Parliament Region: North East Scotland

Case 200902396: Grampian NHS Board

Summary of Investigation

Category

Health: Hospitals; general medical; record-keeping

Overview

The complainant (Mr C) made a complaint about Grampian Health Board (the Board) on behalf of the aggrieved (Mrs A). Mrs A was admitted to Aberdeen Royal Infirmary (the Hospital) after collapsing in a supermarket on 17 February 2009. On the following day, it was recorded that she was very agitated, confused and that she was shouting. Later that day, nurses recorded that they were unable to give the prescribed intravenous antibiotics because Mrs A refused them. The records show that she was subsequently given two doses of haloperidol (an antipsychotic drug) by intramuscular injection 'to settle'.

Specific complaints and conclusion

The complaint which has been investigated is that Mrs A was injected with haloperidol against her will on 18 February 2009 (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) undertake an external peer review in the Hospital to include:	
• the assessment, treatment and care of people with confusion, delirium or behavioural disturbance;	22 December 2010
• the use of the Adults with Incapacity legislation;	
• the use of both physical restraint and restraint by medicines;	

(ii)	review the means by which medical and nursing staff are trained in the assessment and management of acute agitation or confusion, including appropriate use of the Adults with Incapacity legislation and documentation;	22 December 2010
(iii)	review and disseminate their 'Guidance for Rapid Tranquilisation of Psychiatric Emergencies in Psychiatric Hospitals, General Hospitals and Accident and Emergency Departments' document;	22 December 2010
(iv)	remind all clinical staff in the Hospital to carefully document indications for the use of sedative medication, the patient's consent to such treatment and the use of any form of restraint to administer such medication;	22 October 2010
(v)	provide me with details of the findings and the action plan created as a result of the above recommendations and provide updates where relevant;	22 March 2011
(vi)	ensure that the findings in this report are communicated to the staff involved in Mrs A's care and treatment; and	22 October 2010
(vii)	issue an apology to Mrs A for the failings identified in this report.	6 October 2010

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

Main Investigation Report

Introduction

1. The complainant (Mr C) made a complaint about Grampian Health Board (the Board) on behalf of the aggrieved (Mrs A). Mrs A was admitted to Aberdeen Royal Infirmary (the Hospital) after collapsing in a supermarket on 17 February 2009. On the following day, it was recorded that she was very agitated, confused and that she was shouting. Later that day, nurses recorded that they were unable to give the prescribed intravenous antibiotics because Mrs A refused them. The records show that she was subsequently given two doses of haloperidol (an antipsychotic drug) by intramuscular injection 'to settle'.

2. The complaint from Mr D which I have investigated is that Mrs A was injected with haloperidol against her will on 18 February 2009.

Investigation

3. Investigation of Mr C's complaint involved reviewing Mrs A's clinical and nursing records relating to the events. My complaints reviewer also sought the views of a specialist medical adviser (Adviser 1) and a specialist consultant psychiatrist (Adviser 2). Additional comments were requested from a nursing adviser (Adviser 3).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. A glossary of terms used in this report can be found at Annex 2 and a list of the legislation and policies considered at Annex 3. Mr C and the Board were given an opportunity to comment on a draft of this report.

Complaint: Mrs A was injected with haloperidol against her will on 18 February 2009

Background

5. Mrs A, a 74-year-old female with a history of diabetes and hypertension, was admitted to the Hospital on 17 February 2009 after collapsing in a supermarket. Paramedics at the scene had noted that she was unresponsive but conscious, and that she became confused and aggressive as she became responsive. The paramedics also noted that they 'could not take all base line observations as patient would not allow it and removed equipment.' A junior

doctor assessed Mrs A at the Hospital at 19:15 on 17 February 2009 and noted that she was very upset and confused.

6. At 01:30 on the following day, nurses recorded that Mrs A was confused and had muddled speech. A more senior doctor saw her at 03:30 and recorded that she was very agitated and confused and that she was shouting. No formal assessment of mental state or cognitive function was documented. The doctor diagnosed that Mrs A had collapsed due to acute coronary syndrome but noted that she then refused the confirmatory blood test at 04:00.

7. Mrs A was seen by a consultant in Ward 49 later that morning. He recorded that she was 'tearful and anxious' and 'unwilling for investigation'. The consultant was concerned that Mrs A had a brain infection. He suggested a CT scan of her brain and that antibiotic and antiviral treatment should be started. These drugs would normally be given intravenously. The consultant also noted 'psychiatric review' in the records but it is not clear if a psychiatric referral was made.

