SCOTTISH PUBLIC SERVICES OMBUDSMAN

People Centred | Improvement Focused

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 377 7330**
Web **www.spso.org.uk**

Scottish Parliament Region: South of Scotland

Case ref: 202308705, Borders NHS Board

Sector: Health

Subject: NHS Boards and Authorities / Clinical treatment / diagnosis

Summary

The complainant (C) complained to me about the standard of nursing care and treatment provided to their late spouse (A) by Borders NHS Board (the Board). In particular, C was concerned about how nursing staff cared for and treated A.

A was cognitively impaired and suffered from terminal prostate cancer with cancer in their bones. Following a period of delirium, A was admitted to hospital for pain management; they had complex pain needs including neuropathic pain. A also had a tendency to wander.

C complained to me that A's pain, and their tendency to wander, was not managed in a reasonable way and that nursing staff actions, including communication towards C, was unreasonable.

The Board said in their response to C that, overall, they considered A's care was appropriate; A had their pain assessed daily and only required additional pain relief on two occasions. A's tendency to wander had also been managed by following specialist advice. However, there were a number of shortcomings in communication with C for which the Board apologised.

During my investigation I sought independent advice from a registered nurse. Having considered and accepted the advice I received, I found that:

- A was cognitively impaired and their pain was not adequately assessed or managed even though they were admitted for pain management arising from metastatic prostate cancer and had complex pain needs. This meant A was left in unnecessary pain.

- Documentation and record keeping was poor and fell below an acceptable standard including that there was no evidence the Board undertook enhanced observations of care as they should have.
- Nursing staff did not follow specialist advice and instruction in managing A and their pain. They also did not act on the information provided by C and look for non-verbal clues for A being in pain.
- There were a number of avoidable incidents that should not have happened including:
    - the ward ran out of medication at one point;
    - nursing staff could not access the drug cupboard because the keys were locked elsewhere;
    - on two occasions, A managed to take medication they should not have had access to; and
    - A was able to leave the ward and hospital grounds and managed to get on a bus on one occasion.

Taking all of the above into account, I upheld C's complaint about the standard of nursing care and treatment provided to A.

Complaint handling

Having considered the Board's complaint file and the evidence from the clinical records, I also found the Board's complaint handling was unreasonable in that there was a failure to ensure the complaint response was accurate and substantiated by the clinical records. The Board also failed to provide a clear and full complaint response.

Recommendations

Learning from complaints
The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Borders NHS Board to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint (a) I found that the standard of nursing care and treatment was unreasonable in that the Board failed to: • assess and manage A's pain in a reasonable way; • ensure documentation and record keeping	Apologise to C for the failings identified in this investigation in relation to the standard of nursing care and treatment and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	A copy or record of the apology. By: 22 September 2025

Rec. number	What we found	What the organisation should do	What we need to see
	met the required standards; • ensure specialist advice and instruction was taken into account; and • listen to C and involve them in person centred care planning. Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • ensure the complaint response was accurate and substantiated by the clinical records; and • provide a clear and full complaint response.		

We are asking Borders NHS Board to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint (a) I found that the standard of nursing care and treatment was unreasonable in that the Board failed to: • assess and manage A's pain in a reasonable way; • ensure documentation and record keeping met the required standards; • ensure specialist advice and instruction was taken into account; and	Patients who are cognitively impaired and in pain should be assessed by the appropriate tool, and receive adequate pain relief. Patients should receive person centred care and for those with cognitive impairment, information provided by carers and/or family members should be taken into account to ensure person centred care planning. Staff should take into account any specialised advice provided. If a decision is made not to act on it, the reason for this should be documented.	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. Evidence staff are competent in the use of the relevant pain assessment tools and take into account relevant guidance and specialist advice. For example, by the carrying out of a ward audit, and identifying and addressing training needs.

