THE SCOTTISH OFFICE

Department of Health

NHS
MEL(1997)40

NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

11th July 1997

Dear Colleague

REPORTS OF THE HEALTH SERVICE COMMISSIONER

Summary

1. This letter covers 2 important reports from the Health Service Commissioner and requests that they should be distributed widely and used by all Health Boards and NHS Trusts to review performance and take remedial action as required.

Action

2. Enclosed are:

2.1 the Health Service Commissioner's annual report for 1996/97.

2.2 his report on selected cases (October 1996-March 1997).

2.3 epitomes of the selected cases.

3. Board General Managers and Trust Chief Executives are asked to:

3.1 distribute the reports as widely as possible; in particular Section 5 of the Annual Report should be drawn to the attention of staff involved in administering the new complaints procedure. The reports are also available on the Internet:

Addressees

For action:
General Managers, Health Boards

Chief Executives, NHS Trust

General Manager,
Common Services Agency

General Manager,
State Hospitals Board for Scotland

For information:
(Epitomes Only)

General Manager,
Health Education Board for Scotland

Executive Director, SCPMDE

Chief Officers/Secretaries,
Local Health Councils

Deans of Medical Faculties

Enquiries to:

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Health Service Commissioner's Annual Report 1996/97:
http://www.official -document.co.uk/document/health/arep96/areport.htm.

Selected investigations October 1996-March 1997:
http://www.official-document.co.uk/document/health/commrep/creport.htm.

3.2 check performance against the findings in the reports and provide me by 1 October 1997 with a note of remedial action taken to improve procedures in the light of the reports. I need this information, which should be sent to David Steel, Head of Health Gain Division, to prepare for my appearance before the Select Committee.

4. The attached Annex highlights a number of key points in the reports.

Geoff Scaife

GEOFF SCAIFE
Chief Executive

ANNEX

ISSUES ARISING FROM THE HEALTH SERVICE COMMISSIONER'S REPORTS

1. Key Points

1.1 These are the first reports issued by Mr Michael Buckley who succeeded Sir William Reid as Health Service Commissioner in January 1997. Although the Commissioner's criticisms stem from a very small proportion of the number of cases treated by the NHS, there is no room for complacency. Of the 2,219 complaints received by the Commissioner in 1996/97, 169 were from Scotland.

1.2 The Commissioner's reports contain useful lessons to be learned by all NHS bodies and not just those identified in them. He identifies some broad themes which emerge from the complaints investigated. Your attention is drawn to Section 2 of the Annual Report which sets out the main topics covered by the Commissioner's investigations: failures by staff to communicate with each other; poor record-keeping; failures in communication with relatives of dead or dying patients; complaints handling. Regrettably, some of these are issues recurring year after year, despite attention being drawn to them on each occasion.

2. New Complaints Procedure

2.1 I would also like to draw your attention to Section 5 of the Commissioner's Annual Report which gives his experience of the new complaints system and sets out some of the common problems which his Office has begun to encounter. There were failings in 3 specific areas relating to convener's decisions: failure to obtain appropriate clinical advice; failure to provide adequate reason for decision; and investigating and resolving the complaint, showing partiality. The Management Executive will issue a copy of Section 5 to all Health Board and Trust conveners and complaints officers.

2.2 The UK Health Departments, under the leadership of the Department of Health in England, will shortly begin an evaluation of the working of the new complaints procedure and if you would like to provide comment on any aspect of the procedures we would be happy to feed this into the evaluation process.

2.3 I would like to take this opportunity to thank all those who have been working so hard over the last year to ensure the successful implementation of the new complaints procedure. I am grateful for the time, effort and commitment that has been put in at all levels.

GEOFF SCAIFE
Chief Executive

ENE13406

COMMON SERVICES AGENCY
for the
NATIONAL HEALTH SERVICE IN SCOTLAND

Internal memo

From: Robin Wiggs Acting Executive Co-ordinator and Agency Complaints Officer	**To:** Divisional Directors
Subject: REPORTS OF THE HEALTH SERVICE COMMISSIONER	**Your reference:** **Our reference:** **Date:** 1 August 1997

Please find enclosed the recent MEL that accompanied the above report.

Due to the size and cost of the full publication, I have not circulated it, however the library at TPH hold a copy should you wish to refer to it For those with internet access, the Report is also available on-line.

Whilst much of the report is concerned with issues pertaining to clinical care, the Commissioner's recurring themes of Communication between Staff, and Complaints Handling are applicable to us all in our efforts to provide quality services and handle complaints successfully.

I am currently investigating the provision of some "customer care" training for HQ staff. If you would be interested in including any of your staff, please contact me. I will be in touch at a later date when plans are more advanced.

If your require any further information, please do not hesitate to contact me.

Regards.

Robin.

Case No. E.965/94-95 - Relative not told of patient's deterioration and death, delay in viewing body, and handling of complaint

Matters considered

Failure of communication about dying patient, delay in viewing body, complaint-handling

Body complained against

University College Hospitals NHS Trust, London

Summary of case

A woman complained about the failure of staff at University College Hospital, London, to inform her of her elderly father's deterioration and death during the night of 21-22 July 1994. Although the woman lived in another part of the country she had travelled to London intending to visit her father the next day, and could have come into the hospital during the night if she had been contacted. When the woman asked to view her father's body the next morning, she was unable to do so for several hours. The University College London Hospitals NHS Trust did not reply to the woman's complaint to them.