8. At 10:00, the nurses documented that Mrs A was refusing all medication and refusing to stay. They also noted 'liaison psychiatry referral' in the notes. There was no subsequent reference to this referral. At 10:30, 0.5mg of lorazepam (a drug used to treat severe anxiety) was prescribed as a single oral dose. However, the records did not indicate that this was given to Mrs A. There was no specific note in the medical records about the indication for this and no nursing documentation in relation to refusal or consent by Mrs A for the medication.

9. At 13:30 on the same day, staff contacted Mrs A's GP for information. He said that he did not think that her current behaviour was in keeping with her usual state. At 13:50, the nurses documented that they were unable to give the prescribed intravenous drugs for suspected infection to Mrs A, as she was refusing a venflon (a small flexible plastic tube that is inserted through the skin into one of the veins).

10. The nursing documentation stated that Mrs A was given an intramuscular injection of haloperidol at 14:00 'to settle'. The drug record showed that this was a 5mg dose of haloperidol. At 15:10, the nurses noted that Mrs A was given another 5mg dose of haloperidol, as she had not settled enough. The records also showed that Mrs A was given 1mg of oral lorazepam at 16:00, as

she was still not settled. Mrs A has stated that she was held down by five doctors when she was given an injection of haloperidol.

11. The only medical documentation in relation to the administration of sedative medication was written in retrospect at 16:00. This stated that Mrs A had refused blood tests and intravenous access for antibiotics all afternoon. It stated that she had 2 x 5mg intramuscular injections of haloperidol and 1mg of lorazepam for agitation. The entry also stated that staff would continue to approach Mrs A regarding the possibility of blood tests/intravenous access and that they had explained the necessity for these due to her condition.

12. The next entry in the nursing records was at 05:00 on 19 February 2009. The nurses recorded that Mrs A had settled and slept overnight but remained confused and that her behaviour was inappropriate. It was also recorded that Mrs A's daughter had been on the phone the previous night and would be travelling to the Hospital.

13. The next record in the medical documentation was at 13:00 on 19 February 2009. It was recorded that there had been a further episode of confusion that morning. It was also recorded that Mrs A was adamant that she would not accept repeat bloods, cannulation or intravenous antibiotics. A CT scan was then carried out later that day. This showed a stroke in the left posterior frontal cortex part of the brain.

14. Mrs A was subsequently described as agitated on occasions. At one point, she wished to go home against the advice of staff. However, she was not prescribed or given any other sedative medications before her discharge on 3 March 2009.

15. Mrs A and Mr C subsequently complained to the Board about the care and treatment which had been provided to Mrs A. The Board met them on 17 June 2009 to discuss this. The record of the meeting stated that staff considered that getting Mrs A into the CT scanner was going to be very difficult. Mrs A said this was not a problem at all. The consultant confirmed that this was the reason for the administration of haloperidol and that the medical team had achieved what was required. He said that Mrs A was fully conscious throughout the scan and she was calm enough to have it so that a diagnosis could be reached. However, the CT scan was carried out the day after haloperidol was

administered. I have not seen any evidence that further sedation was given at that time to facilitate the CT scan.

16. I asked Adviser 1 for his comments on the complaint. In his response, he said that Mrs A had displayed disinhibited and aggressive behaviour as soon as she became unwell. This suggested to the admitting team that she had an acute confusional state (delirium). Adviser 1 commented that although some of the initial clinical features suggested acute stroke, for example dysphasia (language disorder), the presentation was not typical and the time taken to make the correct diagnosis was, therefore, not unreasonable. He also said that it was reasonable for the admitting team to consider alternative diagnoses such as encephalitis (inflammation of the brain) or sepsis (organisms in the blood) and propose treatment, in the form of intravenous antibiotics and antivirals, and investigations such as a cerebral CT scan.

17. However, Adviser 1 also stated that the documentation of the patient's cognitive function and capacity to participate in decision making was poor. No objective assessment of cognition was undertaken or documented before sedating drugs were administered. Although a review by liaison psychiatry was suggested on 18 February 2009, there is no evidence that this was carried out at that time. Adviser 1 commented that he did not consider that psychiatric review before the administration of sedating drugs is mandatory. However, he said that some assessment of cognition and capacity to consent to treatment, ideally including the use of a standardised scale such as the mini mental state examination (MMSE), should be undertaken and documented before such treatment is administered.