Rec. number	What we found	Outcome needed	What we need to see
	• listen to C and involve them in person centred care planning.	Documentation and recordkeeping should meet the required standards and policy.	Evidence that person centred care documentation meets the required standard. For example, by the carrying out of a ward audit, and identifying and addressing training needs. By: 20 November 2025

We are asking Borders NHS Board to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • ensure the complaint response was accurate and substantiated by the clinical records; and • provide a clear and full complaint response.	Complaints should be investigated fairly and fully and in line with the requirements of the NHS model complaints procedures. Complaint responses should be accurate, complete and address all the points raised in line with the NHS model complaints handling procedure. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. By: 22 September 2025

Evidence of action already taken

Borders NHS Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	What we need to see
(a)	Under complaint (a) I found that the standard of nursing care and treatment was unreasonable in that the Board failed to: • assess and manage A's pain in a reasonable way; • ensure documentation and record keeping met the required standards; • ensure specialist advice and instruction was followed; and • listen to C and involve them in person centred care planning.	Training for nursing staff on detention orders under the relevant legislation.	Evidence training occurred. By: 22 September 2025

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as C and the aggrieved as A. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. C complained to me about the standard of nursing care and treatment provided to their late spouse (A) by Borders NHS Board (the Board) during A's hospital admission. A was cognitively impaired and suffered from terminal prostate cancer. A had been admitted to hospital for pain management following a period of delirium. C also complained about the way the Board handled their complaint.

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

(a) The Board failed to provide a reasonable standard of nursing care and treatment to A during their admission to hospital in 2023 (***upheld***); and

(b) The Board failed to deal with C's complaint in a reasonable way (***upheld***).

Investigation

3. In order to investigate C's complaint, my complaints reviewer and I carefully reviewed the documentation provided by C and the Board in response to enquiries made of them. I also obtained independent advice from an appropriately qualified adviser (the Adviser), a registered nurse. The Adviser had full access to A's relevant medical records and the complaint correspondence.

4. I have decided to issue a public report on C's complaint given my concerns about the serious clinical failings in this case which led to a significant personal injustice to a vulnerable person. I also consider there is potential for wider learning from the complaint.

5. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer and I have reviewed all the information provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report.

6. Key events:

Date of event	Details of event
15 May 2023	A was admitted to a hospital in the board area (the first ward).
18 May 2023	A was assessed by a palliative care consultant who recommended 24 hour care for A and so a social work referral was made.
21 May 2023	A was moved to another ward (the second ward) where mental health and social work assessments would be undertaken.
25 May 2023	An Older Adults Liaison Psychiatry Nurse provided guidance on caring for A.
14 June 2023	A Short term Detention Order and an Emergency Detention Certificate was completed due to A leaving the second ward.
18 July 2023	It was confirmed A had suffered from an ischaemic stroke[1].
23 July 2023	A left the second ward and got on a bus.
4 September 2023	A died.

(a) The Board failed to provide a reasonable standard of nursing care and treatment to A during their admission to hospital in 2023

Concerns raised by C

7. C raised the following concerns:

i. On 23 May 2023, a member of nursing staff (Nurse 1) told C that A was to be discharged the following day as they did not have any medical or care needs. A

[1] When a blockage cuts off the blood supply to part of the brain, killing blood cells.

meeting on 24 May 2023 clarified the plans to assess A but Nurse 1 continued to say A did not need the bed. Nurse 1 repeated this on 1 June 2023.

ii. A's pain was not managed well leading to A suffering. C said they had been giving A breakthrough pain relief at home but in hospital this was not happening as quickly or at all by nursing staff. Also, instead of pain relief, nursing staff administered anti-psychotics[2] which sedated A.

iii. Nursing staff failed to manage A's tendency to wander in a reasonable way. There was an unreasonable delay in relocating A to a safer room. C complained that moving A to a room closest to the door, which led to them leaving the hospital on a number of occasions, was unreasonable. It was not until A managed to leave the hospital and board a bus that nursing staff started to take the issue seriously.

iv. C asked Nurse 2 to assess A's deterioration on 16 July 2023 when A complained of a severe head pain (which was a new development) but they did not take any action. A consultant told C a scan was being organised and later confirmed that A had suffered an ischaemic stroke.

v. C considered that some members of nursing staff did not behave in a reasonable way including that they did not carry out their duties in a caring and compassionate manner. Also, that their communication was unreasonable in that it was poor, confusing and upsetting in relation to: A leaving the second ward; their communication regarding an incident with another patient (C was told A's behaviour was a risk to other patients); a detention order; and discussing A's medication with a visitor which lacked confidentiality. C was very distressed about the way these matters had been dealt with by nursing staff.