Findings

I upheld the complaints. I found that the woman had asked to be contacted immediately if there was any significant deterioration in her father's condition; but staff did not do so until some hours after his death, when an inexperienced student nurse broke the news. I criticised the Trust for their lack of instructions to staff on informing relatives about the condition of patients who are near to death. When the woman arrived at the hospital she had to wait several hours before staff were able to arrange for her to see her father's body. The arrangements were left to the student nurse who was not familiar with the relevant instructions, which in any case were incomplete. When the woman complained to the hospital manager she received a letter of acknowledgement which contained a number of errors, for which I strongly criticised the Trust. A full reply was promised within 20 days; but despite repeated promptings - including several by my Office - none was ever sent. I noted that this was fifth recent case in which I had to criticise the Trust for failings in dealing with complaints.

Remedy

The Trust apologised and agreed to improve guidance on care of the dying, keeping relatives informed, and arranging for them to view the deceased, and to make sure that complaint-handling procedures were properly understood by all staff and carried out.

Case No. E.1190/94-95 - Policy for funding incontinence supplies to residential care homes and complaint handling

Matters considered

Refusal to reimburse care-home residents for incontinence supplies - replies dilatory

Body complained against

East Norfolk Health Authority, Norfolk

Summary of case

In June 1993 the proprietor of a residential care home learned that under new national guidance health authorities had been required from April 1993 to fund the provision of incontinence supplies to people living in independent residential care homes on the same basis as to those living in their own homes. She asked the former Norwich Health Authority, succeeded on 1 April 1994 by East Norfolk Health Authority, about funding for her residents. They replied in October 1993 that funding was available to some but not all residents of care homes. As there was no equivalent restriction on funding for those living in their own homes, the complainant, her solicitor, and her MP wrote several further letters to the Health Authority but received no answer. In August 1994 she wrote to the Department of Health, who passed her letter to the Health Authority. They replied in November that they were working to achieve a consistent funding policy; and in April 1995 one was adopted. However, the Health Authority declined to reimburse those among the complainant's residents' who had had to pay for their own supplies during the two years since April 1993.

Findings

Between April 1993 and April 1995 the Health Authority funded supplies to residents of care homes on a different basis from those to people living in their own homes. That was in contravention of the national guidance which required a consistent approach. The situation was rectified in April 1995 but the Health Authority had no justification for refusing reimbursement to those residents who had had to pay for their own supplies during the two previous years; and they had therefore suffered injustice. I also found that there were repeated delays and failures by the Health Authority in acknowledging and replying to letters sent by the complainant, her solicitor, and her MP. A substantive response was finally sent only because of the enquiries she made through the Department of Health.

Remedy

The Health Authority apologised and agreed to reimburse the residents' costs. They have also changed their procedures for handling enquiries and complaints.

Case No. E.1507/94-95 - Nursing care and record keeping

Matters considered

Fall from bed, failure to record information about earlier operation.

Body complained against

Salford Royal Hospitals NHS Trust, Salford

Summary of case

A woman complained that while her father was in Hope Hospital, Salford, in March 1994 he fell out of bed having been left alone, even though nurses knew that he was restless and confused. The man had recently had an eye operation, which his son mentioned to nurses at Hope Hospital. The woman said that because no note was made of that, insufficient attention was paid to her father's eyes after his fall. A few days later he was found to have restricted vision in his right eye; and despite an operation he lost the sight of that eye.

Findings

The complaint about the fall was not upheld because no evidence was found of lack of reasonable care by the nurses. The complaint that no record was made of the man's eye operation was upheld. What the man's son told nurses about the operation when his father went into Hope Hospital was not written down; and the nurses who cared for the man after his fall did not know about it. They said that if they had known about the operation they would have made sure a doctor examined the man's eyes immediately after his fall.

Remedy

The Trust apologised and agreed to make sure that all information relevant to patients' care and treatment was recorded and passed on when appropriate.

Case No. E.110/95-96 - Response to a critical independent professional review (IPR) report

Matters considered

The Trust's response to an IPR report.

Body complained against

Salisbury Health Care NHS Trust, Wiltshire

Summary of case

In 1992 the complainant's 18 year old daughter died after being admitted to Salisbury General Infirmary. An IPR, under the former NHS clinical complaints procedure, was produced in 1994 and was highly critical of the treatment given to the young woman. It also considered the handling of her parents' complaint. In October 1994 the Trust set up a 'complaint investigation panel' to consider the report and to report to the Trust Board. The complainants considered that the setting up of the panel and its subsequent report to the Board were an inadequate and inappropriate response to the findings of the IPR.

Findings

I found that the Trust put a lot of time and effort into addressing the problems highlighted by the IPR report; and I saw nothing which would cause me to question the seriousness with which they took the report. I considered it appropriate for the Trust to ask a group to study the report and produce a detailed action plan for Board approval; but the Trust did more than that and largely re-investigated the complaint. I did not consider that such a large element of re-investigation was appropriate, as it was bound to appear as if the Trust were acting as a court of appeal on their own case. I also considered it inappropriate for the panel to involve the chief executive and the legal manager both of whom were involved in the investigtation of the original complaint There was some insensitivity on the part of the Trust to the appearance of what they were doing; and the inclusion in the panel's report of a preliminary comment criticising the IPR was unhelpful in that respect. When the Board decided to accept the panel's report those involved in the complaint withdrew from the meeting; but that was not recorded.

Remedy

The Trust apologised. They had already changed their recording of Board meetings to include any withdrawals from the meeting.

