SPSO decision report

Case: **201810154, Tayside NHS Board**
Sector: Health
Subject: admission / discharge / transfer procedures
Decision: some upheld, recommendations

Summary

C is the parent of a teenaged adult (A). A was admitted to an acute admissions ward of a mental health unit as an informal patient. The following day, A contacted C from the ward. A told C that they were in possession of razor blades and intended to self-harm. C contacted the ward to advise them of this and ward staff obtained the razor blades from A. A day later, A contacted C and told C they had left the hospital. C contacted the ward and the police, and A was returned to the ward. A was transferred to another location shortly afterwards. C complained that A had not been properly searched or reasonably assessed on their first arrival at the ward. The board told C that the routine risk assessment at admission had shown no indication A was at risk of absconding, and that this had led to the decision not to lock the ward door. They also said that a check of A's belongings when they were admitted had led to razor blades being taken from A's possession. C was dissatisfied with the board's response and brought their complaint to us.

We took independent advice from a mental health nurse. We found that A had not been properly searched upon their arrival, that it was unreasonable that the board had not carried out a medical, nursing or joint assessment on the day of A's admission and that the standard of assessment and care-planning at the point of admission fell significantly below professional expectations. We upheld C's complaint.

C also complained that the board unreasonably failed to call C, as they had promised, following C reporting A was in possession of razor blades and intended to self-harm. We found that the available written evidence and staff recollection did not support C's recollection that they had been promised someone would call them back. Therefore, we did not uphold C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A that they were not properly searched or reasonably assessed upon their arrival at the ward. The apology should meet the standards set out inthe SPSO guidelines on apology available atwww.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- Medical/nursing assessments should be carried out and clearly documented as part of the admission process, and each patient has a documented initial care plan based upon the information gathered during the admission assessment process.
- The belongings of patients assessed as being at imminent risk of harm to self or others are checked for the presence of harmful objects or substances.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.