[2] Medication that can help to reduce psychotic symptoms such as delusions, hallucinations and agitation.

The Board's response to C's complaint

8. The main points of the Board's complaint response following a review of A's clinical records were:

i. The Board apologised for the misunderstanding by Nurse 1 about discharging A and the stress this caused C. In the initial stages it was wrongly assumed that C's preferred option was discharge home with support. The documented information about home circumstances and the impact of carer stress was not acknowledged. In response to C's complaint new daily rounds at midday, every day, had been initiated which included a multidisciplinary team approach to ensure patient centred information was not missed.

ii. The Board went on to say it was clear from the clinical records that the plan from the palliative care consultant on 18 May 2023 recommended 24 hour care and a social work referral was sent for an assessment to facilitate this. This information about forward planning would now be shared at the daily round, to ensure everyone including patients and relatives were aware of the plan.

iii. The Board apologised if C had perceived from nursing staff that A's conduct had put another patient at risk of harm (see paragraph 7.v) as this was incorrect. There were no notes, DATIX or staff accounts which reported this.

iv. In relation to detention, although a member of nursing staff had referenced detention under the mental health act, this was inaccurate, there was no detention paperwork in A's clinical notes. A had been reviewed by a member of the psychiatric liaison team on 14 June 2023 who would have advised if a short term detention order was appropriate. They apologised for the worry, anger and upset the inaccurate information about a detention order caused C. Learning from this would be shared with the ward team to ensure a clear understanding of detention orders and training would be arranged with mental health colleagues about short term detention orders.

v. A was assessed daily and the National Early Warning Score 2 (NEWS)[3] chart which included the pain score, indicated that it was only above a score of zero twice. Further observed assessment showed A was mobile and medical staff documented that A was pain free. A was on regular paracetamol 1g four times daily, pregablin 125mg twice a day and oxycodone as required and given most days. Consultant review also occurred most days and this included medication review. They apologised that C found the pain relief prescribed insufficient.

vi. Initially A was moved from a side room to another room (room 1) due to clinical demand and another patient requiring end of life care and they apologised, explaining the move had been necessary. A member of the psychiatry liaison team recommended that A should not be moved from room 1 as they were settled and moving A unnecessarily may have caused stress and distress.

vii. In response to C's complaint of lack of confidentiality, privacy and respect by members of nursing staff, they apologised if C felt their behaviour was unreasonable. In terms of privacy and confidentiality, the second ward did not have a designated 'quiet or relatives room' and shared a room with two other wards which is not always available. Even so, staff should conduct conversations in a confidential and professional manner which had been discussed with the team.

viii. In relation to C's complaint of inappropriate statements made by nursing staff and a lack of basic care and compassion towards A, the timeline was difficult to follow as one nurse was on leave during this period. A member of staff had been asked to share their account of events and, as a result, issues were being dealt with at ward level with the support of Human Resources (HR).

9. In response to my complaint reviewer's enquiries, the Board said:

i. The second ward had introduced daily huddles where all ward staff could raise concerns and provide feedback to the nurse in charge. They also had in place

[3] A standardised system for scoring six physiological parameters to score patients and trigger escalation.

formal monthly care assurance walk rounds working within the Excellence in Care framework and the ward was now fully staffed (it had not been during A's stay).

ii. A member of nursing staff has had supportive conversations and been supported by colleagues in line with HR policies, which has led to an improvement.

iii. Another member of nursing staff wanted to apologise if they had been perceived as unprofessional in relation to lack of confidentiality, privacy and respect towards A and C. They reflected on behaviours which were not in keeping with the Board's values and had applied for a compassionate leadership programme.