Case No. E.447/95-96 - Excessive delay in resolving a complaint

Matters considered

Excessive delay in replying to complaint - confusion over complaints procedure - delay in arranging IPR.

Bodies complained against

Pontefract Hospitals NHS Trust, Wakefield Health Authority, and the former Northern and Yorkshire Regional Health Authority

Summary of case

A woman complained in June 1992 about treatment she had received at Pontefract General Infirmary, which was managed by Pontefract Health Authority (now Wakefield Health Authority) until 31 March 1993 and thereafter by Pontefract Hospitals NHS Trust (the Trust). There was a delay of six months until the consultant concerned provided his comments, during which time the woman was sent no holding letters. A substantive reply to her complaint was not sent until February 1993. In April 1993 she asked for her case to

be referred to the Regional Medical Officer (RMO) of the Northern and Yorkshire Regional Health Authority for an independent professional review (IPR) under the clinical complaints procedure which applied at that time. Staff dealing with the complaint at the Trust believed, incorrectly, that only a consultant could refer a case for IPR; and when he refused to do so no action was taken to refer the case until January 1994. Confusion arose between the Trust and the RMO's office about whether the Trust supported the IPR referral; and arrangements for the IPR were not put in hand until November 1994. The IPR was held in May 1995 - more than three years after the woman had first complained about her treatment.

Findings

I considered it a disgrace that the woman had to wait so long for her complaint to be resolved; and I strongly criticised the health authority and the Trust. I recognised that the period in question had seen many organisational changes for the bodies concerned; but that did not excuse the delay in resolving the woman's complaint. Despite his busy operating schedule, the consultant bore much of the blame for the initial delay in providing the woman with a response to her complaint; and staff handling complaints were remiss in failing to monitor progress and to keep the woman informed. When confusion arose about who could refer a complaint for an IPR the matter was allowed to drift, and no effort was made to seek the help of the Trust's chief executive. There was then further confusion over whether or not the Trust supported the IPR referral, which led to more delay. I upheld the woman's complaint.

Remedy

The bodies concerned apologised to the woman for the shortcomings I identified. The Trust's complaints procedure was revised; and the chief executive assured me that complaints were now dealt with promptly and closely monitored.

Case No. E.920/95-96 - Standards of nursing care, record keeping and communication

Matters considered

Failure to meet oral and personal hygiene needs - poor record keeping - poor communication with the patient's family - failure to inform family of circumstances of patient's death.

Body complained against

North Essex Health Authority

Summary of case

The complainant's father was admitted to Princess Alexandra Hospital in Harlow, in January 1995 following a stroke. He was unable to swallow, and a board by his bed read 'nil by mouth'; but staff continued to offer him food and drink. He developed a sore mouth but his wife was told mouthwash tablets were not available. Nursing staff were evasive when members of the family asked about his care. On 28 February his wife visited him and found him covered in excrement. A nurse told her that he had been disturbed during the night by another patient and she had not wanted to waken him. The family later found that there was no record of the incident in his nursing or medical notes. In the evening of 28 February the police informed the family that the complainant's father had died. The family were not aware that he had fallen from a balcony to his death until they were contacted by the Coroner the following day. The hospital was administered by the Health Authority until March 1995. Since then it has been managed by Princess Alexandra Hospital NHS Trust.

Findings

I found that the standard of nursing care received by the complainant's father was inadequate. I commended the Trust for developing and implementing an action plan, following the complaint, to address the inadequacies identified. However, I was concerned to note that senior staff were in some doubt about the effectiveness of the plan. I found that the nursing and medical notes were not as complete as they should have been, and was concerned that this was also a problem elsewhere in the Trust. I found that

communication with the family was poor while the complaint's father was a patient, and that there was an appalling breakdown of communication following his death. I considered it wholly unacceptable that the complainant's mother did not learn about the circumstances of her husband's death till the following day. I upheld the complaint.

Remedy

The Trust apologised and agreed to carry out and act upon a planned independent review of nursing care; review their systems for auditing nursing and medical records to make sure that significant actions, interventions and decisions of staff were recorded and to consider improvements to, and greater awareness of, their policy on untoward incidents.

Case No. E.1009/95-96 - Delays in outpatient clinic and complaint handling

Matters considered

Unacceptable delays before seeing doctor at outpatient appointments - complaint handling.

Body complained against

Salisbury Health Care NHS Trust

Summary of case

In August 1995 a man complained to the chairman of Salisbury Health Care NHS Trust that his wife had waited over an hour to see a doctor at a renal outpatient clinic at Salisbury District Hospital. The chairman replied in September 1995 that the clinic was oversubscribed, and urgent steps were being taken to improve the situation. On her next visit in November 1995 the wait was two hours. The man complained again and was dissatisfied with the Trust's response.

Findings

Salisbury Trust provided accommodation and support staff for the clinic; and Portsmouth Hopsitals NHS Trust provided the services of the consultant. In the past the service had been funded by the Regional Health Authority. Since the introduction of the NHS internal market, funding had been from Wiltshire Health Authority. I found that there was confusion between the two Trusts and the Authority about details of the funding arrangements, and about which Trust was responsible for managing waiting times. That led to delay in obtaining funding for an extra clinic session until June 1996. The Salisbury Trust failed to pursue adequately the need for a realistic clinic schedule while the extra clinic session was being arranged, and should have told the Portsmouth Trust about the complaint earlier.