18. Adviser 1 stated that, given the absence of information in the notes which indicated what the treating team's view of Mrs A's competence and cognition actually was, it was difficult to be certain whether she had the capacity to refuse treatment and investigation. He said that if Mrs A did have the capacity to make decisions, some of her behaviour may have been in response to some of the proposed treatments, particularly those involving needles. Mrs A had a needle phobia, although there was no evidence in the records that the medical team were aware of this at that time. Adviser 1 said that it was conceivable that this could explain her behaviour and that she could not communicate her true feelings clearly because of the dysphasia caused by the stroke. However, he also advised that a stroke in the area of the brain as suffered by Mrs A could cause the speech disturbance and behavioural problems noted.

19. Adviser 1 commented there was no medical/nursing documentation of:

- whether the patient consented to the treatment or whether it was felt necessary to seek consent;
- whether the patient was judged to be competent to participate in decision making or whether her capacity was assessed;
- what non-pharmacological measures were undertaken before using drug treatment to manage the agitation;
- the precise indication for the use of the sedative drugs other than the use of the term 'to settle';
- the involvement of more senior medical or psychiatric staff in the decision making process or choice of drugs or doses.
- whether the patient was offered haloperidol orally before it was administered intramuscularly;
- the circumstances surrounding the administration of the drugs, particularly whether any physical restraint was applied at any time;
- the ultimate outcome of the use of the sedating drugs and whether they were able to give Mrs A the intravenous antibiotics as a result; and
- whether the CT scan was actually going to occur on the afternoon haloperidol was given.

20. Adviser 1 stated that if Mrs A refused treatment and investigation after careful explanation of the risks and benefits of this decision, then her choice should be respected. If she really understood that the medical team was concerned she may have an infection of the brain, and that infection could result in progressive or irreversible damage if untreated, then she could refuse treatment for that infection if judged competent to do so. Should this scenario occur, many clinicians would, in this setting and particularly where a brain disorder was suspected, request a further opinion regarding the patient's capacity at that time, as the patient's life could be endangered by their decision to reject investigation and treatment.

21. Adviser 1 stated that the use of sedation without consent, if the patient was indeed competent, would be wholly inappropriate and below a standard which can reasonably be expected. He also said that if a competent patient accepted or wished sedation, after explanation and with consent, to help them go through an investigation (for example, CT) or treatment (for example, injection of drug) which caused anxiety, intramuscular haloperidol in the doses given would not

be the first choice treatment. However, he stated that there was no evidence to support the idea that the treating team believed the patient to be competent or have capacity.

22. Adviser 1 said that he considered it more likely that the patient's behaviour was primarily due to the effects of the brain injury from the acute stroke. He said that he considered this extended beyond the specific speech problem that she had and had caused an acute confusional state.

23. Adviser 1 stated that his view was that Mrs A's behaviour was not entirely rational. He said that her understanding of any explanations may have been compromised by the presence of a language disorder due to the stroke. He said that it was likely that she was not competent to participate fully in decision making. He also stated that he considered that the treating team felt Mrs A was not competent to make decisions.

24. Adviser 1 commented that if the treating team consider that a patient is unable to make informed decisions and that their refusal to undergo investigation or treatment might jeopardise their welfare, then it is reasonable to take further steps to help provide investigation and treatment. He said that this can, in his view and in standard current clinical practice, include the administration of sedating medication. However, the use of such medication would be regarded as a last resort. It would only be undertaken after other avenues had been exhausted and after considering carefully the risks and benefits.

25. Adviser 1 said that the incompetent patient should be protected from inappropriate actions in such settings. The Adults with Incapacity (Scotland) Act 2000 provides a framework for decision making in relation to this. In such a situation, the treating team should clearly document in the medical record that they consider that the patient lacks capacity. They should also complete an Adults with Incapacity form, indicating the cause and likely duration of the incapacity, and the medical actions to be undertaken under the provisions of the legislation. There was no evidence in Mrs A's case that the completion of an Adults with Incapacity form was ever considered, or that psychiatric review was carried out at that time.

26. Adviser 1 also said that staff should document in the clinical record the reason for the use of any form of restraint and the precise reason for the

administration of sedative drugs. He said that one provision of the current legislation is that the 'least restrictive' option is preferred. Therefore, injections should ideally be avoided if the patient has stated they do not wish to have them, unless all other avenues are exhausted.