Relevant policy, standards and guidelines

10. In providing their advice, the Adviser took account of the following policy, standards and guidelines:

i. NHS Borders Medication Administration Policy

ii. The Nursing and Midwifery Council (NMC[4]) (2019): The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates

iii. NHS Education for Scotland: Person centred care

iv. NHS Borders clinical guidelines: Abbey Pain Scale for measurement of pain in patients who cannot verbalise

v. SNHS: Code of Conduct for Healthcare Support Workers

vi. NHS Scotland: Scottish Palliative Care Guidelines

[4] The regulatory body for nursing and midwifery professionals.

Advice obtained

11. The Adviser told us:

i. A was admitted with metastatic prostate cancer with cancer in their bones and spine causing pain that was complex and difficult to treat. A was cognitively impaired and would not always verbalise if they were in pain or not, but non-verbal clues like rubbing their knees indicated pain.

ii. A's pain was not adequately assessed by nursing staff and the Board's response was inaccurate in this respect - A did not have their NEWS recorded daily. For example, there was a gap of 10 days between 16 and 26 May 2023 with no NEWS score recorded.

iii. A should have had their pain assessed using the Abbey Pain Scale – a pain assessment tool used to appropriately assess the pain that people with cognitive impairment are experiencing. This was never done, and the Board had failed to follow their own guidance from admission as detailed in the Advanced Care Observations and Support plan and the recommended plan documented on 25 May 2023 by a member of the psychiatry liaison team.

iv. It was also the case that the person centred care planning documentation did not mention pain despite this being the reason for admission. A subsequent care plan stated that A's pain score should be recorded every four to six hours, but this was never done.

v. The following practice recorded in the nursing notes was concerning and fell well below a reasonable standard:

> A's Fentanyl patch, delayed in application, was not reapplied because they 'were settled'. However, the mode of action was slow release through the skin so it was therefore important to ensure no delays in applying the analgesia patches;

Nursing staff considered that A, who, as noted above, had prostate cancer, spinal metastases, and complex pain with neuropathic pain (which was not easily managed with regular analgesia), did not have the same level of pain as was verbalised and therefore believed A was getting too much analgesia at home. This was their view even though staff failed to assess A's pain using an appropriate pain assessment tool;

Nursing staff had to be reminded to look for non-verbal cues of A being in pain, even when C advised them that A rubbing their knees was an indication of pain;

Pain medication was not administered in line with relevant policy[5]. It was documented on two occasions that despite nursing staff being advised to carefully observe medication administration that A had access to, A was taking medication they should not have had access to; and

On one instance the ward ran out of pain medication and on another nursing, staff could not access the drug cupboard because the keys were locked elsewhere.

vi. A was supposed to have daily documentation of enhanced care observations. This document was not completed daily despite nursing staff being reminded to do so by medical staff. When this was completed, it was not done to the standard required with complete shifts left uncompleted. The Board could not evidence that A's care to keep them safe and comfortable was to a reasonable standard.

vii. A member of the psychiatry liaison team felt that what was being recorded was inaccurate and that A was being given too much sedation because the behaviours recorded did not match the sedation that was given. They

[5] NHS Borders Medication Administration Policy.

documented their concerns stating that an inaccurate narrative was developing.

viii. The Board's response that placement of patients with clinical and end of life requirements in single rooms was reasonable; however, they failed to follow the detailed advice of the psychiatric liaison team who specified that the placement of A, near the door and with constant activity, was a trigger to their behaviour, and so should be placed as far away as possible from the door.

ix. The Board further failed to follow the advice of the psychiatric liaison team about dealing with A's challenging behaviour. In the absence of risk assessment, enhanced care observations documentation and adequate person centred care planning the Board could not evidence that A was assessed appropriately for placement in a room (room 1) closest to the door. The management of A in this respect was unreasonable.

