharge would make available a bed for her. But in the early evening the consultant told her that no bed was available. According to the complainant she agreed to return the next morning for admission on the understanding that she would be the first patient on the consultant's theatre list. Following admission the complainant was woken at 6.00 am on the day of the proposed operation to be prepared for surgery, but at 12.00 noon she was told that her operation could not be undertaken that day. She sought an explanation from the consultant and was dissatisfied with his response and his failure to promise to undertake her surgery himself the next day. The complainant discharged herself from hospital and subsequently complained to the Authority about her experiences but found their reply inadequate and inaccurate.

Findings

I found that the decisions to call the complainant on the first two occasions and subsequently to cancel these admissions were made in the exercise of a doctor's clinical judgment as to relative priorities for surgery, a matter on which I could not comment. I concluded that in view of the first cancellation

staff had done their best to find a bed for the complainant on the second occasion, but I criticised their failure to warn her that she might have to return home if a bed could not be found for her. I also concluded that the complainant had misunderstood what she was told about her position on the consultant's operating list. As to the cancelled surgery on the day the complainant was prepared for it, I found that she was the last of three patients on the consultant's list, and that the first two operations having over-run his allocated theatre time the consultant had no option but to cancel the complainant's operation. But I found that she was not kept sufficiently informed about the delay that morning and the reasons for it and that the consultant had not fully informed her of the options open to her for surgery on a later date. I also upheld the complaint about the inadequacy of the HA's response to the complainant.

Remedy

The Authority and the consultant apologised for the shortcomings I found.

15. HANDLING OF A COMPLAINT BY A FAMILY PRACTITIONER COMMITTEE - W.243/87-88

Matters considered

Failure by FPC to provide complainant with adequate help to identify doctor against whom he wished to make a formal complaint.

Summary of case

A man complained to the FPC about the actions of his family practitioner (the first FP) and also about a doctor who deputised for her and provided him with advice over the telephone (the second FP). The FPC administrator, acting on the instructions of the chairman of the medical services committee (the MSC), wrote to the first FP asking her to confirm the identity of the second FP but she claimed that, although it would have been a partner in the same group practice, she was unable to assist without knowing the date of the telephone call in question. The administrator sought this information from the man but he could not remember the date of the call. The administrator sent a copy of this reply to the first FP. An MSC hearing involving the first FP later took place, but the complaint against the second FP was not considered; and subsequently the administrator advised the man that it would be necessary for him to supply the date of the telephone call so that the second FP could be identified. Accordingly the man, of his own initiative, wrote to the doctors at the group practice, with the exception of the first FP, and this resulted in the second FP, nearly a year after the original complaint, revealing his identity to the FPC. The man complained to me that the FPC had failed to provide him with adequate help to enable him to identify the second FP.

Findings

I upheld the complaint. Under DHSS guidelines the responsibility for giving advice and assistance to complainants rests with the FPC and their staff rather than the MSC; and to the extent to which the administrator saw himself

as having discharged the FPC's responsibility by simply following the MSC's instructions, I believed that he took too narrow a view of the FPC's role. Given that the first FP was under contract with the FPC, and the FPC's view expressed during my investigation that the first FP had a responsibility to identify her deputy, I believed that the administrator could have been expected to take up with the first FP the complainant's reference to existing records which might have thrown light on the issue and also to have pressed her about her general responsibility for identifying her deputy. I also criticised the administrator for not making it clear to the man at a much earlier stage that the complaint about the deputy would not be part of the original investigation by the MSC, and that the reason for this was that he had not been identified by the complainant. I upheld the complaint and concluded that had it not been for these shortcomings the second FP's identity could have been established much sooner than it was.

Remedy

The FPC apologised for the shortcomings I found.

16. INFORMATION ABOUT PATIENT'S CARE AND HANDLING OF COMPLAINT BY TWO HEALTH AUTHORITIES - W.382/87-88 - W.418/87-88

Matters considered

Information given to relative about various aspects of patient's hospital care - handling of complaint by two Health Authorities.

Summary of case

The complainant's wife was admitted to an acute hospital (the first hospital), managed by one Health Authority, after taking a drug overdose and three weeks later she was transferred to a psychiatric hospital (the second hospital) managed by a second Health Authority. After 11 days the patient was returned to the first hospital, where she died three weeks later. Her husband complained against the first Authority that he was not informed that his wife was undergoing liver tests, that because of her acute medical condition it was inappropriate to transfer her to the second hospital and that he was given no indication of the seriousness of her condition. He complained against the second Authority that given his wife's medical condition it was inappropriate for the second hospital to accept her as a patient, that his wife was not given an appropriate diet at the second hospital and that he was not informed that she was being returned to the first hospital. He complained against both Authorities that he was not informed that his wife's wrist had been fractured, that both Authorities denied knowledge of how the injury was caused, and that the responses they made to the complaints he put through the Community Health Council (CHC) were inadequate and dilatory.

