Scottish Parliament Region: Central Scotland

Case 200502663: Lanarkshire NHS Board

Summary of Investigation

Category

Health: Hospital; Psychiatry; Admission discharge and transfer procedures

Overview

The complainant (Mr C) was concerned about the handling of the internal transfer of his brother (Mr A) at the Hospital where he was a long-stay patient. Mr C felt that the transfer had been made because of staffing issues and not in response to Mr A's needs. He has also complained it had been carried out too quickly and that, as a result of stress caused by the move, his brother had suffered five seizures.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the decision to move Mr A between units was made prior to discussion and on the basis of staffing levels rather than needs (*partially upheld*)*;*

(b) the move was not made at Mr A's pace, was too fast and Mr A required to be medicated to facilitate the move (*not upheld*); and

(c) Mr A has since suffered seizures as a result of the stress incurred (*not upheld*).

Redress and recommendations

The Ombudsman recommends that if further reconfiguration is to occur, the Board should review their guidelines, and in particular their communication, individual patient review and risk management policies.

Main Investigation Report

Introduction

1. On 23 December 2005, the Ombudsman received a complaint from a man (referred to in this report as Mr C) who was concerned about transfer arrangements relating to his brother (Mr A). Mr A had severe learning difficulties and was incapable of representing himself. He was a long stay patient at Kirklands Hospital (the Hospital) and required 24 hour support. On 6 May 2005 a letter was sent to Mr A's mother (Mrs A) inviting her to a meeting to discuss site reconfiguration prior to the planned closure of the Hospital. On 23 May 2005 a transfer meeting was held to discuss the possibility of moving Mr A from his current accommodation (Unit 1) to another unit at the Hospital (Unit 2). The meeting was attended by thirteen NHS staff concerned with Mr A's care, Mrs A, Mr C, an advocacy worker and Mr A's Social Work Department Care Manager (the Care Manager). At the meeting Mrs A, Mr C, the advocacy worker and the Care Manager all stated they were opposed to any transfer. None of the NHS staff opposed this. Further meetings were held on 6 June 2005 and 6 July 2005. Mr C consistently expressed concerns and also asked questions about the process of transfer and how Mr A would be supported through this.

2. It was decided that Mr A would be moved on 6 August 2005. Between 4 and 8 August 2005 attempts were made to introduce Mr A to Unit 2. He was distressed by this. On 9 August 2005 the decision was made to give him medication and Mr A completed the move to Unit 2. Mr A, who suffers from epilepsy, had five seizures in November and December 2005.

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

(a) the decision to move Mr A between units was made prior to discussion and on the basis of staffing levels rather than needs;

(b) the move was not made at Mr A's pace, was too fast and Mr A required to be medicated to facilitate the move; and

(c) Mr A has since suffered seizures as a result of the stress incurred.

Investigation

4. In investigating Mr C's complaint I have reviewed the correspondence between Mr C and Lanarkshire NHS Board (the Board). I have seen all documents

in the complaint file including notes of transfer meetings. I have taken advice from a mental health Adviser to the Ombudsman (the Adviser).

5. 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. Abbreviations used in this report are set out in Annex 1 and a glossary of terms at Annex 2.

(a) The decision to move Mr A between units was made prior to discussion and on the basis of staffing levels rather than needs

6. The Executive's report 'Same as you' published in 2000 recommended the closure of all long-stay hospitals for people with learning difficulties by 2005. In 2001/2002, the Hospital developed a guideline for internal transfer of residents as they recognised there would be a need for internal transfers and site reconfiguration during the closure process. In early 2005 the Hospital had site visits from both Quality Improvement Scotland (QIS) and the Mental Welfare Commission (MWC). They raised a number of issues, including concerns over staffing cover across sites with only a few units still open. The Hospital decided they needed to reconfigure the site to respond to these concerns and in line with planning already ongoing to ensure that they maintained a high quality and continuity of care, ensured all patients had access to a range of professional staff, and provided a safe and healthy environment. On the final point it was noted in the Hospital's response to the draft report that the units were spread across a large area and there had been vandalism in some of the outlying units which were no longer used.