x. In relation to C's concerns that nursing staff did not respond in a reasonable way to C's reports that A had severe head pain on 16 July 2023, the Adviser noted from the nursing entry on that day that C and their friend raised the issue of A being in pain and concern that analgesia was not being given unless C asked for it. It was documented that C was very upset and distressed by A being in pain and not getting analgesia but there was no mention in the notes of headache or worsening symptoms.

xi. Having said that, A's pain assessment and enhanced care observations were not done to a reasonable standard to ensure that A was safe, comfortable and pain free as already stated above and the nursing response to C and their friend was unreasonable (on 16 July 2023) after they raised concern about pain assessment. Nursing staff should have ensured that pain assessment was incorporated into the person centred plan of care and that pain assessment was carried out using the Abbey Pain Scale.

xii. In response to C's concern about Nurse 1's initial statements from 23 May – 1 June 2023 that A should be discharged home, A's clinical notes were clear that

A was not fit for discharge and long term care should be considered as the safety of A was paramount and a social work and older adult mental health referral had been made.

xiii. The Board advised that there was no detention paperwork in A's clinical notes; however, this was inaccurate as there was completed detention paperwork in the notes.

xiv. Even so, there was no record of a conversation taking place between nursing staff and C on the 14 June 2023 about detaining A, but it was recorded in the nursing notes at 00.00 hours that A was subject to a Short Term Detention Order. This entry was substantiated by the Emergency Detention Certificate completed on 14 June 2023 by medical staff due to A absconding. This form required a section to be completed within 12 hours that the next of kin had been advised of this. This was done and so it appeared that C was made aware of the detention order by the clinician who completed the form. There were no other entries relating to this Short Term Detention Order although the Board acknowledged in the complaint response nursing staff discussed this with C on 14 June 2023. The lack of documented information was unreasonable and did not meet the required standards[6]. All conversations should have been recorded.

xv. Regarding communication, there was no evidence in the clinical records that C was told patients were at risk from A's behaviour. If there had been an incident, then a DATIX should have been completed and detailed documentation about it included on the records.

xvi. In relation to what evidence there was in the clinical records about a member of nursing staff discussing A's medication in front of other people, there was an entry that outlined a discussion initiated by C whilst the nurse was administering medication to A, and so it was reasonable for the nurse to answer C's questions when asked in those circumstances.

[6] NMC (2019): The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates.

12. The Adviser went on to say that the identified failures included:

i. Unreasonable failure to ensure documentation was at the standard required by the Board or the Nursing and Midwifery Council (NMC).

ii. Unreasonable failure to assess, plan, implement and evaluate person centred care[7].

iii. Unreasonable failure to adequately assess the pain of a cognitively impaired patient with advanced metastatic cancer[8].

iv. Unreasonable failure to follow palliative care specialist and psychiatric liaison service advice and instruction[9].

v. Unreasonable failure to listen to C (A's spouse and carer) regarding non-verbal clues about pain[10].

13. And that:

i. The failings led to A being in unnecessary pain because nursing staff did not follow palliative care or psychiatric liaison advice or look for non-verbal clues for A being in pain. Nursing staff also failed to listen to C and formed the opinion that C had given A too much analgesia whilst at home. The inappropriate placement of A's bed added to the stress and distress both A and C experienced, which was not rectified despite this being requested by the psychiatric liaison team.

[7] NHS Education for Scotland: Person centred care.
[8] NHS Borders clinical guidelines: Abbey Pain Scale for measurement of pain in patients who cannot verbalise.
[9] NMC (2019): The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associate and SNHS: Code of Conduct for Healthcare Support Workers.
[10] NMC (2019): The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associate and SNHS: Code of Conduct for Healthcare Support Workers. NHS Scotland: Scottish Palliative Care Guidelines.

(a) Decision

14. The basis on which I reach conclusions and make decisions is 'reasonableness'. My investigation looks at whether the actions taken, or not taken, were reasonable in the circumstances and in light of the information available to those involved at the time.

