Table 1

		Tayside NHS Board Area						
	Complaints Received by Subject	A Dentist or Dental Practice	A GP or General Medical Practice	Tayside NHS Board	**Tayside NHS Board Area Total**	Complaints as % of total	**Sector Total**	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	0	0	1	**1**	1%	**15**	2%
	Appliances, equipment & premises	0	0	0	**0**	0%	**1**	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	1	3	**4**	4%	**48**	6%
	Clinical treatment/diagnosis	0	6	38	**44**	49%	**413**	48%
	Communication, staff attitude, dignity, confidentiality	0	2	5	**7**	8%	**91**	11%
	Complaints by NHS staff	0	0	0	**0**	0%	**2**	0%
	Complaints handling	0	1	0	**1**	1%	**20**	2%
	Continuing care	0	0	0	**0**	0%	**1**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	**0**	0%	**6**	1%
	Hygiene, cleanliness & infection control	0	0	3	**3**	3%	**6**	1%
	Lists	0	1	0	**1**	1%	**7**	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	**0**	0%	**1**	0%
	Nurses/nursing Care	0	1	1	**2**	2%	**10**	1%
	Other	0	0	0	**0**	0%	**2**	0%
	Policy/administration	0	3	12	**15**	17%	**156**	18%
	Record keeping	0	1	1	**2**	2%	**7**	1%
	Out of jurisdiction	0	0	2	**2**	2%	**3**	0%
	Subject unknown	0	0	8	**8**	9%	**68**	8%
	Total	**0**	**16**	**74**	**90**		**857**	
2010-11	Admission, discharge & transfer procedures	0	0	1	**1**	1%	**9**	1%
	Appliances, equipment & premises	0	0	1	**1**	1%	**5**	1%
	Appointments/Admissions (delay, cancellation, waiting lists)	0	0	3	**3**	4%	**35**	4%
	Clinical treatment / Diagnosis	1	4	35	**40**	50%	**402**	45%
	Communication, staff attitude, dignity, confidentiality	0	0	6	**6**	8%	**64**	7%
	Complaints handling	0	0	3	**3**	4%	**27**	3%
	Continuing care	0	0	0	**0**	0%	**3**	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	**0**	0%	**1**	0%
	Hotel services - food, laundry etc	0	0	0	**0**	0%	**4**	0%
	Hygiene, cleanliness & infection control	0	0	0	**0**	0%	**1**	0%
	Lists (incl difficulty registering and removal from lists)	1	1	1	**3**	4%	**20**	2%
	Nurses / Nursing Care	0	0	0	**0**	0%	**13**	1%
	Other	0	0	0	**0**	0%	**8**	1%
	Policy/administration	0	2	11	**13**	16%	**143**	16%
	Record Keeping	0	0	0	**0**	0%	**10**	1%
	Out Of Jurisdiction	0	0	0	**0**	0%	**1**	0%
	Subject Unknown	0	1	9	**10**	13%	**142**	16%
	Total	**2**	**8**	**70**	**80**		**888**	

Table 2

Tayside NHS Board Area

Complaints Determined by Outcome		A Dentist or Dental Practice	A GP or General Medical Practice	Tayside NHS Board	**Tayside NHS Board Area Total**	**Sector Total**
2009-10	Discontinued before investigation	0	2	22	**24**	**176**
	Discretionary decision not to pursue	0	0	0	**0**	**1**
	Other	0	0	0	**0**	**7**
	Out of jurisdiction	0	3	7	**10**	**60**
	Premature	0	1	27	**28**	**319**
	Determined after detailed consideration	0	14	23	**37**	**314**
	Report issued: fully upheld	0	0	4	**4**	**33**
	Report issued: not upheld	0	0	1	**1**	**9**
	Report issued: partially upheld	0	0	4	**4**	**32**
	Total	**0**	**20**	**88**	**108**	**951**
2010-11	Premature	2	2	16	**20**	**260**
	Out of Jurisdiction	0	0	1	**1**	**59**
	Outcome Not Achievable	0	2	1	**3**	**25**
	No Decision Reached	0	0	32	**32**	**268**
	Fully Upheld	0	1	2	**3**	**65**
	Partly Upheld	0	0	3	**3**	**50**
	Not Upheld	0	3	4	**7**	**113**
	Total	**2**	**8**	**59**	**69**	**840**