7. As the Hospital was expected to close, a long term plan to resettle Mr A into the community was in place but this was still at the planning stage when, on 6 May 2005, Mrs A received a letter asking her to attend a meeting to discuss the accommodation needs of her son. This meeting was held on 16 May 2005 and, unfortunately notes were not kept. A further meeting was held on 23 May 2005 with Mrs A, Mr C, members of Hospital staff including two consultants, an advocacy worker and the Care Manager. The notes say the meeting was called to give consideration to 'how best to support the transfer'. It is recorded that Mr C said he had been told on 16 May 2005 that a decision had already been made to transfer Mr A. The notes indicated that on 23 May 2005, Mr C was told that no

final decision had been made and that it was repeated this was still a 'possible transfer'.

8. At the meeting, the Hospital set out the reasons for the site reconfiguration. They listed the concerns raised by MWC and QIS which included staffing, the environment, care planning, and the level of activities throughout the site. They also said that in looking at the details of the reconfiguration they had considered the need to move patients only once during closure. In addition individual units could not be sustained due to staff levels and the need for specialised support. Mr C, Mrs A, the Care Manager and the advocacy worker who were present all stated they were opposed to any transfer. It was agreed a further meeting would take place in two weeks as the Care Manager suggested that discharge into the community could be imminent. The Hospital said that if this proved not to be the case, transfer proposals would need to go forward. It was noted, however, that consideration could be given to moving Mr A to a single unit closer to the Hospital.

9. At a further meeting on 6 June 2005, no progress had been made on securing a house or staff to support Mr A in the community. Mr C expressed his concerns about the way Mr A would be introduced to Unit 2 and whether there would be a contingency plan. A Hospital Manager (the Service Manager) was also concerned that there was no recent base line information about a range of Mr A's behaviour, activities and moods. It was agreed these would be monitored, allowing the Hospital to identify changes in patterns. It was also agreed that a further meeting would be held to collect all relevant information about Mr A's response to situations prior to 'any final decision as to how best to take forward the proposed internal transfer'.

10. The Board responded to a formal complaint from Mr C on 21 June 2005. In this letter they said the decision to move Mr A had not been made prior to the meeting of 16 May 2005 and that Mr A 'will have a full clinical assessment, which will inform any future decision'. Further 'Should internal transfer take place it is proposed that [Mr A] should move to [Unit 2]'. The letter also referred to ongoing discussions with the local Council relating to the discharge of patients and said that they had no reason to believe there had been any change to the projected discharge date for Mr A of March 2006.

11. The final transfer meeting was held on 6 July 2005. The base line assessment had been made but its outcomes were not available for the group at the meeting. Mr C said he would prefer Mr A to stay in Unit 1 but was told that the retraction (drawing back of the outlying units) would cause major difficulties in ensuring appropriate staffing levels and staff safety. It was reported that the MWC had raised the issue of Mr A's proposed transfer on 29 June 2005 and it was confirmed that familiar staff and activities would be provided following his transfer.

12. The notes of the meeting state that it was agreed the transfer would go ahead and that Mr A was to be introduced to Unit 2 and continue at a pace he was 'comfortable' with. A guideline, which had been completed previously to assist staff in introducing Mr A to a range of environments, would be followed. A specific guideline for the transfer was also created and the date for the transfer was set as 6 August 2005.

