Scottish Parliament Region: South of Scotland

Case 200501601: The State Hospitals Board for Scotland

Summary of Investigation

Category

Health: Complaints investigation

Overview

The complainant (Mr C)'s advocacy worker raised a complaint on his behalf against the State Hospitals Board for Scotland (the Board) about the way they had investigated Mr C's complaint about the conduct of a student nurse.

Specific complaint and conclusion

The complaint which has been investigated is that the Board inadequately responded to Mr C's complaint about the conduct of a student nurse (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board remind staff that they should ensure that all aspects of a complaint are addressed when providing the response.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 8 July 2005 a complaint was made by a Patients Advocacy Service key worker (Ms D) on behalf of the complainant (Mr C), a patient at the State Hospital (the Hospital), to the Hospital's complaints officer.

2. Mr C was very concerned that a student nurse had reported him for bullying a fellow patient, an allegation he denied. Additionally, Mr C was concerned that this allegation came about, he believed, as a result of an earlier incident where Mr C considers he may inadvertently have caused the student nurse offence. Mr C states that the student nurse had asked him what he thought of a previous Ward Manager. Mr C had given some negative opinions about this individual who he later found out was a relative of the student nurse.

3. On 7 September 2005 the Chief Executive of the State Hospitals Board for Scotland (the Board) provided her response to Mr C's complaint and advised that if he remained unsatisfied, he could refer the matter to the Scottish Public Services Ombudsman's office (the Ombudsman).

4. On 13 September 2005 the Ombudsman received a letter from Ms D advising that Mr C believed that the Board had provided an inadequate response to his serious complaint. He considered the Board had avoided answering the main issues. As a result of the alleged failure to properly investigate, Mr C said that he has lost his trust in the Board.

5. The complaint from Ms C which I have investigated is that the Board inadequately responded to Mr C's complaint about the conduct of a student nurse.

6. I must highlight that I have not looked at the alleged bullying incident itself or the issues arising from the alleged conversations between Mr C and the student nurse.

Investigation

7. I have examined correspondence including responses to Mr C's complaints from the Board. I have made written enquiries of the Board and have obtained clinical records and the background complaints correspondence. I have also sought clinical advice from our professional adviser (the Adviser). I

have set out, for Mr C's head of complaint, my findings of fact and conclusions.

8. 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.

Complaint: The Board inadequately responded to Mr C's complaint about the conduct of a student nurse

9. The NHS complaints procedure details the process which should be followed when considering a complaint. On 8 July 2005, Ms D wrote to the complaints officer at the Hospital to advise that she would like to raise a formal complaint on behalf of Mr C regarding recent events in the ward.

10. Mr C was concerned about the conduct of a student nurse. He was concerned that this student nurse reported Mr C for allegedly bullying another patient. It was alleged that Mr C had pushed past another patient. Ms D advised the complaints officer that Mr C was clear that he had not done this. She highlighted that Mr C was concerned that this allegation was made in response to a previous occasion where Mr C may have caused unintentional offence to the student nurse. Mr C claimed that he was asked by the student nurse what he thought about a previous Ward Manager. Mr C indicates that he responded in a negative way, reflecting his experience of this individual. Mr C claims that it was only after this questioning by the student nurse that he was made aware that the student nurse was closely related to the previous Ward Manager.

11. Mr C admitted that he was wary of the student nurse after finding out his relationship to the previous Ward Manager and felt that the allegation was associated with these comments.

12. The clinical notes record that it was reported by a student nurse that he had observed Mr C pushing past a fellow patient. It goes on to detail that when Mr C was asked about this, he demanded to know which member of staff had made the allegation. He also made a request to telephone his Advocate, this request was granted.