Remedy

The Salisbury Trust apologised and agreed to approach the Portsmouth Trust and the Authority to clarify the responsibilities of each Trust for the clinic and the arrangements for monitoring its performance. They also agreed to clarify responsibilities for any similar jointly resourced clinics and to review their complaints procedure in respect of complaints involving other Trusts.

Case No. E.1072/95-96 - Communication with relatives after patient's death

Matters considered

Inadequate efforts by Trust to contact a man after his mother's death.

Body complained against

St George's Healthcare NHS Trust, London

Summary of case

In September 1995 a woman was taken to the accident and emergency department of St George's Hospital, London. She was admitted to a ward where she died shortly afterwards. Her next of kin were not contacted; and it was only three weeks later, when a cheque which she had sent to her grandson was returned marked 'drawer deceased', that her son learned of her death. When he met the director of nursing at the Trust in October 1995 he complained about the failure to contact him, and he received a written reply in November 1995, but remained dissatisfied.

Findings

There was no clearly understood policy about who was ultimately responsible for making sure that details of patients' next of kin were obtained. In this case the woman's details were not obtained when she was admitted. The hospital had two sets of notes for the woman - with different versions of her first name -the one used on this occasion did not include next of kin details. Efforts to trace the woman's relatives after her death were inadequate. Although staff contacted the woman's bank, the local council, and the local police that provided no help in tracing her relatives. The Trust should have contacted the police formally at a more senior level about an apparent change in their policy about making enquiries. They should also have considered other actions such as contacting the woman's neighbours, entering her flat using the keys (which she had taken to hospital with her), or seeking involvement of the social services department. It seemed possible that if the cheque had not been returned the hospital would have arranged the woman's funeral without further effort to contact her family.

Remedy

The Trust apologised and agreed to complete their written policy on the arrangements for obtaining and recording information about next of kin, and to consider making further efforts to avoid the creation of duplicate records. The Trust also undertook to agree new procedures with the local police and to produce written guidance to staff on action to take if the police were unable to assist in such situations.

Case No. E.1129/95-96 - Complaint handling by a Regional Health Authority.

Matters considered

Complaint to Regional Health Authority (RHA) about Community Health Council (CHC) and refusal of an independent professional review (IPR).

Body complained against

The former North Thames Regional Health Authority

Summary of Case

In March 1995 a woman complained to the RHA about a delay by a CHC in providing help to pursue her concern about the RHA's refusal to arrange an IPR of the clinical care of her late sister. In September 1995 she complained to the RHA about both the CHC's and the RHA's failure to act on her concerns. She received no reply; and in November her MP wrote to the RHA on her behalf. The RHA replied in December 1995; but the woman remained dissatisfied. On 1 April 1996 the RHA ceased to exist and their responsibilities for complaints about CHCs were transferred to a regional office of the NHS Executive. Complaints about CHCs are not within my jurisdiction.

Findings

I found that the manager of the CHC unit at the RHA contacted the CHC's chief officer on a number of occasions, but apparently only when prompted by the woman. The manager had agreed that she would contact the woman after a meeting with the CHC chief officer but failed to do so, leaving the woman with a false expectation that her case was being transferred to another CHC. I found a lack of awareness by RHA staff involved of relevant local and national guidelines on complaints. There was a delay in the RHA's recognising that they should also respond to the woman's concern about the IPR; and they did not draw the matter to the attention of the CHC chair despite their difficulty in getting action from the CHC chief officer. I upheld the complaint.

Remedy

The NHS Executive agreed to make sure that all regional offices were clear whose responsibility it was to agree procedures for handling of complaints about CHCs and to ensure that all outstanding matters concerning complaints about them were resolved as soon as possible.

Case No. E.1134/95-96 - Inadequate nursing care in a private nursing home

Matters considered

Inadequate nursing care - role of Health Authority.

Body complained against

East and North Hertfordshire Health Authority

Summary of case

In October 1994 a man was transferred from an NHS hospital to a new private nursing home, where his care was funded by East and North Hertfordshire Health Authority. On 1 January his wife was told he had developed sores on both knees. When he was admitted to hospital on 3 January, it was noted that he also had a sore on his right hip, which appeared to have been dressed while he was in the home. There was no reference to the sore on his hip in the home's records. His wife complained to the Authority about the care he had received while in the home, but remained dissatisfied with their explanation.

Findings

I could not establish exactly why the man's sores developed, but concluded that they were a result of inadequate nursing care. Serious administrative findings lay behind that. The level of record keeping and care planning was inadequate. There were considerable staffing problems in the home at that time, with high turnover, sickness, and use of agency and inexperienced unqualified staff. After two staff failed to attend there had been only two nurses (one unqualified) to care for 30 elderly mentally infirm patients on Christmas Day. Patients had been admitted to the home too rapidly by the Authority. The specification for the care of NHS patients was inadequate, as were the arrangements for monitoring the patients' care.

Remedy

The home acknowledged the inadequacy of the nursing documentation - nursing notes were now audited three-monthly. The Authority recognised the inadequacy of their monitoring arrangements and had made improvements. The Authority maintained that they now had confidence in the care provided by the home, and agreed to review their contracting and monitoring arrangements.

Case No. E.1242/95-96 - Preparation of deceased and complaint handling

Matters considered

Preparation of deceased's body in the ward - loss of medical records - inadequate and dilatory investigation of complaint.