Findings

I found that the decision to transfer the patient to the second hospital and that hospital's decision to accept the patient were decisions made solely in the exercise of clinical judgment. I upheld all the other complaints.

I found that both Authorities failed to communicate with each other in order to provide a coherent response and I noted that it was the CHC secretary who performed the role of co-ordinator between the two. I commented that I had seen few cases more ineptly handled.

Remedy

Both Authorities apologised for the shortcomings I identified. They also assured me they would review their procedures for communicating information about patients who are transferred between their hospitals and for co-ordinating the handling of complaints in which more than one Authority was involved.

17. HANDLING OF COMPLAINT BY A HEALTH AUTHORITY - W.446/87-88

Matters considered

Inadequate complaints procedure - unsatisfactory handling of a complaint - inconsistencies in sending copy correspondence.

Summary of case

A woman, with the assistance of her local community health council (CHC), wrote to the Authority complaining about events surrounding her ante-natal care and the birth of her baby at a hospital, but did not receive a response until four months later. She complained that in the meantime the Authority ignored a reminder letter she sent; that the hospital's unit general manager (UGM) ignored telephone calls from the CHC; and that the UGM's secretary told the CHC that the Authority had no knowledge of the complaint. The woman also complained that it required the intervention of her Member of Parliament (MP) to prompt the Authority to investigate her complaint. She further complained that when she finally received the response to her complaint copies of it were sent automatically to the MP and the CHC yet she, the complainant, had not received a copy of an earlier reply the Authority had sent to the MP in response to his enquiry about the progress of her complaint.

Findings

I found that following the woman's letter of complaint the UGM had intended to ask a consultant for his comments but as he had believed - erroneously as it turned out - that the consultant was away, the file was put to one side pending his return and was then overlooked. I also found that when the woman wrote her reminder letter that too 'vanished'. And it was not until the MP wrote that the file came to light and the consultant was belatedly asked for his comments so that a reply could be made. It seemed to me that an ill-defined system for handling complaints and general laxity were the cause of the overall delay. I upheld the complaint that the woman's reminder letter was ignored. I found that the UGM had failed to return the CHC's telephone calls and that his secretary had subsequently either advised the CHC, or given them the very strong impression, that the Authority had no knowledge of the complaint. I also upheld the complaints that it required the intervention of the MP to prompt the Authority to investigate the complaint. I found that the MP had not made the complaint for the woman as her agent, for he had merely been trying to help her by stirring-up the Authority, and

that there had been no reason why the information sent to him could not have been given to the complainant. And I expressed concern that confidential medical information had been disclosed to a third party without the express permission of the woman. I commented that all in all the UGM's performance fell far short of the standards I would expect to find in someone of his seniority and experience.

Remedy

The Authority, who had taken steps to improve the handling and monitoring of complaints since the events which gave rise to this complaint, apologised to the woman for the shortcomings I identified.

18. REGISTRATION OF NURSING HOME - SW.70/86-87

Matters considered

Health Board's procedures for registration of nursing home.

Summary of case

The complainer and her husband opened a nursing home in November 1985 and had it registered by a Health Board. Two handicapped patients were admitted in February 1986 but the Board's visiting inspection team questioned this and the owners were advised that the home was authorised to take only elderly patients. The Board amended the registration with effect from June 1986 with the intention of allowing the admission of handicapped patients. The complainer argued that from the outset they had made clear their intention to admit handicapped patients and that the Board had therefore failed initially to effect the appropriate registration. She further complained that once this had become apparent there was undue delay before the registration was amended, leading to the loss of DHSS allowances.

Findings

I found before the registration was granted the home's owners had mentioned their intention to take handicapped patients and that they were not informed that the Board intended the registration to cover elderly patients only. But in any case, because the Board failed to follow procedures set out in the relevant legislation, there had never been any such limitation on the registration. Once the presence of the handicapped patients was known the Board misled themselves - and the complainer - into believing that the terms of the registration required to be widened. The Board also misinformed DHSS about the original registration and in consequence the full rates of benefit to which the handicapped patients were entitled were not paid.

Remedy

The Board agreed to find out if arrears of benefit could be paid by the DHSS and, if not, to consider making an ex gratia payment to cover any moneys outstanding. DHSS subsequently agreed to pay £1868 arrears to the complainer.