13. In the afternoon following the incident, it appears from the nursing notes that staff discussed the incident with the patient who was allegedly barged passed by Mr C. The patient, when questioned about any problems he had

experienced with fellow patients, made a number of references to experiences which, in the opinion of the nurse, were clearly psychotic in nature. However, when questioned further, the patient advised that he had not been involved in any incidents of concern that day and was not intimidated by anyone in the ward at that time. The nurse informed the Ward Manager of the outcome of the discussion.

14. The Ward Manager and consultant Psychiatrist visited Mr C the day after the incident. The Ward Manager reported that at this meeting all the issues were discussed in full and all persons seemed happy with the outcome, especially Mr C who was fully reassured that the matter was now resolved. The nursing records, however, do show that Mr C was denying that anything took place.

15. On receipt of the complaint from Ms D the matter was investigated by the Ward Manager who responded to the complaints officer with details of the background to the case.

16. In his response he detailed that he had investigated Mr C's allegations and established that the student nurse had observed the incident and reported to staff what he had witnessed. The Ward Manager advised that he did so in a professional and mature manner and was subsequently applauded for his vigilance and observation skills.

17. He further detailed that in the letter from Ms D to the complaints officer, there was a suggestion that Mr C thought that the student nurse would be negative in his interactions with the patient because of what Mr C said about his relative. This, the Ward Manager has advised, was never an issue or concern and at no time during the placement was the student nurse ever negative towards the patient. Indeed, the Ward Manager has indicated that, to the best of his knowledge, the student in question did not ask the patient's opinion of another member of staff. He believed that another patient had pointed out to Mr C that the student in question was the son of a previous ward manager.

18. The Chief Executive provided the Board's formal response to Ms D on 7 September 2005. The response was based on information provided by the Ward Manager. The Chief Executive did advise that the Ward Manager had assured her that any comments Mr C may have made did not impact on their

care or treatment of him in any way, but that he apologised if Mr C had felt that this was the case.

19. The nursing notes I have obtained describe the patient's progress, with entries for each day and additional recordings of particular events, including meetings. Our Adviser is of the opinion that the notes are of a good standard and clearly signed. On 4 July 2005, the report by the student nurse is recorded in the nursing notes. The nursing notes indicate that this was followed up in an appropriate manner and that all parties were spoken to by members of staff and their responses documented. Mr C's request to discuss his distress with the Patients Advocacy Service and his key worker were agreed with staff. He was also made aware of the complaints procedure.

Conclusion

20. The response to Ms D provided by the Board dealt with the management of the alleged bullying incident. Based on the information received from the Board it is clear that this incident and subsequent interviews were properly recorded in the nursing notes and that it was followed up appropriately by staff. The nursing notes also detail that the level of care and support provide to Mr C was not affected in any way by the alleged incident with the student nurse. The incident appears to have been very well managed at the time.

21. The response from the Chief Executive did not, however, include any details in respect of investigations carried out into Mr C's own allegations about the incident where he alleges he was asked to comment on the student nurse's relative.

22. The Board made minimal comment in respect of the concerns raised by Mr C in relation to the lack of trust of the student nurse. Mr C mentioned that he felt that there was a significant abuse of his trust as a result of the incident. This point was not fully responded to. The response from the Chief Executive details that the ward manager 'assures me that the comments made did not impact on their care or treatment of him in any way.' There is, however, no detail of how the ward manager was able to make this assurance nor is there any detail of what action was taken to investigate this point. The Board has, however, apologised for any perception of lack of care.

23. Because the Board have not addressed a central aspect of Mr C's complaint within their formal response, I uphold the complaint.

Recommendation

24. The Ombudsman recommends that the Board remind staff that they should ensure that all aspects of a complaint are addressed when providing the response.

25. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendation has been implemented.

Annex 1

Explanation of abbreviations used

Ms D	Mr C's Patients Advocacy Service key worker
Mr C	The complainant
The Hospital	The State Hospital
The Board	The State Hospitals Board for Scotland
The Ombudsman	The Scottish Public Services Ombudsman's office
The Adviser	The Ombudsman's professional adviser