Body complained against

King's Healthcare NHS Trust, London

Summary of case

In December 1994 a man was admitted to King's College Hospital, where he died two days later. His wife, son and a family friend arrived at the hospital shortly after the man's death; and the son and the family friend viewed the body in the ward. They were distressed by its condition, and considered that it had not been prepared in any way. In January 1995 the man's wife complained to the Trust about that and other matters. In June 1995 the Trust wrote, informing her that they could not locate the medical records. Meetings were held in July and September 1995; but the woman remained dissatisfied. She complained to me that she and her son were caused additional distress because of the failure to prepare her husband's body in the ward; that his medical records were lost because of inadequate monitoring procedures; and that the Trust's investigation into her complaints was inadequate and dilatory.

Findings

The ward staff could not recall the events surrounding the man's death; and on the available evidence I could make no finding on the complaint about the preparation of his body. The ward staff said that when a patient died the usual practice was to make the body presentable; but it was not the practice formally to lay out the body until after the relatives had seen the deceased. I upheld the complaint that the Trust misplaced the man's records; and I found that other documents in relation to this case had, at times, been mislaid. I also upheld the complaint about the way the Trust had handled the woman's grievances. I strongly criticised the Trust for not clarifying the woman's central concerns at the outset. Instead, issues became confused and a muddle was allowed to develop. The Trust accepted that initially they were dilatory in dealing with the complaint because the man's medical records were not available.

Remedy

The Trust apologised. They said that had already introduced revised arrangements for dealing with complaints. They had also made a number of changes to improve the safeguarding of records; and they agreed to monitor closely and audit the effectiveness of those new procedures.

Case No. E.1275/95-96 - Communications with relatives, mortuary procedures and complaint handling

Matters considered

Failure to communicate with relatives about seriousness of condition and on visiting arrangements - unsatisfactory mortuary procedures - inadequate handling of complaint.

Body complained against

Barnsley District General Hospital NHS Trust, South Yorkshire

Summary of case

In early 1995 a woman was admitted to Barnsley District General Hospital for breast surgery. Following the surgery an infection in the woman's foot became worse, and she experienced breathing difficulties. An unconfirmed diagnosis of a pulmonary embolism was made; and she died on 5 February. The woman's daughter complained that the medical staff did not communicate the seriousness of her mother's condition, and that the nursing staff did not explain to her relatives that the policy on visiting hours was flexible. She also complained that her mother's body was stored unrefrigerated in the hospital mortuary after her death, rendering the body unsuitable to be viewed at the undertaker's. The daughter considered that the Trust failed to investigate adequately her complaint about a breach of confidentiality by a nursing auxiliary.

Findings

The opinion of the clinicians involved in the woman's care was that her death could not have been foreseen; and I did not criticise the medical staff for not telling her relatives that her condition was potentially serious. I was not persuaded that her relatives were deliberately denied information about flexible visiting arrangements; and I did not find that complaint made out. The Trust said that woman's body was too large to be placed in the refrigerated cabinet in the mortuary. The Trust's staff and the undertaker's employees

gave different accounts about the condition of the body; but I was persuaded that there was some deterioration. The position was not properly monitored and documented, and there was a failure to liaise with the woman's relatives. I upheld the complaint. I was critical of the lack of records in relation to the complaint about a breach of confidentiality; and I considered that the Trust could have done more to identify the staff member involved. I also upheld that complaint.

Remedy

The Trust apologised. They agreed to give guidance to medical staff about communication with relatives, and to remind mortuary staff of the need to monitor the state of bodies and to liaise with relatives if there were storage difficulties. They also agreed to reinvestigate the complaint about a breach of confidentiality and to remind staff dealing with complaints of the importance of recording significant discussions and of providing complainants with full replies.

Case No. E.1312/95-96 - Mislabelling of test result

Matters considered

Inadequate steps to make sure a specimen was correctly labelled -inadequate checks for test result - delay in doctors being informed about the mistake - delay in informing the patient.

Body complained against

The Hammersmith Hospitals NHS Trust, London

Summary of case

In February 1995 a man had an operation to remove what was thought to be a benign tumour from his heart. In July 1995 he had a second operation to remove a blood clot from the same area. In reply to a complaint made in September 1995 his son was told by the Trust that the growth removed during the first operation had been mislabelled with the details of another patient who had an operation on the same day. The error was identified only when the growth unexpectedly recurred, and the test result, showing that the first growth had also been a blood clot, was traced in July.

Findings

I found that several opportunities were missed to identify the problem much earlier. It should have been noticed in the operating theatre - the label and form accompanying the specimen should have been checked. The apparent lack of a test result for the man should have been picked up when his care was reviewed; and the change in diagnosis should have prompted action when test results were reviewed. The system for checking test results failed; the man did not receive the appropriate treatment; and by the time the problem was identified he needed a second operation. Doctors treating the man were aware of the problem as soon as it was discovered in July; but until the family complained in September no one took responsibility for giving a full explanation of the mistake to the man or for taking action to avoid any repetition of the problem.

Remedy

The Trust apologised and agreed to remind staff of the importance of completing theatre documentation accurately, to audit it periodically, to amend their theatre policy, and to review and audit its arrangements for reviewing test results. They also agreed to remind staff of their responsibilities when such errors are discovered.

Case No. E.1315/95-96 - Patient care and communications with relatives

Matters considered

Inadequate nursing care - failure to follow 'not for resuscitation' policy.