13. The Adviser who reviewed the complaint file and Mr A's clinical records for the relevant period noted there were inevitable difficulties involved in hospital closures and that the Board had to balance duties towards staff as well as towards patients. She said that the internal transfer guidelines produced in 2000/2001 were clear but did not fully address issues raised in this case where there was a need to resolve disputes, a patient without capacity and the need for re-assessment:

> 'Any patient being relocated in a hospital closure programme should have a full re-assessment of his or her needs, with the involvement of carers and advocates as needed, and the eventual solution should be based on these assessed needs. This is particularly important where someone has lived in an institution for a long time and is moving to a community setting. I could not see any evidence of a systematic re-assessment of [Mr A]'s needs in the documentation supplied, nor (assuming that this had been done) that this assessment was considered in relation to the internal transfer. I note, however, that in June 2005 there were concerns that no baseline information existed of the type that I would expect to be in a full assessment and the need for a proper risk assessment was noted. I could not see any such assessment, and indeed I note that [Mr A] was able to escape from his accommodation on the first night following his transfer and on several subsequent occasions, although he clearly needed secure accommodation.

14. In concluding the Adviser said:

'it is my view that the need to transfer [Mr A] did result from organisational and staffing requirements, rather than being based on [Mr A]'s needs. This was unfortunate, but probably unavoidable in the context of the reprovision of services at the time and the recommendations of external bodies with responsibilities for auditing and monitoring the quality of services. Although [Mr A]'s needs were clearly considered in relation to the move, in my view there should have been a clear re-assessment of his needs in the context of service re-provision and a risk assessment related to the move, with clear management plans for addressing problems following the move, such as environmental security, relationships with other residents etc. I am also unclear about how well the need for the move was communicated to [Mr C] and [Mrs A], as there are no records of the meeting on 16 May. The need to move [Mr A] in the context of site retraction clearly was taken before 23 May, although I could not say that the decision to move him to [Unit 2] was taken before that date.'

(a) Conclusion

15. The process of closing a hospital which has long-stay patients is complex and difficult for all involved. The Hospital had to balance their need to respond to concerns from QIS and MWC about the Hospital generally and the concerns of Mr A's family and support workers about the impact on him individually. In the circumstances, I consider their decision to move Mr A from Unit 1 to Unit 2 was reasonable and that, given the long-term plan to move Mr A to a house in the community could not be brought forward because of resource issues elsewhere, likely to be the only one they could have made. However, the Adviser has suggested that the way this was communicated to Mr A's family could have been improved and it does appear that the 'proposed transfer' was inevitable but the details of the decision were not confirmed until the meeting of 6 July 2005. I consider that the Hospital should have been clearer at the outset about the limitations on their options and that this may have helped the family come to terms with the move and allowed the focus to remain on how to facilitate this.

16. Although the Adviser has found that Mr A's needs were clearly considered in relation to the move she has expressed concerns that the initial guidelines did not provide guidance for situations such as Mr A's where there was a dispute or set out

the need for re-assessment of patients. Taking this into account and the concerns expressed about the Hospital's communications with the family by the Adviser, I have decided to partially uphold the complaint to the extent that communications with the family and the re-assessment could have been better managed.

(a) Recommendation

17. If further reconfiguration is to occur, the Board should review their guidelines, and in particular their communication, individual patient review and risk management policies.

(b) The move was not made at Mr A's pace, was too fast and Mr A required to be medicated to facilitate the move

18. Between 4 and 8 August 2005 Mr A was walked to and from Unit 1 and Unit 2.[1] The records show that there were reports of increased anxiety and a deterioration in behaviour. On 9 August 2005 this was discussed at a clinical review and it was agreed that medication would be given to Mr A and the family informed. Mr A was given Lorazepam and moved to Unit 2 in the evening. He absconded from Unit 2 that night but was returned and settled quickly. On 10 August his normal routine of walks and family visits was reintroduced.