15. C complained to me about the standard of nursing care and treatment provided by the Board to A during a hospital admission. In reaching my decision, I have carefully considered C's account, the evidence from A's clinical records and the advice I have received which I accept in full. I recognise it will be very difficult for C in trying to come to terms with A's loss reading this report. They have my utmost sympathy. I also recognise reading this report will be difficult for Board staff.

16. When responding to C's complaint the Board have said that they have introduced new rounds at midday, every day, which included a multidisciplinary team approach to ensure patient centred information was not missed. I welcome this. Nevertheless, the advice I have received is that the standard of nursing care provided fell below a reasonable standard in a number of important respects:

i. A was cognitively impaired and their pain was not adequately assessed or managed even though they were admitted for palliative pain management arising from metastatic prostate cancer and had complex pain needs including neuropathic pain.

ii. Nursing staff failed to follow palliative care and psychiatric liaison advice. They also did not act on the information provided by C and look for non-verbal clues for A being in pain. Nor did they act on advice about the placement of A's bed or note in the clinical records the reason why this was not actioned.

iii. Documentation and recordkeeping were poor and fell below an acceptable standard including that there was no evidence the Board undertook enhanced observations of care as they should have.

I accept the advice I have received.

17. While I recognise A had complex needs that must have been challenging for staff to manage, it is clear from the advice I have received that there were basic failings in pain management including a failure to:

i. assess pain for ten days;

ii. use the appropriate pain management assessment tool; and

iii. administer appropriate pain relief.

18. Given the complexity of A's case, specialist advice and instruction were appropriately provided but the evidence indicates nursing staff did not follow the advice given and there is no reason documented in the nursing records for not doing so. It is of concern to me that one specialist documented their concern that nursing staff had developed an inaccurate narrative about A, however, no further action was taken.

19. Moreover, the advice I received (and accept) was that nursing staff believed A did not have the level of pain they indicated and that they had been getting too much pain relief at home (see paragraph 11. v above). I am troubled that this view was taken even though the appropriate pain management tool was not used to assess A's pain. I am highly critical of these failings.

20. There are also a number of incidents documented in A's clinical records that I want to draw attention to which I consider were avoidable and should not have occurred:

i. the second ward ran out of medication on one occasion;

ii. on another occasion, nursing staff could not access the drug cupboard because the keys were locked elsewhere;

iii. on two occasions, A managed to take medication they should not have had access to; and

iv. A was able to leave the second ward and hospital grounds and managed to get on a bus on one occasion.

21. I am satisfied the evidence (as set out in paragraphs 16-20) indicates a number of significant failings which I consider points to challenges within the second ward that the Board should deal with as a matter of urgency.

22. Turning now to C's complaint about the communication by nursing staff, in relation to:

i. A's detention under the relevant legislation;

ii. being informed that A's behaviour was putting another patient at risk;

iii. public statements about confidential matters.

23. I recognise C's strength of concern about communication on the aforementioned matters, and how distressed C was by what happened. The Adviser said there is detention paperwork in A's clinical records, and that C was informed of the related Emergency Detention Certificate by medical staff when it was completed. There is no other documentation about this. Nevertheless, the Board acknowledged that this was discussed with C by nursing staff on 14 June 2023 and apologised for the impact this had on C. While I welcome the Board's apology, it is clear the Board's complaint response was inaccurate about this matter. I consider this point in more detail under complaint b). It is also clear from the advice I have received that all conversations about this should have been documented and it was unreasonable not to do so.

24. The Adviser also said there is no evidence in A's clinical records of the incident involving A and another patient (referred to in paragraph 7. v) nor any communication with C about this. If there had been an incident then a DATIX should have been completed and any discussion documented in the records. While I recognise C's recollection of a discussion taking place my investigation has been unable to evidence definitively what occurred. Likewise, my investigation has been unable to evidence definitively what occurred regarding C's complaint of nursing staff making public statements about confidential matters. Nevertheless, I welcome the Board raising this with staff and reminding them of the need for confidentiality (see paragraph 8. vii).

