Scottish Parliament Region: Lothian

Case 200500917: Scottish Ambulance Service

Summary of Investigation

Category

Health: Ambulance Transport, Staff Attitudes

Overview

The complainant (Mrs C) raised a number of concerns about the care provided to her husband (Mr C) by Ambulance staff on 7 January 2005 during his discharge home from hospital. Mr C was terminally ill with advanced cancer at this time.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the ambulance crew failed to take adequate care in carrying Mr C from the ambulance to his home (*upheld*);

(b) a crew member spoke aggressively to Mr C's family when they challenged the crew about how they were carrying Mr C (*no finding*); and

(c) there was an excessive and uncomfortable delay while waiting for a new crew to arrive (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Service:

(i) apologise in writing to Mrs C for the distress and anxiety caused by the failure to provide suitable equipment to staff and ensure that staff had been adequately trained in manual handling techniques for the equipment available; and

(ii) consider the recommendations from the Specialist Adviser and provide the Ombudsman's office with an action plan arising from consideration of the recommendations.

The Service have accepted the recommendations and will report back to the Ombudsman on progress towards achieving them.

Main Investigation Report

Introduction

1. On 1 July 2005 the Ombudsman's office received a complaint from Mrs C that the Scottish Ambulance Service (the Service) had failed in the care provided by them to her husband (Mr C) on 7 January 2005. Mrs C previously complained to the Scottish Ambulance Service (the Service) on 7 February 2005 and received a written response on 9 March 2005. A follow-up meeting was held on 12 April 2005. This meeting and a subsequent telephone call from the Service did not resolve matters for Mrs C who remained unhappy with the response and complained to the Ombudsman's office. Mrs C was supported in her complaint by her sister-in–law (Ms D) who was present during the events complained of.

2. The complaints from Mrs C which I have investigated are that:

(a) the ambulance crew failed to take adequate care in carrying Mr C from the ambulance to his home;

(b) a crew member spoke aggressively to Mr C's family when they challenged the crew about how they were carrying Mr C; and

(c) there was an excessive and uncomfortable delay while waiting for a new crew to arrive.

Investigation

3. Copies of the relevant complaint file were obtained from the Service and advice sought from a Hospital and Specialist Adviser on ambulance services. The Service also provided copies of relevant policies and procedures and further comment on aspects of this complaint. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Service were given an opportunity to comment on a draft of this report.

(a) The ambulance crew failed to take adequate care in carrying Mr C from the ambulance to his home

4. Mrs C stated that the staff at the hospital had asked her for details about access to her home prior to her husband's discharge and she had informed them that she lived in a bungalow with two steps leading to the front door. On the day of discharge Mr and Mrs C had to wait several hours for an ambulance and were very anxious that Mr C might not get home that day and were relieved when the crew turned up to take them home. Mrs C drove home ahead of the

ambulance and, accompanied by Ms D, was there to meet the ambulance on its arrival. Mrs C said that Crew Member 1 repeatedly bashed the trolley, on which he was carrying Mr C, against her front-door opening. Mrs C was later given verbal assurance at the meeting on 12 April 2005 that transport ambulances would now also carry a lightweight stretcher but she wished to have this officially confirmed.

5. In the response letter of 9 March 2005, the Service stated that information regarding Mr C's home address had been passed on to the ambulance crew who also enquired about this when collecting Mr C from the ward. The crew denied bashing the door opening and did not think that this would have been possible as they had been unable to lift the trolley over the steps as it had become unbalanced. The letter also stated that non-emergency ambulances which are dedicated to patient discharge are fitted with a Falcon 6 trolley cot. This trolley type is not designed for lifting up stairs (of any height). In their statements to the Service, Crew Member 1 acknowledged that the family were irritated and upset by the situation and Crew Member 2 agreed that the situation had caused unnecessary anguish to the family.

6. Ms D wrote to the Service on 30 March 2005 to support Mrs C's view that her brother had been bumped and the trolley bashed on the steps to the house. She commented that the second ambulance crew had successfully carried Mr C in on the stretcher without the trolley wheels.

7. The Service internal briefing note (3 March 2005) on the complaint recommended training of non-emergency crews in the use of orthopaedic stretchers and that such stretchers should be provided in non-emergency vehicles.

8. The Hospital Adviser noted that the information provided to Ambulance Crew 1 by the ward had alerted them to a potential difficulty but that the equipment provided in the ambulance was not designed to deal with even the smallest steps and was, therefore, inappropriate to the job. The Specialist Adviser noted that the information given to Ambulance Crew 1 at the hospital indicated a lack of understanding by the ward staff concerning the manual handling capabilities of the crew. He noted that the internal briefing note had made a number of appropriate recommendations which would have contributed significantly to preventing the problems which arose in this case and that the further information provided by the Service indicates that these

recommendations have been carried out i.e. supply of orthopaedic stretchers and staff training in manual handling. The Specialist Adviser noted, however, that the training and risk management documents provided to us by the Service in this case highlighted a number of other specific issues which he would recommend that the Service address (see Recommendations below). In response to requests for further information the Service provided details of manual handling training undertaken by Ambulance Crew 1 in November 2005, following this incident.

(a) Conclusion

9. The Specialist Adviser's view is that Ambulance Crew 1 were not provided with adequate information, training or equipment to properly undertake the task they were asked to perform. I conclude that these failings gave rise to a situation which was inevitably stressful for all concerned but which could have been avoided. I acknowledge the actions already taken by the Service to address these difficulties once they became aware of them but nonetheless uphold this complaint.

