Learning Lessons from Complaints to the Ombudsman

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Society for Acute Medicine

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Final Stage of NHS Complaints Procedure

“We want complaints to make a difference and help to improve public services for everyone”

“More impact for more people”
The complainant states

“Harold Shipman lives on in the guise of Dr X in your appalling so called hospital”
62 year female
Asthma: BMI 62

- Thursday 13th - 1033 - attended ED
- Episode of severe breathlessness
- Observations = HR 104, RR 20, T and BP normal, spO2 92% (air), Peak flow 220
- Right leg swollen “cellulitis”
- Diagnosis: CCF and cellulitis
- Treatment: Steroids and Coamoxiclav
- Discharged home: follow next day
62 year female
Asthma: BMI 62

- Friday 14th - Returned to Medical Decision Unit
- Observations Normal
- Right Leg 5 cms > left leg
- Erythmia right leg
- ABG (am) po2 8.0, pCO2 and pH normal
- Seen by consultant
- “Clexane not needed because coming back soon”
- Discharged home - review next week
62 year female
Asthma: BMI 62

- Monday 17th - Consultant reviewed blood tests
- WCC 14.8, CRP 11, D-dimer 2.5
- Phoned patient to recall for CTPA
- Learned collapsed and died 16th
- Investigation revealed that blood test results were available and viewed by nurse 45 minutes before discharge
General Themes: TOP 10

- Diagnosis - delay or failure
- Treatment or procedure - failure
- Assessment (clinical)
- Communication
- Inappropriate discharge
- Medication errors
- Access failure - delayed admission
- Complications - failure to recognise
- Referral - failure
Lessons from complaints analysis (1)

- Poor communication
  - Between professionals
  - With the patient
  - With relatives

- Poor record keeping

“If it isn’t recorded it didn’t happen”
Lessons from complaints analysis (2)

- Poor clinical supervision
- Poor clinical leadership
- Poor clinical assessment
- “Aberrant clinical thinking”
- Clinical investigation delays
- Errors in data interpretation
- Treatment delays
- Withholding treatment without due process
76 year female carer of husband (stroke), fit and active

- PH
- 2 years right hemicolecotmy ca colon, post-operative pulmonary embolism
- Hypertension on amlodipine
- Smokes 20/day
76 year female carer of husband (stroke), fit and active

- 8\textsuperscript{th} February, 0735 - emergency admission
- Cough with green sputum 2 weeks
- Breathlessness 1 day
- Collapsed at home
- Paramedic Sp02 59\% air
76 year female carer of husband (stroke), fit and active

- **Obs:** Temp 37.1, pulse 100 regular, BP 145/85 Resp 30, Sp02 (HF 02) 96%
- **CXR:** large right pleural effusion
- **WCC** 16.8, CRP 26, Urea 10.2, Creat 78
- **ABG (HF 02):** O2 14.6, CO2 8.7, pH 7.31
- **Diagnosis:** “parapneumonic pleural effusion, COPD, type 2 respiratory failure, ? PE
76 year female carer of husband (stroke), fit and active

- **Plan:** BIPAP, co-amoxiclav, steroids, nebulised bronchodilators, USS pleural tap, enoxaparin prophylaxis
- **1145** - seen by ITU registrar - NIV ceiling of care, not for invasive ventilation, DNAR
- **1530** - on-take round - “improved, awaiting pleural tap
- **ABG (BIPAP, 24%02) 02 6.9, CO2 7.8, pH 7.37
76 year female carer of husband (stroke), fit and active

9th February

- 0930: “drowsy, chest bubbly, pleural tap not done yet”
- WCC - 18.3, CRP 38, U7.2, Creat 74
- 1420 - “suddenly collapsed”, and died
- No post mortem
Issues

- Poor notes
- In frequent observations
- The diagnosis
- Management of pleural effusion
- ? PE
- Not for invasive ventilation and DNAR
- Consultant’s statement and Trust response
Consultant’s statement

• “Too ill for pleural drain”

• “Pleural drainage would have made no difference”

• “Anticoagulation would have made no difference”
“Don’t think, don’t do anything, just stand there……”
“You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.”
Don’t go here…

- “That’s ridiculous…”
- “Don’t they know how hard we work…”
- “Don’t they know how busy we are…”
- “That’s just totally unrealistic…”
- “Bolshy b***** woman”
- “Stupid man…”
In preparing your statement, DO (1)

- Explain your role
- Express regret for the need for a complaint
- Make a factual statement based on the record
- Add additional facts only if you can support your recollection
- Be objective
- Use plain English
- Explain medical terms
In preparing your statement, DO (2)

- Explain your decisions and actions
- Evidence and reference your actions
- If no fault, express regret for poor outcome
- If there was an error acknowledge & apologise
- Explain how you have reflected on the case
- Describe any changes in practice that have followed
In preparing your statement, DO NOT

- Use emotive language
- Express defensiveness
- Criticise the complainant
- Make any statement you could not justify when challenged
- Blame colleagues
- Evade responsibility
Complaint management - common problems

- Delays
- Inefficient administration
- Inconsistency in response
- Lack of independent clinical review
- No, or inadequate, action planning
- Failing to engage the complainant
Avoiding complaints

• Make excellent notes
  “If it isn’t recorded it didn’t happen”

• Communicate well:
  - With patient
  - With family
  - With colleagues