Scottish Parliament Region: Highlands and Islands

Case 200502475: Highland NHS Board – New Craigs Mental Health and Learning Disabilities Service

Summary of Investigation

Category

Health; Hospital

Overview

The complainant considered that his care at a mental health and learning disabilities service (the Unit) in August 2005 was poor, did not meet his needs and put him at increased risk of suicide because staff ignored his suicidal feelings.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) his needs were not met *(not upheld)*;

(b) on arrival at the Unit, he was left with two patients in a locked ward and only one nurse on duty *(no finding)*;

(c) he needed to see his clinical neuropsychologist, but this was refused by a psychiatrist *(not upheld)*;

(d) there was a lack of confidentiality in that medication was given in front of patients and external workpeople such as painters (*not upheld)*; and

(e) the Unit's discharge sheet was not ready in time on 10 August and, when Mr C received it, the staff signature space was blank *(not upheld).*

Recommendation

The Ombudsman has no recommendation to make, however, suggests that the Highland NHS Board consider whether the Unit might be able to take a more proactive approach to reassure patients on confidentiality issues.

Main Investigation Report

Introduction

1. I shall refer to the complainant as Mr C. On 23 January 2006 the Ombudsman received his complaint about a mental health and learning disabilities service (the Unit). He was an in-patient there from 8 to 10 August 2005, having been admitted with suicidal thoughts.

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

(a) his needs were not met;

(b) on arrival at the Unit, he was left with two patients in a locked ward and only one nurse on duty;

(c) he needed to see his clinical neuropsychologist, but this was refused by a psychiatrist;

(d) there was a lack of confidentiality in that medication was given in front of patients and external workpeople such as painters; and

(e) the Unit's discharge sheet was not ready in time on 10 August and, when Mr C received it, the staff signature space was blank.

3. I should say here that Mr C made various complaints that certain things had been said to him. One of these was that a doctor misled him about his grade and that a nurse was rude to him. The doctor and nurse denied this, although the nurse said he probably raised his voice to make himself heard above Mr C, who had raised his voice. The nurse said he had felt quite provoked by Mr C's behaviour and had felt he was trying to start an argument. The doctor said that he clearly remembered Mr C's asking him if he was a psychiatrist and his reply that he was one. As far as he could remember, he also felt he had spent some time explaining that he was a staff grade psychiatrist and what that meant. A similar complaint concerned whether a remark had been made to Mr C about medication (and which could be seen also to have a meaning about the illegal use of drugs). I have not pursued any complaints about what was said because it was clear that it was simply not going to be possible to establish the facts.

4. Mr C had many other complaints about the Unit, some of which he put to me. I was mindful that he had not put all these to Highland NHS Board (the Board) to give them the chance to resolve matters. This is a requirement of the Scottish

Public Services Ombudsman Act 2002, except in cases where this office considers that it would be unreasonable to expect the complainant to do so. I am satisfied that there was no reason for that exclusion to apply in this case. I was also mindful of the need for a Complaints Investigator to focus on the heart of the matter. I considered this to be complaints (a) to (d) and, therefore, focused the investigation on them. I added complaint (e) in case it indicated some widespread procedural failure by the Unit.

Investigation

5. I was assisted in the investigation by one of the Ombudsman's advisers, a consultant psychiatrist. His role was to explain to me, and comment on, the complaint's clinical aspects. We examined the papers provided by Mr C, the Board's complaint file, Mr C's clinical records in relation to his various admissions to the Unit and the Board's replies to my enquiries. We also examined local and national policies and procedures for referral, assessment and discharge in relation to the Board's mental health services.

6. To identify any gaps and discrepancies in the evidence, the content of relevant correspondence on file was checked against information in the clinical records and was compared with my own and the adviser's knowledge of the issues concerned. I am, therefore, satisfied that the evidence has been tested robustly. In line with the practice of this office, the standard by which the events were judged was whether they were reasonable in the circumstances. By that, I mean whether the decisions and actions taken were within the boundaries of what would be considered to be acceptable practice by the medical profession in terms of knowledge and practice at the time. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

The complaints

7. I turn now to complaints (a) to (e), which I shall cover as they arise. Mr C, who was 31 at the time, was known to the Unit and had a history of low mood. The adviser considers that the clinical records over the years give a clear picture of a man who has found it difficult to cope with life's events, with a history of alcohol misuse and deliberate self harm, and, at times, hostile, verbally abusive, behaviour, with an ongoing theme of criticisms about his clinical care. I should add

that Mr C considers the clinical records to be false. I have, therefore, left out of this report further details but I share the adviser's view that it is important to include a brief clinical picture so that the Unit's actions can be considered in the context of the clinical records.