27. Adviser 1 also commented that a psychiatrist should preferably be consulted, but in an emergency or urgent situation the absence of psychiatric input before administration of sedation is not, in itself, unreasonable. He said that in this case, there was: no clear documentation of the assessment of capacity; no clear documentation of the team's overall view about the patient's capacity; and no clear documentation of the indication for the use of drug treatment.

28. Adviser 1 raised a number of other specific concerns in relation to this. He said that it was not clear:

- if the patient understood the purpose of the injection;
- whether consent was sought or obtained for the sedating injection;
- whether oral treatment was offered first;
- whether everything else was done before resorting to the use of sedative drugs;
- that the patient posed sufficient risk to herself or others to warrant administration of the drugs;
- what the actual indication for the use of the drugs was;
- whether the treating team believed the patient to be capable of making reasoned decisions; and
- whether use of the Adults with Incapacity legislation was considered.

29. The Board also provided my complaints reviewer with a copy of their document entitled 'Guidance for Rapid Tranquilisation of Psychiatric Emergencies in Psychiatric Hospitals, General Hospitals and Accident and Emergency Departments'. Adviser 1 reviewed the policy and said that it was of good quality. He said that he considered that it was relevant to the clinical situation in Mrs A's case but there was no evidence that the guidance had been followed or referred to by the treating team.

30. Adviser 1 also stated that the circumstances surrounding the actual administration of haloperidol were not entirely clear. He said that the account by the patient that she was held down by five doctors when she was given an

injection of haloperidol by a sixth doctor appeared, at face value, to be extraordinary. He said that, in his view, it was extremely unlikely to represent an accurate account of the events. He said that it was more likely that, as the Board have stated, three members of staff were present. Adviser 2 also commented that it would be very unusual indeed for six members of staff to restrain somebody in order to give them an injection in a medical ward. There is no documentation in the records about whether any physical restraint was applied to administer haloperidol.

31. Adviser 1 commented that the use of restraint to administer sedative drugs can be justified in extreme circumstances but should be supported by detailed documentation at the time of the incident. He considered that the treating team were of the view that Mrs A lacked the capacity to participate in decision making, although they did not document this clearly. He said he considered that a decision was made to use sedating drugs to permit administration of the antimicrobials (a drug for killing or suppressing the growth of microorganisms) for suspected meningoencephalitis (inflammation of the brain and meninges). However, he also said that the records suggested that none of the antimicrobials prescribed were able to be given before or after the sedating drugs.

32. In the response provided by Adviser 1, he commented on the Board's responses to the complaints received from Mrs A and Mr C. He said that it was helpful that they offered and arranged a meeting with the complainants. However, the Board's letter to Mr C dated 24 August 2009 stated that there was no record that Mrs A did not consent to any injection. He said that this was an insufficient justification for the actions which were undertaken.

33. Adviser 1 also commented that the precise indication for sedation had not been made clear in the responses to Mrs A and Mr C. It had been suggested that the drugs were given to facilitate CT scanning. Adviser 1 said that this seemed an unlikely explanation. He said that alternative drugs would normally be used for this purpose and there was no documentation by nurses or doctors that the CT scan was actually planned for that afternoon.

34. Adviser 1 also said that the Board had refuted the allegation that Mrs A was forcibly injected. However, they had failed to provide a clear alternative description of how administration occurred, evidenced by the members of staff

involved, although there was an acknowledgement that three members of staff were present.

35. Adviser 1 said that, overall, he considered that the Board had failed to justify the actions that were taken in Mrs A's case. In particular, he said that they had failed to explain:

- if they considered that the patient was or was not competent;
- why the drug was not given orally if the patient was competent, particularly as the patient had a needle phobia;
- why several staff members needed to be present to administer the drug;
- why Adults with Incapacity documentation was not completed;
- why no assessment or documentation of cognitive function was undertaken before administration of drug treatment; and
- why the actions were not in line with their own guidance document.

36. Adviser 1 stated that the standard of the explanation and response to the complainant was below a standard that could reasonably be expected.

37. I also obtained comments on the matter from Adviser 2. In his response, he said that, although only a total of 10mg of haloperidol was administered to Mrs A (this was two injections of 5mg, one hour apart), which was not a particularly high dose, this was above the British National Formulary[1] maximum dose for someone of her age and for the indication of 'for agitation'. This was also well in excess of the dose range covered by the Board's Guidance for Rapid Tranquilisation of Psychiatric Emergencies. This states that 0.5 to 2mg should be given to frail/elderly patients.

