Case 200700114: Fife NHS Board

Summary of Investigation

Category

Health: hospital; psychiatry, policy and administration

Overview

The complainant (Mrs C) was concerned about the way in which a ward closure in Lynebank Hospital (the Hospital) was handled. Her niece (Ms A) was resident on the ward.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the closure of a ward in which Ms A was resident was poorly handled (*upheld*); and

(b) the response to Mrs C's complaint about this matter was inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that Fife NHS Board:

(i) apologise to Ms A and Mrs C's husband for the limited time available to prepare for and consult about the move between wards;

(ii) draw on the experience of this ward transfer to review the way in which such moves are planned in future; and

(iii) review the way in which such decisions are documented.

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

Main Investigation Report

Introduction

1. In June 2004, the complainant (Mrs C)'s niece (Ms A) had been taken in to Lynebank Hospital (the Hospital) to be treated for a deterioration in her mental health and an exacerbation of her Parkinson's disease. She was admitted to a secure ward (Ward A) under a Compulsory Treatment Order. By late spring 2006, Ms A was ready to be discharged into appropriate accommodation in the community, and it was hoped that this would be completed by October 2006. This was delayed because Ms A's new accommodation was not ready. As part of a long-term planned discharge programme, the number of patients on Ward A was decreasing and a decision was taken to close the ward in December 2006 and move the remaining residents elsewhere in the Hospital pending discharge into community-based facilities. Ms A was moved to another ward (Ward B) and eventually moved into her new accommodation in May 2007.

2. At the time of the decision to close Ward A, Mrs C complained that neither she nor Ms A had been given enough notice of this major change, that it was planned to take place too close to Christmas, and that it was not necessary to close the ward when Ms A would soon be discharged. She remained dissatisfied with Fife NHS Board (the Board)'s response to her complaint and submitted her complaint to the Ombudsman on 7 April 2007.

3. Ms A did not have capacity to make informed decisions about major matters concerning her welfare. Mrs C was her next-of-kin and was named as such on Ms A's care plan. Sadly, Mrs C died in the course of the investigation of this complaint. Her husband (Mr C) continued to pursue the complaint on behalf of Ms A.

4. The complaints from Mrs C which I have investigated are that:

(a) the closure of a ward in which Ms A was resident was poorly handled; and
(b) the response to Mrs C's complaint about this matter was inadequate.

Investigation

5. To investigate this complaint, I reviewed the relevant correspondence and internal documentation and considered the wider Scottish policy background to the closure programme. I also spoke to family members and health professionals involved in the transfer between Ward A and Ward B. I made

inquiry of the Board on 22 August 2007 and received their detailed response on 20 September 2007. I also sought the advice of the Ombudsman's independent nursing adviser (the Adviser) who has experience of the oversight of discharge programmes.

6. 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.

Background

7. Over the last two decades, there has been a steady movement away from delivering services to adults with learning disabilities in long-term residential institutions. This process gathered pace with programmes to close major residential institutions from the mid-1990s. In 2000, the Scottish Executive's[1] review of services for people with learning disabilities, The Same as You?, set a target date of 2005 for the closure of the remaining long-stay residential facilities.

8. Staff at the Hospital were engaged in the process of planning and managing the discharge of the majority of patients to community-based residential and support services at the time Ms A was resident there. This process was at an advanced stage at the time and only 30 residents remained. Their discharge team was disbanded in July 2007.

(a) The closure of a ward in which Ms A was resident was poorly handled

9. Ms A was admitted to Ward A in June 2004 to treat a deterioration in her mental health and an exacerbation of her Parkinson's disease. She was treated under a Compulsory Treatment Order and was admitted to a locked ward because her mental health needs. Prior to this admission, she had held a tenancy and was living with support in the community. This tenancy lapsed when she was admitted to the Hospital. Ms A had previously been a short-term resident of the Hospital in a different ward after her mother's death.

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[1] On 3 September 2007 Scottish Ministers formally adopted the title Scottish Government to replace the term Scottish Executive. The latter term is used in this report as it applied at the time of the events to which the report relates.

10. Because of the lapse in her tenancy, it was necessary for the Social Work department to arrange for new accommodation for Ms A. A property was identified but was not ready for immediate occupation as there was ongoing building work. As noted in paragraph 1, Ms A was ready to be discharged from late spring 2006, and it was originally envisaged that she would be able to move in to her new home in October 2006. Due to circumstances beyond the control of the Hospital, this was not possible and Ms A was still resident in Ward A by December 2006.

11. Because of the Hospital's ongoing discharge programme, residents were being moved from wards into other residential settings and this, in turn, had an impact on the numbers of residents still in the Hospital. By the beginning of December 2006, Ms A was one of only three patients resident in Ward A. The ward was divided in two, and Ms A was the only remaining patient in her part of the ward.

12. The decision was, therefore, taken to close Ward A and transfer Ms A to Ward B. The decision involved care managers of both wards, the consultant psychiatrist and members of the multi-disciplinary team. Some of the staff who had been involved in Ms A's care continued to work with her in her new ward to ensure a degree of continuity for her. Medical notes record that Ms A was in a stable condition four days after the move and that there was no deterioration in her mental health.

13. On 12 December 2006, Mrs C telephoned the Board to complain about Ms A's unexpected move to a new ward. At this time, it was assumed that she would be discharged by the end of January. Mrs C felt that this disruption was unnecessary, had been decided too quickly, and was planned to take place too close to Christmas (the closure date for Ward A was 18 December 2006).

