

Table 1

Grampian NHS Board Area

Complaints Received by Subject		A GP or General Medical Practice	Grampian NHS Board	Grampian NHS Board Area Total	Complaints as % of total	Sector Total	Complaints as % of total
2009-10	Admission, discharge & transfer procedures	1	1	2	4%	15	2%
	Appliances, equipment & premises	0	0	0	0%	1	0%
	Appointments/admissions (delay, cancellation, waiting lists)	0	5	5	10%	48	6%
	Clinical treatment/diagnosis	1	23	24	48%	413	48%
	Communication, staff attitude, dignity, confidentiality	0	5	5	10%	91	11%
	Complaints by NHS staff	0	0	0	0%	2	0%
	Complaints handling	0	3	3	6%	20	2%
	Continuing care	0	0	0	0%	1	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0%	6	1%
	Hygiene, cleanliness & infection control	0	1	1	2%	6	1%
	Lists	0	0	0	0%	7	1%
	Lists (incl difficulty registering and removal from lists)	0	0	0	0%	1	0%
	Nurses/nursing Care	0	0	0	0%	10	1%
	Other	0	0	0	0%	2	0%
	Policy/administration	1	8	9	18%	156	18%
	Record keeping	0	0	0	0%	7	1%
	Out of jurisdiction	0	0	0	0%	3	0%
	Subject unknown	0	1	1	2%	68	8%
	Total	3	47	50		857	
2010-11	Admission, discharge & transfer procedures	0	2	2	4%	9	1%
	Appliances, equipment & premises	0	0	0	0%	5	1%
	Appointments/Admissions (delay, cancellation, waiting lists)	0	5	5	10%	35	4%
	Clinical treatment / Diagnosis	0	21	21	43%	402	45%
	Communication, staff attitude, dignity, confidentiality	1	2	3	6%	64	7%
	Complaints handling	0	1	1	2%	27	3%
	Continuing care	0	0	0	0%	3	0%
	Failure to send ambulance/delay in sending ambulance	0	0	0	0%	1	0%
	Hotel services - food, laundry etc	0	0	0	0%	4	0%
	Hygiene, cleanliness & infection control	0	0	0	0%	1	0%
	Lists (incl difficulty registering and removal from lists)	1	0	1	2%	20	2%
	Nurses / Nursing Care	0	0	0	0%	13	1%
	Other	0	0	0	0%	8	1%
	Policy/administration	0	9	9	18%	143	16%
	Record Keeping	0	1	1	2%	10	1%
	Out Of Jurisdiction	0	0	0	0%	1	0%
	Subject Unknown	0	6	6	12%	142	16%
	Total	2	47	49		888	

Table 2

Grampian NHS Board Area

Complaints Determined by Outcome		Grampian NHS Board Area				
		A Dentist or Dental Practice	A GP or General Medical Practice	Grampian NHS Board	Grampian NHS Board Area	Sector Total
2009-10	Discontinued before investigation	0	0	5	5	176
	Discretionary decision not to pursue	0	0	0	0	1
	Other	0	0	1	1	7
	Out of jurisdiction	0	0	5	5	60
	Premature	0	0	22	22	319
	Determined after detailed consideration	1	2	16	19	314
	Report issued: fully upheld	0	0	2	2	33
	Report issued: not upheld	0	0	0	0	9
	Report issued: partially upheld	0	0	2	2	32
	Total	1	2	53	56	951
2010-11	Premature	0	0	11	11	260
	Out of Jurisdiction	0	0	3	3	59
	Outcome Not Achievable	0	0	2	2	25
	No Decision Reached	0	1	11	12	268
	Fully Upheld	0	0	6	6	65
	Partly Upheld	0	0	3	3	50
	Not Upheld	0	1	7	8	113
	Total	0	2	43	45	840

Grampian NHS Board

Published	Case Ref.	Summary	Overall Report Decision	Recommendation(s)
23/06/2010	200903204	the treatment which Ms A received at the Hospital from 12 July 2008 to 14 July 2008 was inadequate (upheld).	upheld	(i) remind staff of the importance of good record-keeping; 30 July 2010 (ii) share this report with the staff concerned, in order that they can reflect on their actions; and 30 July 2010 (iii) apologise to Ms A for the failings which have been identified in this report. 30 July 2010 The Board have accepted the recommendations and will act on them accordingly.
22/09/2010	200902396	Mrs A was injected with haloperidol against her will on 18 February 2009 (upheld).	upheld	(i) undertake an external peer review in the Hospital to include: • the assessment, treatment and care of people with confusion, delirium or behavioural disturbance; • the use of the Adults with Incapacity legislation; • the use of both physical restraint and restraint by medicines; (ii) review the means by which medical and nursing staff are trained in the assessment and management of acute agitation or confusion, including appropriate use of the Adults with Incapacity legislation and documentation; (iii) review and disseminate their 'Guidance for Rapid Tranquilisation of Psychiatric Emergencies in Psychiatric Hospitals, General Hospitals and Accident and Emergency Departments' document; (iv) remind all clinical staff in the Hospital to carefully document indications for the use of sedative medication, the patient's consent to such treatment and the use of any form of restraint to administer such medication; (v) provide me with details of the findings and the action plan created as a result of the above recommendations and provide updates where relevant; (vi) ensure that the findings in this report are communicated to the staff involved in Mrs A's care and treatment; and (vii) issue an apology to Mrs A for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.
19/01/2011	201000168	(a) Consultant 1 did not care for and treat Mr C's wounds and pressure sores appropriately (upheld); (b) Consultant 1 did not understand and direct the vacuum assisted closure (VAC) treatment of Mr C's wounds appropriately (upheld); (c) Consultant 1's attitude towards Mr C was inappropriate and he discriminated against Mr C because of his age and disability (not upheld); and (d) the Board's handling of Mr C's complaint, including the investigation, was inadequate (upheld).	partially upheld	(ii) review their protocols for the use of VAC treatment to ensure that it is used appropriately in conjunction with other treatments for relief of pressure sores pre-operatively; (iii) remind staff of the importance of good record-keeping; (iv) review their processes to ensure they obtain responses from relevant staff when investigating complaints; and review their processes for recording the investigation of complaints; and (v) apologise to Mr C for the failings identified in this report. The Board have accepted the recommendations and will act on them accordingly.
16/02/2011	201001566	the care and treatment which Mrs C received at the Hospital on 18 March 2010 was inadequate (upheld).	upheld	(i) bring this report to the attention of the On-call doctor's clinical supervisor and determine whether there is a training requirement for the interpreting of x-rays; and (ii) formally apologise to Mr C for the On-call doctor's failure to correctly interpret the x-ray on 18 March 2010. The Board have accepted the recommendations and will act on them accordingly.