38. Adviser 2 said that, if there were good reasons for this, the reasons should have been documented. He stated that it seemed more likely that Mrs A was sedated in order to facilitate intravenous access to treat what the consultant considered to be potentially a very serious illness, rather than for a CT scan. However, there was no clear record of this.

39. Adviser 2 commented that there was no indication of why Mrs A required to have haloperidol by intramuscular injection, rather than orally. In general, if sedation is required, then it would be the norm to offer oral medication first.

[1] The British National Formulary provides UK healthcare professionals with information on the selection and clinical use of medicines.

Injections would only be required if the patient was unable or unwilling to take the oral medication. Adviser 2 said that there was no indication of Mrs A refusing oral medication but there was also no record of restraint having been used. He commented that if restraint was required, consideration should have been given to using detention under the Mental Health (Care and Treatment) (Scotland) Act 2003.

40. Adviser 2 also said that there was no documentation about Mrs A having received treatment under the Adults with Incapacity Act. He said that if she was indeed 'confused' as described, then the appropriate paperwork should have been completed. Although Adviser 2 said that this was clearly wrong, he also said that this was a very common failing, perhaps more so at the time that Mrs A was in Hospital than now. He said that it was sometimes argued that medical admission wards are emergency situations and therefore do not have to comply with the appropriate forms, but this is not the case. Even in emergency situations, it is often possible to complete the appropriate paperwork. Adviser 2 stated that completion of the Adults with Incapacity Act paperwork is poorly policed and it has become fairly common practice to ignore it.

41. Adviser 2 also said that the documented evidence that Mrs A was indeed confused was poor and that her apparent confusion may have simply been her dysphasia. He stated that there should have been some evidence documented as to the basis of why Mrs A was considered incapable of consenting. This should have gone beyond statements about the patient being 'confused'.

42. Adviser 3, a specialist nursing adviser, also considered the matter and said that her view was that the principles relating to the nursing staff are the same as those applied to the medical staff. She said that she agreed with Adviser 1's comments on the poor record-keeping and lack of rationale for the actions taken. She said that this would not have been in line with the Nursing and Midwifery Council Code. This states that:

- you must ensure that you gain consent before you begin any treatment or care;
- you must respect and support people's rights to accept or decline treatment and care;
- you must uphold people's rights to be fully involved in decisions about their care;

- you must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision making and are fully safeguarded; and
- you must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency.

Conclusion

43. Delirium or acute confusional state is a common problem on admission to acute hospitals. Admitting units and their staff should be used to dealing with such patients, some of whom may exhibit aggressive or non-compliant behaviour. The management of such behaviour should be properly documented and take into account relevant local guidance and national guidelines, where appropriate.

44. It is clear that Mrs A exhibited behaviour as soon as she became unwell which suggested to the medical team that she had acute confusional state (delirium). Psychiatric advice should preferably have been sought if the treating team were uncertain about Mrs A's capacity. While a psychiatric referral was considered, there is no evidence to suggest it was obtained. This action is particularly important where the situation is life threatening and where the patient's decision making may risk their life. While I have received advice that, in an emergency situation, the absence of psychiatric input before administration of sedation is not in itself unreasonable, in Mrs A's case, having been admitted to a medical admission ward, there should have been clear documentation of the assessment of capacity.

45. Adviser 1 has indicated that it is likely that the treating team considered that Mrs A was not competent to make decisions at that time. However, if this was the case, it should have been documented and Adults with Incapacity documentation should have been completed. There is no documentary evidence that the medical team reached a decision that Mrs A was not competent at that time.

46. There is also no evidence that there was any consideration given to obtaining consent prior to the use of the sedative drugs or that the medical team took into account relevant guidance put in place by the Board for dealing with such a situation. In addition, there is no justification in the records for the decision to use intramuscular treatment first before offering oral treatment. This is of particular concern given Mrs A's needle phobia. The dose of haloperidol

chosen was also considerably higher than standard practice would suggest and higher than that suggested by the Board's own guidance.

47. I also note with concern that the Board failed to provide a satisfactory explanation to Mrs A and Mr C in response to the complaints they made about this matter. I am particularly concerned that the consultant indicated that the use of haloperidol was to sedate Mrs A prior to the CT scan, when in fact the CT scan was carried out the day after the drug was administered. This inconsistency is a reflection of the lack of documentary evidence and reinforces the need for good record-keeping.