19. NURSING CARE AND ATTITUDES - SW.79/86-87

Matters considered

Actions and attitudes of nursing staff - pressure area care - communication - discharge arrangements - information passed to community nursing staff.

Summary of case

A man complained that while his wife was an in-patient nursing staff had let her slip off the edge of her bed and scrape her back; took no action when she suffered nose bleeds and coughed up blood; were unsympathetic towards her; ignored her; left her on a bed pan for too long and often refused her the use of a commode; and that she developed a pressure sore because of insufficient care. He also complained that there was confusion about who would accompany his wife on her journey home; that the ambulance provided was inappropriate and no provision was made to protect her pressure sore during the journey; and that the hospital nursing staff did not inform him, the community nurses or the family practitioner about the pressure sore.

Findings

I found no evidence to persuade me that the woman had slipped off the edge of her bed and I accepted that the back pains of which she had complained to her husband were probably muscular. I found that consideration had been given by nursing staff to reports that the woman was having nose bleeds and coughing up blood, but I criticised the nurses' failure to explain to the husband why this was not significant. I did not uphold the complaints that the nursing staff had adopted inappropriate attitudes towards the woman although I found that there had been a short period when, in accordance with the consultant's instructions, the nursing staff had adopted a firmer approach in an attempt to encourage her to do more for herself. I did not believe that the woman had been deliberately ignored, although there may have been occasional delays in attending to her which I considered to be unavoidable. I found that at times she was refused the use of a commode but that such refusals were made in her best interests and I was satisfied that regular pressure area care had been given to her and with special equipment being available if required. I did not believe that the development of the pressure sore was due to a lack of nursing care. I considered there had been a failure in communication which had led to confusion about who was to escort the woman on her journey home, but found that the ambulance provided had been suitable and selected with her needs in mind. I criticised the ward sister for not ensuring that the husband was advised of his wife's pressure sore and I upheld the complaint that neither he nor the community nursing sister, who visited the woman's home on the day of discharge, were aware of the pressure sore until they saw it for themselves. I did not however uphold a similar complaint in respect of the family practitioner, who had learned of the sore from the community nursing sister which was how he expected to be informed of such matters.

Remedy

The Board agreed to remind nursing staff of the importance of being alert to the needs of relatives and of the need to note all complaints, even those which initially seem insignificant, and to remind nursing staff of the need to provide full and detailed information to relatives who are to care for patients due for discharge. They apologised to the complainer for the shortcomings I had found.

20. MANNING OF AMBULANCES IN RURAL AREAS - SW.11/87-88

Matters considered

Staffing levels in ambulance service - duties required of staff on single-manned vehicles - efforts made to improve the service - cause of resuscitation pack falling - steps taken to rectify problem.

Summary of case

A man became ill during a drive in the country and was taken by ambulance to hospital where he later died. The man's wife who accompanied him in the ambulance complained that the single-manned vehicle was inadequately staffed and that a resuscitation pack was not safely secured and nearly hit her when it fell.

Findings

The director and staff of the Scottish Ambulance Service shared the complainer's view that single-manned accident and emergency vehicles were inadequately staffed and provided a service which was less than desirable. I found that considerable efforts had been made over many years to reduce the incidence of single-manning, but that progress had been slow due to demands on the limited funds available to meet expansion in other areas of the service. I commended current initiatives designed to eliminate single-manning within five years. There was no dispute that the resuscitation pack fell from a shelf. I found that there were no previous reports of similar occurrences and that as soon as attention was drawn to this incident the necessary alterations were made to the securing devices in the vehicle in question, and to all others of a similar type.

Remedy

The Scottish Ambulance Service assured me that they were continuing to make strenuous efforts to eliminate single-manning. The Common Services Agency, who are responsible for the Scottish Ambulance Service, apologised to the complainer for providing a service which was less than desirable and for the incident involving the resuscitation pack.

21. DELAY IN TREATING PATIENT'S INJURY - SW.14/87-88

Matters considered

Nurses' response to questions about patient's condition - staffing levels and nursing experience - record keeping - cause of injury - explanations given to complainer.

Summary of case

A woman's elderly mother was admitted to hospital following a stroke. On 12 January 1987 she was moved to a newly opened ward where on 17 January the woman found her apparently in great pain and with her right leg unnaturally

contorted. X-rays taken on 21 January showed a fractured right femur. The woman complained that although she had expressed concern about her mother to nursing staff on 17 January no note was made of it and no action was taken until four days later, thus causing her mother unnecessary suffering and distress. The woman also complained that she was given conflicting accounts of how her mother could have sustained her injury, and that at a meeting held to discuss the matter a director of nursing services (the DNS) appeared unprepared and gave no satisfactory explanations.