25. Turning finally to the injustice A suffered as a result of the above failings, the advice I have accepted is that A was left in unnecessary pain. I am critical of the failings that led to this particularly given it involved a vulnerable patient.

26. I uphold this complaint.

(b) The Board failed to deal with C's complaint in a reasonable way

Concerns raised by C

27. C raised the following concerns:

i. The Board's response was inaccurate about: a member of nursing staff being on leave on 14 June 2023; the detention order; and advice about placement of A's bed.

ii. The Board's response was wrong that C had received feedback from the individual investigating C's complaint (the lead clinical investigator) on 17 July 2023. This is because it was on that day C informed the lead clinical investigator of the members of nursing staff C was concerned about and so they could not have been in a position to provide feedback then on their enquiries. C met the lead clinical investigator again, briefly, on 21 July 2023. They said they would meet with C in person to give feedback but this meeting did not take place.

iii. It was unclear if the Board had upheld C's complaints about the behaviour of members of nursing staff and what action the Board took to address any failings identified by their investigation.

The Board's response

28. In response to my complaints reviewer's enquires, the Board said:

i. The lead clinical investigator apologised for incorrectly identifying a member of nursing staff as being on leave (on 14 June 2023) when this was another

member of staff and that they did not seek clarity at the time of responding to C's complaint.

ii. The lead clinical investigator spoke with C on 17 July 2023 at A's bedside and continued the conversation in a private area. They acknowledged and apologised this was not recorded in A's clinical records.

iii. The lead clinical investigator apologised for not meeting with C in a timely manner nor explaining the reasons why this did not happen until 17 July 2023. This was due to the competing demands of workload. C had been made aware of how to contact them when they were on the second ward, by informing the ward clerks who would message them.

iv. When responding to C the Board also apologised that the lead clinical investigator did not meet C when they had agreed saying this was due to their competing workload demands.

NHS Model Complaints Handling Procedure

29. The NHS Model Complaints Handling Procedure states the report of the Board's investigation should:

i. address all the issues raised and demonstrate that each element has been fully and fairly investigated;

ii. include an apology where things have gone wrong;

iii. highlight any area of disagreement and explain why no further action can be taken.

(b) Decision

30. In reaching my decision on the complaint about the way the Board dealt with C's complaint, I took into account the NHS Model Complaints Handling Procedure, the Board's responses and the advice I received on record keeping.

31. Under the NHS Model Complaints Handling Procedure, the Board should address all the issues raised and demonstrate that each element has been fully and fairly investigated. I do not consider this happened in C's case. The Board acknowledged they failed to take action to clarify which member of staff was complained about and I welcome their apology in this regard.

32. Notwithstanding this, there were also clear and significant inaccuracies in the Board's complaint response, which was not substantiated by A's clinical records in a number of important respects. For example, the Board advised in their complaint response that there was no detention paperwork in A's clinical notes, this was inaccurate as it is clear there was completed detention paperwork in the notes and that C was informed of the related Emergency Detention Certificate by medical staff on completion (see paragraph 11. xiii above). Furthermore, the psychiatry liaison team had advised placement as far away as possible from the door, which was also contrary to the Board's response which stated that the advice was not to move A.

33. An essential element of NHS complaints handling is ensuring complaint responses accurately reflect the clinical records. I am therefore concerned the Board provided inaccurate information when they responded to C, and missed an opportunity to correct that during my investigation especially given the significance of this case and that it involved a vulnerable person. This was unreasonable. Finally, I can appreciate the reasons for C's frustration about the complaint response.

34. Turning now to C's concerns about how individual members of nursing staff behaved, the Board shared information about this in such a way that left C unclear if their complaint had been upheld or not. Under the NHS Model Complaints Handling Procedure, C should have received a clear explanation from the Board on this matter that addressed the issues raised including the outcome. This did not happen, which was unreasonable.

35. In view of the failure to provide a full and accurate complaint response, I find that the Board's complaint handling was unreasonable and I uphold this complaint.