8. At paragraphs 8 to 11, I give Mr C's account. On 8 August 2005 an out-of-hours GP referred Mr C to the Unit after telephone calls saying he was going to harm himself. On arrival, he was left on his own in a locked ward with two other patients and only one nurse.

9. Mr C remained in the Unit until 10 August and disagreed with everything there. Staff were negligent and derogatory; medication was given in front of patients and workpeople; overall, he was given no help and his needs were not met.

10. Mr C asked to see his clinical neuropsychologist (the neuropsychologist), but the psychiatrist who treated Mr C during his admission (whom I shall call the psychiatrist) refused to find out if she was available and refused to read his clinical records, despite Mr C's increasing distress and suicidal thoughts. Therefore, at a meeting on 10 August to discuss his discharge later that day, Mr C told the psychiatrist and a nurse (Nurse 1) that he was going to the canal (ie to drown himself) and left the Unit in tears. He felt that he should not have been discharged and that he should not have been allowed to leave in that emotional state.

11. Later that day, Mr C tried to get other help and, amongst other people, spoke to the Manager of an advocacy service. She and Mr C went to the Unit, where they were met by another nurse (Nurse 2), who was rude and defensive. When Mr C asked whether he had been discharged or not, Nurse 2 told him he knew he had been discharged. Mr C was told that the discharge form was not ready and would be sent by post. When he received it, it was dated the following day (11 August) and was unsigned.

12. At paragraphs 12 to 17, I summarise some information from the files. The Board told me that, as a result of risk assessment, their policy is to admit all patients who arrive between 21:00 and 08:00 to the locked ward where Mr C was placed. The clinical records show Mr C as having arrived at approximately 05:00 on 8 August 2005. Although Mr C said that only one nurse was with him and the

other two patients, the Board said that four nurses were on duty in the ward overnight. I have not looked further into the number of nurses because it is not possible to prove how many were present (the number of nurses on duty could probably be checked but that would not show how many were actually present with Mr C.)

13. The Board expressed their regrets to Mr C for his embarrassment at being given medication in the presence of workpeople. They assured him that such workers were required to meet strict confidentiality requirements. They said they did tend to give medication wherever the patients happened to be, to avoid interrupting them to go elsewhere when medication was due. They also told me that staff did have the discretion to make other arrangements if they felt that the type of medication required extra confidentiality. Overall, they told me that efforts were made to respect patient confidentiality.

14. The clinical records state that Mr C himself felt that a support package as an out-patient would most suit him and that this had been arranged but that Mr C's hostility at the meeting on 10 August to discuss the discharge made it difficult to explain this to him. In a letter to a GP on 12 August, the psychiatrist said that the package had included support by a community psychiatric nurse. The records say that, on 10 August, Mr C refused a prescription (which he had wanted) and an out-patient appointment to see the psychiatrist on 18 August. However, Mr C was also sent that appointment by post and attended both it and other out-patient appointments with the psychiatrist over the following months. I also note comments by a doctor and nurse that it was difficult to be clear what Mr C's needs were.

15. The psychiatrist said that he had no reason to read Mr C's clinical records at the time that Mr C wanted him to, because he had not only already read them but had also contacted Mr C's GP for more information about him. He said that he had told Mr C that he did not know if the neuropsychologist was in the building or whether she would be able to see him and that he would not be asking her to do so at the present time. The clinical records state that Nurse 1 had contacted the neuropsychologist's department on 8 August to see if Mr C had been attending his appointments with her and had found out that the neuropsychologist would not be available until a later date. (The adviser considers that it was not for Mr C to

decide whether the neuropsychologist should be called and that the psychiatrist's actions, as reported in the clinical records, were reasonable.)