14. Mrs C followed up the conversation with a letter to the Board on 14 December 2006. A senior manager from the relevant Community Health Partnership responded on 12 January 2007 saying that the decision had been taken carefully (as described in paragraph 12) and that Ms A had settled well into her new environment. At this point, it was still envisaged that she would be discharged by the end of January.

15. In addition to Mrs C's representations, an advocacy worker met with Ms A and then shared some of Ms A's concerns about the manner of her move with

the Hospital in a letter of 13 January 2007. He said that Ms A had felt unsettled by the move, that she did not feel that she had been adequately consulted and that her confidence in the arrangements for her eventual discharge had been shaken by these events. The advocacy worker raised a number of other concerns including the loss of some of Ms A's possessions during the transfer between wards. These have not been included in this investigation.

(a) Conclusion

16. From the evidence I have seen, there had been discussion about the need to close Ward A since the end of October 2006. Indeed, the possibility of the need to transfer Ms A to another ward was noted in a care plan of 10 May 2006 and Mrs C had a copy of this document. However, the final decision to close the ward was taken quickly. The decision should be understood within the context of the overall discharge programme, but does not appear to have been a part of that programme. The need for the decision was understandable, given the changing composition of the wards. It is also clear that this was due in large part to circumstances beyond the control of the Hospital. I have no reason to question the care and rigour with which the decision was taken or the transition managed.

17. However, I have seen no evidence that either Ms A or Mrs C had more than a few days' notice of the proposed closure and the lack of time to prepare for this move was the cause of some distress to both of them. Clinicians involved in the decision to close the ward considered that Ms A would not benefit from a long preparation time for the move but it does not appear that this issue was discussed with Mrs C. Although the Board reasonably commented that it is not possible to discuss all decisions with patients' relatives, this was a significant decision which had previously been highlighted in Ms A's care plan as requiring particular attention. As noted in paragraph 3, Ms A did not have capacity with respect to such decisions and Mrs C was recorded as the nearest relative. I can also understand Mrs C's unhappiness that the move took place close to Christmas.

18. Furthermore, I have not seen evidence to suggest that the need to close Ward A was so urgent as to preclude a longer preparation time. Indeed, the planning involved in the long-term development of the Hospital and in the discharge of patients requires careful scheduling over a significant period of time. Notwithstanding the uncontrollable factors relating to new arrangements for patients about to be discharged, the Adviser considered that it is likely that

the need to close Ward A was known in advance of Mrs C becoming aware of the plans. I conclude, therefore, that it is possible that the ward closure could have been delayed by a few weeks to allow for fuller consultation with Mrs C and avoid a disruption close to Christmas. In these circumstances, I uphold this complaint.

(a) Recommendation

19. It is likely that internal moves of the sort experienced by Ms A will cause a degree of anxiety and distress. While this may not be of the same magnitude as a move to a different kind of residential setting, a significant level of planning and consultation is still required to ensure the best possible transition. The Ombudsman, therefore, recommends that the Board:

(i) apologise to Ms A and Mr C for the limited time available to prepare for and consult about the move between wards; and

(ii) draw on the experience of this ward transfer to review the way in which such moves are planned in future.

(b) The response to Mrs C's complaint about this matter was inadequate

20. As noted in paragraphs 13 and 14, there was an exchange of correspondence between Mrs C and the Board about her complaint. Following the Board's letter of 11 January 2007, a meeting was arranged between Mrs C and staff at the Hospital. There was also a meeting between staff at the Hospital, Ms A and her advocacy worker, which Mrs C was invited to attend. Both meetings took place on 23 February 2007.

21. The written response to Mrs C's complaint of 12 January 2007 focussed on issues relating to the closure of Ward A. This same issue was addressed at Mrs C's meeting at the Hospital on 23 February 2007 along with a range of other matters which are beyond the scope of this investigation. The note of this meeting records that not all the issues raised by Mrs C were addressed at the meeting, but that the senior nurse who had met with her followed up the meeting with a telephone call. There is no record of what was discussed during this call.

22. Mrs C was not satisfied with the responses she received to her complaints. In particular, she did not consider that she had received adequate explanation for the manner in which the ward closure took place. She referred her complaint to the Ombudsman on 7 April 2007.

(b) Conclusion

23. Staff at the Hospital and patient liaison staff at the Board responded promptly when Mrs C expressed her dissatisfaction at the way in which the ward closure took place. A written response was offered and meetings were arranged to address the concerns that she and Ms A had raised.

24. It is clear that the explanations offered for the decision to close Ward A did not satisfy Mrs C. From the evidence I have seen, although reassurances were given that the decision had been made carefully and with Ms A's best interests in mind, some of Mrs C's principal questions do not appear to have been answered. I have not seen evidence that the Board gave an adequate explanation for the short time scale or for the timing of the move close to Christmas. Furthermore, the Board were not able to provide me with any documentation which recorded or supported the decision to close Ward A in December 2006. For these reasons, I uphold this complaint.

(b) Recommendation

25. Mrs C said that if the Board had apologised at the time for the way the ward closure was planned, she would have regarded the matter as having been concluded. The Ombudsman has already recommended that the Board apologise for this (paragraph 19). The Ombudsman further recommends that, when the Board consider the lessons to be learned from these events, they review the way in which such decisions are documented.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Ms A	Mrs C's niece, a resident on Ward A
The Hospital	Lynebank Hospital
Ward A	A secure ward in the Hospital in which Ms A was resident
Ward B	The ward to which Ms A was moved following the closure of Ward A
The Board	Fife NHS Board
Mr C	Mrs C's husband
The Adviser	The Ombudsman's independent nursing adviser