Body complained against

Eastbourne Hospitals NHS Trust, East Sussex

Summary of case

The son of a woman who died in Eastbourne District General Hospital in January 1995 complained about aspects of her care. He believed that insufficient care was taken to ensure that his mother received adequate amounts of fluid, that nursing observations were often either omitted or not recorded, and that a doctor's specific instruction for two-hourly observations was not followed. He also complained that family members were not consulted before medical staff instructed that his mother should not be resuscitated in the event of cardiac arrest.

Findings

I upheld the complaint about the woman's fluid intake: I found that the absence of a proper care plan, the lack of certain fluid charts, and the unsatisfactory nursing records together constituted a failure of care in that matter because there was no clinical management structure in place to make sure that such care was given. I found that the care which the woman received, including her observations, was not fully and properly recorded. Because of inadequate documentation, I was unable to make a finding on frequency of the observations or whether a doctor's instruction in relation to that was ignored. The Trust's 'not for resuscitation' policy stated that relatives were not normally involved in making the decision but should, where possible and appropriate, be informed of the decision and why it had been taken, and have their comments noted. I was not persuaded that the medical staff told the family of th decision not to resuscitate the woman, and found that other aspects of the Trust's 'not for resuscitation' policy were not followed.

Remedy

The Trust apologised and agreed (i) to give clear guidance to staff about monitoring the fluid intake of patients who are sedated, drowsy or confused, and to remind staff of the need to make full records about fluid intake; (ii) to issue clear, written instructions to nurses about recording the care which is given; (iii) to remind ward managers and consultants to make sure their staff are aware of and implement protocols on patient observations; and (iv) to remind all medical staff of the requirements of their 'not for resuscitation' policy and that, in particular, consultants should make sure that all junior staff are aware of that policy and follow it.

Case No. E.1344/95-96 - Cancellation of a child's test at short notice, no new appointment offered

Matters considered

failure in service when a child's test was cancelled at short notice and a new test date was not given; conflicting explanations given for the cancellation of the test.

Body complained against

Chelsea and Westminster Healthcare NHS Trust, London

Summary of case

A child was referred by a consultant from Chelsea and Westminster Hospital for a food absorption test. The test was to be performed by the Vitamin B12 unit, which was located on the same site as the hospital but was not one of the services offered by the Trust. The child had had no food or drink for 17 hours when he attended an appointment for the test on 19 December 1995. At 5.00 pm the test was cancelled without warning. The child's mother complained about that; that in the following months she received different explanations for that cancellation from the Trust; and that no new appointment had been offered.

Findings

I found that the Trust had been trying to formalise their relationship with the Vitamin B12 unit since August 1995. They set the doctor a list of conditions to be met if the Trust was to continue to allow their consultants to refer patients. The Trust had offered the child an appointment before the issues of concern about the unit had been resolved. I considered it disgraceful that differences between the principal players caused the child's test to be cancelled at such a late stage. Once the appointment was offered, the test should have taken place. I also found that the Trust had failed to offer a new appointment for the test while it had been administratively possible to do so during the time when the doctor heading the unit had an honorary contract with the Trust. I did not uphold the complaint that the Trust had given conflicting explanations to the complainant about the reasons why the test had been stopped: the reasons why an appointment was not offered changed as events developed.

Remedy

The Trust apologised and agreed to make every effort, with the complainant, to resolve the impasse over the child's test, including considering alternative provision.

Case No. E.419/96-97 - Trust's communications with a patient's GP and complaint handling

Matters considered

Communication between the Trust and GP about an unsubstantiated allegation - handling of complaint.

Body complained against

North Tyneside Healthcare NHS Trust, Tyne & Wear

Summary of case

A man complained that in August 1995 the Trust wrote to his GP conveying an unsubstantiated allegation about his behaviour: the allegation concerned an incident which occurred when the man attended the pathology department of the hospital to hand in some samples for testing. The Trust maintained that the receptionist in the pathology department had felt threatened by the man's manner; and the biochemistry departmental manager said that she wrote to the GP for several reasons, one of which was to prevent his patients coming to the pathology department with misconceptions about when their test results would be ready. As a consequence of the departmental manager's letter the GP removed the man from his list. The man further complained about the Trust's handling of his complaint about the matter.

Findings

The departmental manager's letter to the GP was very short and emphasised a view that the man's conduct had been threatening, which he strongly denied. I was unable to establish the manner in which the man had spoken to the receptionist; but I found that the letter to the GP lacked balance. I was not persuaded that there was sufficient evidence to justify the type of phraseology used in the letter; and I considered that before writing to the GP in terms they did the Trust should have raised their concerns with the man and given him the opportunity to respond. To that extent I upheld the complaint. I also found shortcomings in the way in which the Trust dealt with the man's complaint.

Remedy

The Trust apologised and agreed to remind staff of the need to deal with all complaints thoroughly and to comply with the terms of their new complaints procedure.

Case No. E.587/96-97 - Response to request for access to records

Matters Considered

Poor and insensitive handling of request for copies of records and corrections; consultant's manner.

Body complained against

Greenwich Healthcare NHS Trust

Summary of case

In September 1994 a woman's baby was delivered at home by staff of Greenwich Healthcare NHS Trust, and died the next day in Greenwich District Hospital. The woman applied for access to the Trust's records of the delivery. She was allowed to view the records; but when she asked for copies hospital staff told her that she would first have to meet the consultant paediatrician. When they met the woman found the consultant's manner intimidating. The records contained statements that the woman had refused to go into hospital for the delivery. The Trust accepted that was not the case; but there was a long delay before they agreed to change the records to reflect the true position.