19. The Hospital have said that Mr A had been given the medication on a regular basis prior to occasions which Mr A may find anxious and prior to his original move in to Unit 1. As well as the general guidelines, specific guidelines for this move were created and followed (see paragraph 12). The Adviser has said on the guidelines that these were 'unsophisticated' but 'adequate'. As indicated in paragraph 13 the Adviser was concerned about the lack of an individual re-assessment but on the actual move the Adviser has commented:

> 'The process of moving itself appears to me to have been relatively well-managed, with a gradual introduction to the house, resulting in [Mr A] entering of his own volition. This followed one previous trial to get him to enter where he became very distressed and so a decision was made to use medication to facilitate the move. Once inside the house, he clearly became distressed and wanted to leave. This situation was dealt with using medication. In both these instances, I believe this decision was appropriate as it would not have

[1] See paragraphs 11 to 15 for details of planning undertaken prior to this move.

been right to leave him in a distressed and aroused state when medication could have lessened his distress. I also believe the speed and pace of the move was reasonable in the circumstances, there was no evidence that it was unduly rushed although it did have to be firmly progressed once he became distressed. I think that to prolong the process could have caused more distress to [Mr A] and reinforced his fears of [Unit 2]. I note that the family asked for no medication to be used during the process. This wish appears to have been taken into account. It is recorded in the notes made was discussed at the time. The decision to use medication was used by the clinical team who are responsible for such decisions and were clearly acting to relieve [Mr A]'s distress. Only a minimal amount of medication was used, and reasonable attempts were made to communicate with the family ([Mr C] was not contactable at the time). Mr A himself settled well within 2 or 3 days of being moved.'

(b) Conclusion

20. As the Adviser is clear that once the decision was made to move this was carried out appropriately and Mr A was not inappropriately given medication without consideration of the family's views, I do not uphold this complaint.

(c) Mr A has since suffered seizures as a result of the stress incurred

21. Mr A suffered five seizures during November and December 2005; two on 24 November and one each on 5, 6 and 18 December 2005. The Adviser has confirmed that 'prior to this period, he had had seizures in July, August and September of 2004 (3), June, August and December of 2003 (3), and March, May, June and November of 2002 (7). In 2006 (to date) he has had 4 seizures'.

22. The Adviser commented further:

'[Mr A] has clearly suffered from severe and life-threatening seizures for many years. Usually these are well controlled with medication but he does appear to have periodic seizures a few times every year. I could see no connection between the onset of seizures in November [2005] and the move in August 2005. However, I would note that in the weeks prior to the onset of seizures, [Mr A] suffered a number of challenges to his immune system, with a mouth infection, a cold and then a flu vaccine. These in themselves could have increased his vulnerability to seizures. It is also possible that he was

experiencing stress in his new environment which could have contributed to the seizures, however, I could not see any clear evidence of that. It can be difficult to determine the precise trigger for seizures in an individual person, however, it also appeared that his anti-convulsant levels were sub-therapeutic (ie too low a concentration in the blood to have an effect) and so the dose was appropriately increased. The pattern of [Mr A]'s seizures at this time does not appear to be markedly different from his previous episodes.'

23. The Adviser concluded:

'There is no evidence that the move itself exacerbated [Mr A]'s epilepsy and [Mr C]'s assertion that his brother had been seizure free for some years before the move is not supported by the clinical records. His seizures appear to have been brought under control appropriately.'

24. When commenting on the draft report, the Board noted that, in response to Mr C's concerns about the number of seizures his brother had over this period, Mr A's consultant had been contacted and had replied in a similar fashion to the Adviser. This information was recorded in Mr C's records.

(c) Conclusion

25. As the Adviser was unable to see any link between the move in August 2005 and the seizures suffered by Mr A during November and December 2005, and there is evidence that Mr A has previously suffered with seizures, I do not uphold this complaint.

27 February 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mr A	The complainant's brother
Mrs A	Mr C and Mr A's mother
The Hospital	Kirklands Hospital
The Board	Lanarkshire NHS Board
The Adviser	Mental health Adviser to the Ombudsman
The Care Manager	Mr A's Social Work Department Care Manager
MWC	The Mental Welfare Commission
QIS	NHS Quality Improvement Scotland
The Service Manager	A manager at the Hospital

Annex 2

Glossary of terms

Lorazepam	A drug in the benzodiazepine family which is used for the treatment of anxiety.