48. A decision to give sedating treatment to facilitate investigation or administration of other drugs is not in itself unreasonable in certain situations, but should only be undertaken after exhausting other avenues and carefully considering risks and benefits. There is no evidence that such an assessment was carried out. In this case, the documentation by medical and nursing staff of the circumstances surrounding the use of the sedative drugs is clearly unsatisfactory and below a standard that could reasonably be expected.

49. In the absence of contemporaneous documentary evidence that Mrs A was not competent or, alternatively, that she consented to the intramuscular injections, I have upheld the complaint that Mrs A was injected with haloperidol against her will.

50. Given the fact that delirium or acute confusional state is a common problem on admission, and given the significant failings I have identified, I make the following recommendations:

Recommendations

51. I recommend that the Board:	*Completion date*
(i) undertake an external peer review in the Hospital to include: • the assessment, treatment and care of people with confusion, delirium or behavioural disturbance; • the use of the Adults with Incapacity legislation; • the use of both physical restraint and restraint	22 December 2010

by medicines;

(ii)	review the means by which medical and nursing staff are trained in the assessment and management of acute agitation or confusion, including appropriate use of the Adults with Incapacity legislation and documentation;	22 December 2010
(iii)	review and disseminate their 'Guidance for Rapid Tranquilisation of Psychiatric Emergencies in Psychiatric Hospitals, General Hospitals and Accident and Emergency Departments' document;	22 December 2010
(iv)	remind all clinical staff in the Hospital to carefully document indications for the use of sedative medication, the patient's consent to such treatment and the use of any form of restraint to administer such medication;	22 October 2010
(v)	provide me with details of the findings and the action plan created as a result of the above recommendations and provide updates where relevant;	22 March 2011
(vi)	ensure that the findings in this report are communicated to the staff involved in Mrs A's care and treatment; and	22 October 2010
(vii)	issue an apology to Mrs A for the failings identified in this report.	6 October 2010

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

Ombudsman's comment

53. It is important that this case and my conclusions on it, are correctly understood. There is no dispute about the facts of the case. In a nutshell, a distressed woman was injected with antipsychotic drugs by hospital staff against her will. There is no documentation to show that this action was properly assessed in advance, or properly recorded after the event.

54. In upholding the complaint, however, I wish to make clear that the complaint was not about restraint, but about consent. I accept that there are times when restraint is justified. What is unacceptable is for health practitioners

not to show proper understanding of the legislation and policies that exist to ensure that patients' human rights are not breached. I believe that in this case they were. Staff must also be made aware of the vital importance of recording the reasons for taking action to restrain or inject despite a patient's clear protestations.

55. As well as patients' rights, I am concerned about the rights of health practitioners. The legislation and policies should act as a safeguard for them. Health Boards have a duty to provide staff with the right information and training that will enable staff, when difficult situations arise, to make the right split-second decisions. Health professionals working in stressful situations need to be well equipped and supported. My recommendations are intended to ensure that in future staff will have the right information and training. For the sake of patients and health practitioners, lessons from this disturbing incident must be learned not only across the Board concerned but across the NHS in Scotland.

Annex 1

Explanation of abbreviations used

Mr C	The complainant's representative
The Board	Grampian NHS Board
Mrs A	The aggrieved
The Hospital	Aberdeen Royal Infirmary
Adviser 1	Specialist medical adviser
Adviser 2	Specialist consultant psychiatrist
Adviser 3	Specialist nursing adviser
MMSE	Mini mental state examination

Annex 2

Glossary of terms

Antimicrobials	A drug for killing or suppressing the growth of microorganisms
Antiviral	Drugs which stimulate defences against viruses
Cannulation	Inserting a tube into the body, often for the delivery or removal of fluid
Cerebral	Of, or pertaining to, the brain
Delirium	Acute confusional state
Disinhibited	Loss of inhibition
Dysphasia	Language disorder
Encephalitis	Inflammation of the brain
Haloperidol	An antipsychotic drug
Lorazepam	A drug used to treat severe anxiety
Meningoencephalitis	Inflammation of the brain and meninges
Sepsis	Organisms in the blood
Venflon	A small flexible plastic tube which is inserted through the skin into one of the veins

Annex 3

List of legislation and policies considered

The Adults with Incapacity (Scotland) Act 2000

Mental Health (Care and Treatment) (Scotland) Act 2003

NHS Grampian Guidance for Rapid Tranquilisation of Psychiatric Emergencies in Psychiatric Hospitals, General Hospitals and Accident and Emergency Departments