16. At the meeting on 10 August with the psychiatrist and Nurse 1, to discuss his discharge later that day, Mr C appears to have been particularly distressed at the thought of leaving. There is disagreement between Mr C and the Unit about whether he mentioned either suicide or going to the canal, although Nurse 1 and Nurse 2 said he did refer to suicidal thoughts on his return to the Unit later that day (having walked out during the discharge meeting). The Board said that the risk assessment of Mr C by the psychiatrist and another nurse had been that he was not 'actively' suicidal (the adviser has explained this term as suicidal intentions, which is not the same as suicidal thoughts). The Board also said that expressions of suicide would not automatically delay a discharge or result in a re-admission.

17. The Board explained that the discharge form was not ready when Mr C left the Unit because he had not been scheduled to leave until later that day (10 August). Mr C is correct in saying that it was dated 11 August, but I am satisfied that there is no fault in that. This is because one would assume that, because Mr C had left without it, it was no longer urgent and could be posted at leisure (a discharge does not require a discharge form in order to be a valid, proper, discharge). The discharge form has a space for a nurse's signature, with the declaration that the person signing the form has given an explanation of the care received to the patient. As Mr C left during the discharge meeting, that explanation could not fully be given to him and so the form could not be signed.

The adviser's views

18. As well as the comments elsewhere in this report, the adviser has given other comments, which I summarise at paragraphs 18 to 21. The responsibility of the mental health services is to identify treatable mental illnesses, such as clinical depression, to offer advice and help for any drink and drug problems and to treat symptoms such as anxiety. It is for those services to identify what they consider the patient's needs to be and to offer help, if possible, for those identified needs which fall within their scope. Most mental health services would not feel they should continue to give resources for patients who do not appear to have an illness but, rather, have difficulty coping with problems in their life. Clearly, however, mental health staff must accept that their patients may be likely to present

challenging behaviour and must generally treat them courteously.

19. Patients who present with Mr C's clinical picture (see paragraph 7) are not uncommon. The management of someone with this picture is early discharge, which in this case was correctly assessed and applied. It is noted that staff found it difficult to identify what Mr C's needs were, and it is fairly common for such patients not to be explicit about their needs. However, it is noted that the records say that Mr C had identified certain out-patient needs and that efforts were made to meet these. Those out-patient arrangements appear to have been appropriate because the clinical records do not indicate any reason for in-patient treatment. It is also noted (see paragraph 14) that Mr C attended out-patient appointments that were arranged for him. The presence of workpeople is a problem on a mental health ward because there tend to be more confidential remarks and activities than on other wards. The Board did express regrets to Mr C when he complained, but it would have been helpful if he (and, indeed, other patients) had received more explanation and assurances while he was in the Unit, for example, that workpeople were required to maintain confidentiality. The discharge arrangements were satisfactory. There is no reason to think that a signed discharge form would not have been ready for Mr C if he had left on 10 August at the scheduled time, rather than earlier.

20. While it might seem that a patient who is thinking of committing suicide should be given extra protection, this depends very much on what is considered to be wrong with the patient. Those who (like Mr C) are not judged to be mentally ill, and who, therefore, are responsible for their own actions, have to be allowed to do as they wish although, clearly, staff can try to persuade them not to take certain actions.

21. Like me (see paragraph 3), the adviser considered that it would not be useful to try to establish what was said, and with what attitude, to Mr C. Overall, the adviser considers that Mr C's care was appropriate and certainly within the bounds of reasonableness which I explained at paragraph 6.

Conclusions

22. As explained at paragraph 6, I am satisfied that the evidence in this case has been tested robustly. That includes the adviser's advice, which was unambiguous

and, where relevant, was clearly and logically based on the evidence. Therefore, I accept that advice. The adviser considers that reasonable care was given to Mr C. Therefore, I do not uphold complaints (a) and (c) to (e). I make no finding on complaint (b), for the reason explained at paragraph 12. Finally (see paragraph 19), I can understand that patients in the sensitive area of mental health may well be concerned about confidentiality in the presence of workpeople from outside. The Ombudsman, therefore, invites the Board to consider whether the Unit might be able to take a more pro-active approach to reassure them in future.

Recommendations

23. The Ombudsman makes no recommendation but invites the Board to consider the point at paragraph 22.

26 September 2006

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Board	Highland NHS Board
The Unit	New Craigs Mental Health and Learning Disabilities service
The neuropsychologist	A clinical neuropsychologist at the Unit
The psychiatrist	A psychiatrist at the Unit, who dealt with Mr C during his admission
Nurse 1	A nurse at the Unit
Nurse 2	Another nurse at the Unit, about whose manner Mr C complained.