(a) Recommendation

10. The Ombudsman notes the actions already taken by the Service to address the difficulties encountered in this case. In addition to this action the Ombudsman recommends that the Service apologise in writing to Mrs C for the distress and anxiety caused by the failure to provide suitable equipment to staff and ensure that staff had been adequately trained in manual handling techniques for the equipment available. The Ombudsman further recommends that the Service consider the following recommendations from her Specialist Adviser and provide the Ombudsman's office with an action plan arising from consideration of the recommendations.

11. The Specialist Adviser recommends:

(i) a system and criterion for managing hospital discharges is needed to ensure all parties are aware of the operational capabilities of the crew designated to undertake the work and the information that they need to be provided with;

(ii) undertaking a review of the Generic Operational Risk Report on the Falcon Six Trolley (the type used in this incident) to include reference to its use (or otherwise) in gaining access to a private dwelling. Such a review should take into account the tasks that would reasonably be expected to be undertaken by this type of crew ensuring appropriate additional

equipment is considered and provided along with information, instruction, training and supervision; and

(iii) training should ensure ambulance personnel are competent in the use of the specific trolley(s) being used by the Service. This can be achieved by the production of skill assessment sheets following the rules sets produced in the manufacturer's instructions.

(b) A crew member spoke aggressively to Mr C's family when they challenged the crew about how they were carrying Mr C

12. Mrs C complained that when the ambulance crew bashed the trolley against the steps she and Ms D remonstrated with Crew Member 1 and were very anxious that Mr C would have to return to hospital when he so desperately wanted to be home. They suggested that two neighbours (both doctors) be asked to help but this suggestion was rejected by the ambulance crew.

13. In the response letter dated 9 March 2005 the Service noted Crew Member 1's recollection of events was that he had decided to abort the attempt to manoeuvre Mr C in to the house as the trolley could not be safely lifted over the steps. In his statement (undated) to the Service, Crew Member 1 stated that he felt Mrs C and her sister became anxious and started pulling on the trolley, an action he considered to be a danger to all concerned. He requested that they stop but they did not do so until he had asked a third time. He stated that this final request was made in a more firm manner but he did not consider it to be aggressive. He acknowledged that the family were irritated and upset by the situation. In her statement to the Service (undated) Crew Member 2 described the family as becoming 'hysterical, screaming and pulling at the stretcher' and that Crew Member 1 had had to ask them firmly to stop before they would let go. The Service response letter noted that the allegations against Crew Member 1 were atypical of his character and any request to leave the trolley were made with the best intentions.

14. Mrs C did not accept this explanation and complained to the Ombudsman's office that her complaint to the Service about Crew Member 1 had not been taken seriously and no action had been taken to discipline him for his uncaring and callous manner. In response to the draft of this report Mrs C disputed the use of the term 'hysterical' to describe her or her sister-in-law and noted that the latter had left the scene at one point specifically in order to avoid any confrontation with the ambulance crew as she was so upset by there actions.

(b) Conclusion

15. The Specialist Ambulance Service Adviser noted that Crew Member 1 had indicated he was stressed by the situation (the difficulty of using the trolley on steps) but that he behaved appropriately but Mrs C believed that Crew Member 1 displayed inappropriate behaviour. Mrs C's views were supported by Ms D and Crew Member 2 supported Crew Member 1's views. I cannot see that any further evidence can be found in support of either view and, therefore, conclude that it is not possible to resolve this issue. I make no finding on this aspect of the complaint.

(c) There was an excessive and uncomfortable delay while waiting for a new crew to arrive

16. Mrs C complained that there was a wait of an hour while a second ambulance crew were called to assist, during which time they all had to wait in the ambulance which was either too hot or too cold. The atmosphere was very unpleasant.

17. In the response letter of 9 March 2006 the Service stated that the ambulance crew had contacted the hospital for advice and been advised to return to the hospital but they had also contacted the Emergency Medical Dispatch Centre to try and find an emergency ambulance that would be suitably equipped to transfer Mr C into his home. Such an ambulance was found but took 40 minutes to arrive because of emergency demands at that time. The Service noted that it can be difficult to stabilise the temperature in some ambulances but that Crew Member 2 had tried her best to achieve this and had had particular regard to Mr C who she talked to throughout the enforced wait. In her statement (undated) to the Service, Crew Member 2 described her attempts to reassure Mrs C and keep her warm on a very cold night. She acknowledged the emotional distress experienced by Mrs C but felt that she had understood on the night hat there was nothing else Ambulance Crew 1 could do but wait for the emergency ambulance to arrive.

(c) Conclusion

18. I have already concluded in (a) that Ambulance Crew 1 were placed in a very stressful situation which could have been prevented by better information, equipment and training. However, given the difficult situation in which they found themselves I consider that they did all that could be done to try and make the situation as comfortable as possible for Mr C and his family but that this was

an impossible task. I acknowledge that the wait was uncomfortable and any delay was going to be unpleasant but I do not consider that this was due to any failure on the part of Ambulance Crew 1 and do not uphold this complaint.

19. The Service have accepted the Recommendations.

22 August 2007

Annex 1

Explanation of abbreviations used

Mrs C	The Complainant
The Service	Scottish Ambulance Service
Mr C	The complainant's husband (the aggrieved)
Ms D	Mr C's sister
The Hospital Adviser	An adviser to the Ombudsman
The Specialist Adviser	An adviser to the Ombudsman
Crew Member 1	The member of Ambulance Crew 1 who allegedly mishandled Mr C
Crew Member 2	The other member of Ambulance Crew 1 that accompanied Mr C from hospital to home