Findings

I considered the woman's representations on 17 January had not been as forceful as she recalled with hindsight, and that a staff nurse had reacted appropriately to the enquiries put to her. However in one instance the daughter's disquiet was not relayed to the nurse in charge and I criticised this omission. I was satisfied that prior to 21 January staff saw nothing to indicate the presence of a fracture and therefore I did not uphold the complaint that lack of action on their part caused unnecessary pain and distress. However I criticised the lamentable standard of record keeping, particularly as the woman's mother was unable to communicate. I found that the explanations given to the woman about her mother's injury were generally consistent, but that a doctor failed to check with nursing staff before suggesting to her that her mother might have fallen and I criticised his careless handling of the situation. I was unable to resolve a direct conflict of evidence between the complainer and a nurse who, according to the complainer, had said that her mother was dropped on 18 January. I found that the DNS was familiar with the case and at the meeting with the woman on the absence of an explanation she had declined to speculate on how the mother's injury was sustained.

Remedy

The Health Board apologised for the shortcomings identified and undertook to review the scope and content of nursing records.

22. LACK OF INFORMATION TO RELATIVES - SW.19/87-88

Matters considered

Communication with relatives - efforts made to feed patient - delay and confusion in readmitting patient - insensitive action by hospital technician.

Summary of case

An elderly man who underwent major surgery in March 1985 was readmitted to hospital in December 1985 and died on 2 January 1986. The man's son complained that after his father's operation in March the family were given no indication that he was suffering from tumours which would inevitably lead to his death and, in fact, were reassured by nursing staff that he was recovering well

following his operation. He also complained that the nursing staff did not adequately feed his father; that after being allowed home for Christmas Day his father was refused readmission through the A & E department and was left in a cold corridor for 30 minutes; and that shortly before his father's death a technician changed a light fitting in his room despite the family's requests not to.

Findings

The responsible consultant expressed the view that it was for the relatives to ask to speak to a clinician if they required information of a medical nature. He expressed surprise that the relatives had not approached him for further information as they had known a growth was removed during the man's operation in March. He said that if he had been asked he would have given information willingly. I considered however that in this case the relatives had been unaware that nurses could give only limited information of a general nature and that if they wished to know the father's prognosis they had to approach the medical staff. I found the relatives justified in feeling let down by the hospital staff because they were not positively encouraged to seek a meeting with the consultant. I found no evidence of lack of attention to feeding on the part of the nursing staff. None of the hospital staff knew of any reason why there should have been any difficulty about the patient's readmission arrangements on Christmas Day, but I found that wrongly he had been refused admission through the A & E department, which led to unnecessary delay. I was unable to establish who had been responsible for the lengthy delay which occurred while the man lay in a corridor and because it may have been caused by the actions of ambulance staff who were not employed by the Board I was unable to find the complaint made out. Finally, I found that it had been essential that the light fitting be changed but that it had been approached in an insensitive manner and without the relatives being forewarned by the ward staff.

Remedy

The Board apologised to the complainer and his family for the shortcomings I had identified. They also agreed to consider ways of encouraging relatives, in appropriate cases, to seek information about a patient's clinical condition from a doctor, and to remind staff in the A & E department of the policy in respect of readmitting patients who have been out on a pass.

23. CARE OF ELDERLY PATIENT IN ACCIDENT AND EMERGENCY DEPARTMENT - SW.20/87-88

Matters considered

Alleged delay before examination - decision to discharge - adequacy of dress following examination - response to request for extra covering - Health Board's response to complaint.

Summary of case

An elderly woman fell at home and lay overnight before being found and taken by ambulance to the accident and emergency (A & E) department of a hospital where she was examined and discharged home. Her son complained that paperwork

needed to admit his mother to the A & E department was not raised, causing delay before she was seen by a doctor; that the decision to discharge her took insufficient account of her home circumstances and the family's views; that she was left wearing only a paper gown while waiting for an ambulance and was refused extra covering; and that she was not dressed in her own clothes for her return journey home. The son also complained that the Board's investigation of these issues and their reply to him were unsatisfactory.

