SPSO decision report

Case: **201709192, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Mrs C complained on behalf of her daughter (Miss A) about the care and treatment she received for ongoing ear problems. Miss A had received care and treatment at Crosshouse Hospital over a number of years. Mrs C complained about information that was shared with her about Miss A at an Ear Nose and Throat (ENT) clinic consultation, specifically that Miss A might be putting fake blood in her ear; the decision to cancel another opinion; and the decision to discharge Miss A from the ENT service and refer her to mental health services. Mrs C also complained about the length of time it took the board to respond to her complaint.

We took independent advice from a consultant ENT surgeon. We considered that it was reasonable to consider the possibility of a psychological factor, cancel the third opinion, and refer Miss A to mental health services, on the basis that extensive investigations and treatments had not identified a physiological disorder. We also noted that Miss A had not been discharged from the ENT service but had been referred to mental health services. However, we found that there was no definitive evidence to clearly show that a fluid sample taken was in fact fake blood. In addition, we considered that the way in which the matter was approached with the family could have been more appropriately dealt with by mental health staff or at the very least their opinion should have been sought in the first instance. We considered that elements of Miss A's care and treatment were not handled reasonably and we upheld this aspect of Mrs C's complaint.

In relation to complaint handling, we found that the board had not responded to Mrs C's complaints correspondence within the 20 working day timescale. Mrs C was advised on two occasions that this may not be possible. We considered that this was reasonable given the board would have needed to review a number of years of care and treatment. However, we were critical that there were many occasions where Mrs C had to contact the board for updates after the 20 working day timescale had passed. On a number of occasions, the board did not proactively update Mrs C, as they should have done, with an expected timescale for the completion of their investigation. In addition, when they had suggested a revised timescale, this was not met. Therefore, we upheld this aspect of Mrs C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Miss A and the family for matters related to the fluid sample. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

What we said should change to put things right in future:

- Staff should obtain speciality advice where appropriate and ensure that accurate information is shared with patients and their families.

In relation to complaints handling, we recommended:

- The board should have in place the necessary systems to ensure that complaints are handled in line with the NHS Scotland Model Complaints Handling Procedure, and that all staff responsible for dealing with complaints are aware of their responsibilities in this respect.