Recommendations

Learning from complaints
The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking Borders NHS Board to do **for the complainant**:

Rec. number	What we found	What the organisation should do	What we need to see
1.	Under complaint (a) I found that the standard of nursing care and treatment was unreasonable in that the Board failed to: • assess and manage A's pain in a reasonable way; • ensure documentation and record keeping	Apologise to C for the failings identified in this investigation in relation to the standard of nursing care and treatment and complaint handling. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/meaningful-apologies	A copy or record of the apology. By: 22 September 2025.

Rec. number	What we found	What the organisation should do	What we need to see
	met the required standards; • ensure specialist advice and instruction was taken into account; and • listen to C and involve them in person centred care planning. Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • ensure the complaint response was accurate and substantiated by the clinical records; and • provide a clear and full complaint response.		

We are asking Borders NHS Board to **improve the way they do things**:

Rec. number	What we found	Outcome needed	What we need to see
2.	Under complaint (a) I found that the standard of nursing care and treatment was unreasonable in that the Board failed to: • assess and manage A's pain in a reasonable way; • ensure documentation and record keeping met the required standards; • ensure specialist advice and instruction was taken into account; and	Patients who are cognitively impaired and in pain should be assessed by the appropriate tool, and receive adequate pain relief. Patients should receive person centred care and for those with cognitive impairment, information provided by carers and/or family members should be taken into account to ensure person centred care planning. Staff should take into account any specialised advice provided. If a decision is made not to act on it, the reason for this should be documented.	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. Evidence staff are competent in the use of the relevant pain assessment tools and take into account relevant guidance and specialist advice. For example, by the carrying out of a ward audit, and identifying and addressing training needs.

Rec. number	What we found	Outcome needed	What we need to see
	• listen to C and involve them in person centred care planning.	Documentation and recordkeeping should meet the required standards and policy.	Evidence that person centred care documentation meets the required standard. For example, by the carrying out of a ward audit, and identifying and addressing training needs. By: 20 November 2025.

We are asking Borders NHS Board to **improve their complaints handling**:

Rec. number	What we found	Outcome needed	What we need to see
3.	Under complaint point (b) I found that complaint handling was unreasonable in that there was a failure to: • ensure the complaint response was accurate and substantiated by the clinical records; and • provide a clear and full complaint response.	Complaints should be investigated fairly and fully and in line with the requirements of the NHS model complaints procedures. Complaint responses should be accurate, complete and address all the points raised in line with the NHS Model Complaints Handling Procedure. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.	Evidence that the findings of my investigation have been fed back to the staff involved, in a supportive manner, for reflection and learning. By: 22 September 2025.

Evidence of action already taken

Borders NHS Board told us they had already taken action to fix the problem. We will ask them for evidence that this has happened:

Complaint number	What we found	What the organisation say they have done	What we need to see
(a)	Under complaint (a) I found that the standard of nursing care and treatment was unreasonable in that the Board failed to: • assess and manage A's pain in a reasonable way; • ensure documentation and record keeping met the required standards; • ensure specialist advice and instruction was followed; and • listen to C and involve them in person centred care planning.	Training for nursing staff on detention orders under the relevant legislation.	Evidence training occurred. By: 22 September 2025.

Terms used in the report **Annex 1**

A	the aggrieved
C	the complainant, A's spouse
the Adviser	a registered nurse
the Board	Borders NHS Board
the hospital	a hospital in the board area
NEWS	National Early Warning Score, a standardised system for scoring six physiological parameters to score patients and trigger escalation

List of legislation and policies considered **Annex 2**

NHS Borders Medication Administration Policy

NHS Borders clinical guidelines: Abbey Pain Scale for measurement of pain in patients who cannot verbalise

NHS Scotland: Scottish Palliative Care Guidelines

NHS Education for Scotland: Person centred care

Scotland NHS: Code of Conduct for Healthcare Support Workers

The Nursing and Midwifery Council (NMC) (2019): The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates. NHS Education for Scotland: Person centred care