Findings

The consultant's views about granting access to the records were properly sought by hospital staff under the terms of the Access to Health Records Act 1990. He decided to release the records only after meeting the woman and her husband, and subsequently stated that was because he wanted to take the opportunity to counsel them. However, I found no evidence that any counselling was offered at that meeting. The consultant was concerned that the parents might be contemplating legal action and questioned them about that at the meeting. I criticised him for allowing such considerations to affect his actions, and for making the meeting a precondition of the woman receiving copies of the records. I found that it took the Trust almost four months to respond effectively to the request for a correction to the record.

Remedy

The Trust apologised and agreed to review their arrangements for dealing with applications for access to records and requests for corrections to be made to those records under the Act.

Case No. E.591/96-97 - Convener's decision not to convene an independent review

Matters considered

The procedure followed by a convener in deciding not to convene an independent review of a man's complaint.

Body complained against

North Staffordshire Hospital NHS Trust

Summary of case

A man sought an independent review, under the national procedures introduced on 1 April 1996, of his grievances about the care and treatment of his mother, who was a patient at North Staffordshire Hospital, Stoke-On-Trent. His request was considered by the Trust's convener. In July 1996 the convener told the man that his request for an independent review had been refused.

Findings

I found that the convener did not follow the NHS Executive guidance for the handling of complaints in the NHS. The convener obtained independent medical advice from the Trust's medical director, who had not seen the patient's medical records at that time and who, therefore, could not have made an effective assessment. The convener failed to address the specific issues raised by the man, and did not set out fully his reasons for his decision to refuse an independent panel.

Remedy

The Trust apologised and agreed to review the convener's decision in the light of the procedures laid down in the national guidance, and to consider whether there was scope for further efforts at local resolution.

Case No. E.859/96-97 - Convener's decision not to convene an independent review

Matters considered

The procedures followed by a convener in deciding not to convene an independent review

Body complained about

Croydon Health Authority (the HA)

Summary of case

A man sought an independent review, under the national procedures introduced on 1 April 1996, of his grievances arising from a visit to his general practitioner (GP) in May 1996. He also complained that it was unreasonable to refuse him access to his health records. In September 1996 the HA's convener told him that his request for an independent review was refused. The convener said that a review panel could not release medical records to him, and he should consider taking legal advice to obtain the access he sought.

Findings

I found that the convener did not comply with the national guidance for the handling of complaints by the NHS because he failed to take all reasonable steps to consider whether a review panel would resolve the conflicting account of events given by the man and the GP. In particular he took no steps to discover whether there were witnesses who might help to resolve the different accounts, or whether the medical records might do so. The clinical adviser to the convener had not seen the man's medical records before giving advice: I considered it a matter of self-evident good practice that an adviser should see such records. The convener did not address all the man's concerns. I also found that the convener had not established the reasons why the GP had refused the man access to his records and that the convener had wrongly concluded that a panel could not consider such a matter.

Remedy

The Health Authority apologised and agreed to review the convener's decision in the light of fresh clinical advice obtained from an independent adviser who had seen the man's medical records.

Case No. E.944/96-97 - Convener's decision not to convene an independent review

Matters considered

The procedure followed by a convener in deciding not to convene an independent review of a man's complaint.

Body complained against

Epsom Health Care NHS Trust, Surrey

Summary of case

A man sought an independent review, under the national procedures introduced on 1 April 1996, of his complaint about the failure to take a blood test when his daughter attended the accident and emergency department of Epsom General Hospital in August 1995 suffering from pain in her leg. The man's daughter was due to fly to Australia the following day. During the journey her symptoms worsened and she was later diagnosed as having leukaemia.

Findings

I found that the convener did not comply with the NHS Executive guidance for handling complaints in the NHS. The convener misdirected the man by applying an inappropriate test in deciding to refuse an independent review; defended those complained against; and did not tell the man she had obtained independent clinical advice on his complaint. That advice supported key elements of the man's complaint and I strongly criticised the convener for failing to take due account of it.

Remedy

The Trust apologised and told the complainant that they accepted the conclusions of the independent clinical adviser.

Case No. E.1298/96-97 - Trust's response to a request for an independent review and the convener's decision

Matters considered

Handling of request for independent review procedure followed by convener.

Body complained against

St Helens and Knowsley Hospitals NHS Trust, Merseyside

Summary of case

A man complained to the Trust that, in December 1995, doctors at Whiston Hospital failed initially to diagnose a condition affecting the muscles of his leg. After an operation he may now be permanently disabled. His request for an independent review of his case was refused by the Trust's convener.

Findings

I found that the Trust had delayed passing the man's request for an independent review to the convener and that the convener, investigated matters herself instead of referring them back for further local resolution. I did not uphold a complaint that the convener had failed to take independent clinical advice, though she had not told the complainant about that advice.

Remedy

The Trust apologised and agreed to reconsider the man's request for an independent review. In future, requests for independent review will be sent straight to the convener, who will tell complainants whether independent clinical advice has been taken in reaching a decision.

Case No. S.64/95-96 - Communications with patient and relative

Matters considered

Communication with patient and relatives - nutrition - nursing care - escort and transport arrangements.