Tayside NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
18/08/2010	200902198	(a) there was inadequate monitoring of blood pressure (upheld); (b) there was lack of intervention to increase blood pressure (upheld); (c) the reintroduction of blood pressure and cardiac medications all at once was inappropriate (not upheld); (d) there was a delay in the swallow assessment and nasogastric tube being inserted (not upheld); and (e) there was a delay in the Board responding to the complaint (upheld).	partially upheld	(i) review its policy regarding the monitoring of patients with acute stroke who are given treatment that may cause unexpected and precipitous falls in blood pressure; (ii) provide ongoing evidence, such as Scottish patient safety reports, which demonstrates consistency and continuity of care for those patients being transferred between wards or units; and (iii) review the need for a protocol in the stroke unit regarding the immediate management of patients with acute stroke who suffer sudden, severe and symptomatic falls in blood pressure. The Board have accepted the recommendations and will act on them accordingly
20/10/2010	200900692	the Board failed to diagnose and treat Mr C's haematoma adequately, resulting in a prolonged hospital admittance (not upheld).	not upheld	(i) review the pre-operative planning for dental patients with pre-existing disease and/or drug history to ensure that effective treatment plans are available in the event of post-operative complications. This should include a review of their post-operative information packs given to patients to ensure that they provide detailed instructions to patients on Warfarin therapy; and (ii) apologise to Mr C for their failure to carry out effective pain control. The Board have accepted the recommendations and will act on them accordingly.
16/02/2011	200900775	(a) Tayside NHS Board (the Board)'s decision making processes to transfer Mr A from the Unit to the IPCU at Hospital 1 were unclear (upheld); (b) the decision taken to allow escorted leave from the IPCU was inappropriate for Mr A on 16 January 2008 (upheld); and (c) Mr A's physical care and treatment was inadequate on his return to the IPCU from a period of unescorted leave on 16 January 2008 (upheld).	upheld	(i) urgently review their procedures for the transfer of patients under a CTO to ensure that non urgent transfers are properly categorised and dealt with as such; and that decisions are properly recorded; (ii) ensure that, where there is a statutory right of appeal against the decision to transfer, the appropriate persons are formally notified of that right; (iii) ensure that every consideration is given for the named person to have the opportunity to provide their views formally and for these views to be recorded and considered as part of the decision making process; (iv) ensure that decisions taken about the level of leave allowed during any episode of care and the level of escorts are explained and understood by the patient and their relatives (where appropriate) and a full record is made of these; (v) consider the introduction of a locally based alert system within the vicinity, which would enable staff to draw attention to potential incidents sooner than the time taken to return to the ward; (vi) review the escort arrangement at the IPCU for accompanied time out, to ensure that the arrangement is clinically appropriate in terms of the risk assessment for the patient; (vii) provide training to ensure the adequate medical examination, nursing observation and assessment of vital signs within the IPCU, when managing a patient recently having consumed an illicit substance; (viii) ensure that there is appropriate consideration for review of the procedure or protocol for referring a patient to the local Accident and Emergency department for further consideration of physical care and treatment when they admit to having consumed illicit substances; (ix) remind staff of their professional responsibilities towards the care and treatment of a patient received into their care with or without prior advice provided by other professional disciplines; (x) conduct an audit to ensure full compliance of the use of assessment tools and measures and completion of monitoring charts and vital signs monitoring charts; (xi) ensure that this report is shared with all staff involved in Mr A's care when he returned to the IPCU on 16 January 2008, so that they can learn from the findings of this report; and (xii) provide an apology to Mrs C for the failures identified in this report. The Board have accepted the recommendations and will act on them accordingly.