Findings

I found that there had been no significant delay before the woman was seen by a doctor and that the complainer's brother had misjudged the lapse of time between his mother's and his arrival at the hospital. I was satisfied that proper enquiry was made into the woman's social circumstances before it was decided to discharge her, and that contrary to what the complainer believed no protest against that decision had been made to the examining doctor by his brother. I found that the complainer was also wrong in his belief that his mother had waited in a corridor wearing only a paper gown. As the woman's own clothes were wet I did not criticise nursing staff for sending her home in a hospital gown and wrapped in blankets, but I found that a request for socks had been met with an unhelpful response. I considered the Board's investigation was prompt and thorough but that their written reply could have been improved.

Remedy

The Board apologised to the complainer for the shortcomings I found and agreed to emphasise to A & E staff the importance of a constructive response to requests for help.

24. ATTITUDE AND BEHAVIOUR OF A CONSULTANT - SW.25/87-88

Matters considered

Presence of medical students at examination - failure to seek patient's agreement - attitude and behaviour of a consultant - handling of complaint by Health Board.

Summary of case

A woman who was expecting her first child was examined by a consultant in the presence of medical students at her first ante-natal appointment. She subsequently complained to the Board that her prior agreement to their presence was not sought. She complained also that the consultant did not introduce himself, did not speak to her directly but merely pushed her into position for the examination and made a series of sarcastic remarks about her to the students. The woman complained to me that the Board's response was unsatisfactory and unnecessarily delayed.

Findings

I found that there was nothing in the hospital's appointment card or patients' handbook to inform the woman that she was attending a teaching hospital or of the possible presence of medical students. Furthermore the Board had taken no steps to advise the complainer of this and of her right to refuse to have medical students present. And at the ante-natal clinic no attempt was made to obtain her consent to their presence. I was pleased to note however that as a result of the woman's complaint the Board had reminded consultants of their responsibilities in this respect and were reviewing the wording of their appointment cards. I found that the consultant did not introduce himself, and the evidence of various members of staff persuaded me that he had little direct communication with the woman. I also considered that on occasion the consultant probably moved the woman into position for examination rather than asking her to do so herself. I believed that the consultant made remarks which the woman found offensive but although I accepted that he made the remarks jokingly with the intention of putting the complainer at her ease, I found that unfortunately they served instead to increase her apprehension and discomfort. While the consultant's approach and manner may be perfectly acceptable to many patients I criticised him for his failure to take account of the need to modify and soften these in respect of others. I found that the Board failed to advise the woman that their replies to her letters would be delayed. I considered their initial reply was chiding in tone and failed to give an appropriate apology.

Remedy

The Board apologised for the shortcomings I identified.

25. INJURY TO AN ELDERLY PATIENT - WW.32/86-87 - WW.14/87-88

Matters considered

Inter-hospital ambulance transport - information issued to nursing staff concerning categories of ambulance transport - mobilisation of elderly patient by ward staff - information given to relatives - handling of complaint by two health authorities.

Summary of case

A husband and wife complained that the husband's mother was transferred by ambulance from a hospital managed by one Health Authority to another hospital managed by a second (adjacent) Health Authority, in an ambulance provided by the first health authority. After her return the mother complained to ward staff of pain in her right foot but no bony injury was detected from an x-ray a week later. She was discharged the day after the x-ray but three days later a further x-ray ordered by her family practitioner revealed a fracture. The complainants alleged that the mother was made to walk in to and out of the ambulance, whereas she should have been carried in a chair and that the ambulance crew and nurse escort failed to provide adequate support as she alighted from the vehicle, thus injuring her ankle; nursing staff on the ward at the second hospital made his mother walk against her will; and they were given misleading information concerning the availability of x-ray services over the weekend.

Findings

I upheld the complaint that the patient was made to walk in to and out of the ambulance which I found stemmed from varying interpretations by the staff of inadequately worded procedures issued by the first Health Authority; I was glad to learn that the procedures had since been revised. I did not uphold the complaint about the fall while alighting from the ambulance because there was no evidence that the patient had complained at the time or that the accident to her ankle had occurred then. It was not disputed that the patient was made to walk against her will at the second hospital, but I found that the consultant in charge of her care had given instructions that she should walk and I could not question his clinical judgment. However, I did not believe that the nursing staff had been uncaring in their attempts to mobilise her and I did not uphold this complaint. I found there had been a misunderstanding between a nurse and the complainant as to the availability of x-ray facilities at weekend. I was in no doubt that the mother had suffered the injury but I could not determine whether it had occurred while she was in the care of the first or second Health Authority or even on some other occasion. But I found reason to criticise aspects of the handling of the complaint by both Health Authorities and in particular I considered that they should have co-operated more positively and efficiently so as to convince the complainants that their complaint had been thoroughly investigated.

Remedy

Both Health Authorities apologised for the shortcomings I found.