Body complained against

Hairmyres and Stonehouse Hospitals NHS Trust, East Kilbride

Summary of case

A man underwent surgery in 1992 for cancer of the gullet. His symptoms recurred in 1994, and on 12 August he attended a routine outpatient follow-up appointment at Hairmyres Hospital. On 23 August he was admitted to the hospital for a prostate operation. He died in hospital on 18 September. His wife complained that at no time was the man told of the strong probability that the cancer had recurred or spread; after his admission to hospital inadequate attention was paid to his nutritional state; he was taken for a bone scan to another hospital in an unsuitable ambulance without a proper escort, and his intravenous fluids were discontinued for the journey; and in one ward he was nursed in a draughty area where he was continually cold.

Findings

I found that the man and his family were left without adequate information. During the period in question the man's care passed between different clinicians, none of whom told him of the suspicion that the cancer had returned. I upheld the complaint about his nutritional state to the limited extent that it was inadequately managed during part of his time in hospital. Although a suitable ambulance was used to transport the man for his scan, I found that his fluids should not have been discontinued for the journey and that the lack of a trained nurse escort substantially delayed his return. I did not believe that nursing staff were aware that the man was cold until they were told by his wife; but I considered that they should have been more alert to his needs.

Remedy

The Trust have agreed to take steps to ensure that where a patient passes through the care of a number of clinicians, the responsibility for keeping the patient and his family informed is clearly established, and to remind nurses of the fluid requirements of patients being sent for bone scans.

Case No. W.34/95-96 - Care of an elderly person and communication with relatives

Matters considered

Supervision and assistance with eating and hygiene needs -administration of medication - communication with relatives -procedure for certifying death.

Bodies complained against
Llanelli/Dinefwr NHS Trust, Llanelli and Derwen NHS Trust West Wales, Carmarthen

Summary of case

In October 1994 a woman was admitted to Prince Philip Hospital, which is managed by Llanelli/Dinefwr NHS Trust. She was later transferred to Mynydd Mawr Hospital, which is managed by the same Trust, and then to Bryntirion Hospital which is managed by Derwen NHS Trust West Wales, before being re-admitted to Prince Philip Hospital on 20 January 1995. The woman's son complained that in the first two hospitals his mother's hygiene needs were not met, and that because of inadequate supervision she did not eat her meals or take her medication. He also complained that a nurse told him, incorrectly, that his mother had died; that instructions left in all three hospitals to the effect, that his mother should not be revived if she suffered a total collapse were ignored; and that when she did die the correct procedure for certifying her death was not followed.

Findings

Because there was no documentary evidence from Prince Philip Hospital about the woman's dietary needs, and because nurses could not remember her, I was unable to reach a conclusion about the standard of dietary care there. Nurses in Mynydd Mawr Hospital recognised the woman's dietary problems; but their efforts to encourage her to eat were unsuccessful. I was not persuaded that there were failures in supervision and assistance at mealtimes, and did not uphold that aspect of the complaint. I did not find made out the complaint that the woman's hygiene needs were not met, though it was possible that during her first week or so in hospital she was not included in two-hourly incontinence checks because she was assessed initially as 'self-caring'. Insofar as nurses did not make sure that medication they had given out was taken, I upheld that aspect of the complaint. I found no maladministration in the action taken when the woman's condition deteriorated;

but because of a nurse's error the woman's son was told that his mother was dead when that was not the case. When the woman did die the cause of death was certified by a doctor who had not seen her within the previous 14 days. Because of that the coroner could not accept the certificate, and the woman's son had to return to the hospital to obtain another from a different doctor before the death could be registered. I criticised Llanelli/Dinefwr NHS Trust for failing to make sure that their staff were fully aware of their duties in that respect.

Remedy

Llanelli/Dinefwr NHS Trust apologised and agreed to remind staff that patients must be properly supervised when taking medicines, and that patients' specific needs should be accurately identified and care plans prepared promptly. They also agreed to issue written instructions about nurses' responsibilities with regard to informing relatives about a patient's death; and to make sure that doctors' induction training and supporting written guidance in respect of their contacts with registrars and coroners fully met requirements.

Case No. W.44/95-96 - Nursing care and adequacy of nurse staffing

Matters considered

Adequacy of nutritional care - removal of vomit and urine containers - administration of medication - availability of nurses.

Body complained against

East Glamorgan NHS Trust, near Pontypridd

Summary of case

In April 1994 a man with cancer was admitted to East Glamorgan General Hospital. His wife complained that because the man was too ill to complete a diet sheet he received inadequate nourishment while he was in the hospital. When the man's wife visited she found full vomit and urine containers by his bedside. She also found medication which had been left on the man's bedside locker. She considered the level of nurse staffing in the ward to be inadequate, and said that there were never any staff around when she needed help.

Findings

I considered it less than satisfactory that it took eight days to draw up a care plan dealing with the man's nutritional needs, despite it being known that his condition could lead to poor appetite and fluid intake; but I found no evidence of any lack of attention to the man's nutritional needs, so did not uphold that aspect of the complaint. I did not uphold the complaint that full vomit and urine containers were left by the man's bedside. There was evidence that his wife often removed containers; herself but that did not arise from any laxity on the part of the nurses. I partially upheld the complaint that medication was left on the man's bedside locker; for I found deficiences in the records detailing its administration and a divergence of view as to whether the man was capable of taking the medication himself. I considered it probable that, if medication was left with the man, proper monitoring was not carried out to make sure the drugs were taken. I found no evidence that the general level of staffing in the ward was inadequate.

Remedy

The Trust apologised for the shortcomings I identified and agreed to review their policy on drug administration to make sure that nursing practice was consistent.