Scottish Parliament Region: Lothian

Case 201003775: Lothian NHS Board - Royal Edinburgh and Associated Services Division

Summary of Investigation

Category

Health: Hospital; Psychiatry; clinical treatment

Overview

The complainant (Mrs C) complained about the care and treatment provided to her sister (Ms A), who had a diagnosis of Borderline Personality Disorder, after she was admitted to the Royal Edinburgh Hospital (Hospital 1) in September 2010. Mrs C was also unhappy with Lothian NHS Board's (the Board) responses to her complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Ms A did not receive appropriate care and treatment from Hospital 1 during the period 13 September 2010 to 7 October 2010 (*upheld*); and

(b) the Board have failed to provide satisfactory answers to Mrs C's questions about the matter (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) undertake an external peer review in Hospital 1, to include: the assessment of patients on admission; care-planning practice; the completion of risk management plans and proformas; and communication with the named person and relatives and their involvement and participation in decision-making. Practices in these areas should be audited against relevant professional body expectations; national standards, policies and codes of practice; and existing local policy intentions;	17 February 2012
(ii) provide him with details of the findings and the	16 March 2012

	action plan created as a result of the above recommendation;	
(iii)	ensure that the findings in this report are communicated to the staff involved in Ms A's care and treatment; and	16 December 2011
(iv)	apologise to Mrs C and Ms A for the failures identified in this report.	30 November 2011

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) complained about the care and treatment provided to her sister (Ms A), who had a diagnosis of Borderline Personality Disorder, after she was admitted to the Royal Edinburgh Hospital (Hospital 1) in September 2010. Mrs C was also unhappy with Lothian NHS Board's (the Board) responses to her complaints.

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

(a) Ms A did not receive appropriate care and treatment from Hospital 1 during the period 13 September 2010 to 7 October 2010; and

(b) the Board have failed to provide satisfactory answers to Mrs C's questions about the matter.

Investigation

3. Investigation of the complaint involved reviewing the Board's medical records for Ms A and other documents received from Mrs C and the Board. My complaints reviewer also obtained advice from a professional mental health adviser (Adviser 1) and a psychiatric adviser (Adviser 2).

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 list of the legislation and policies considered in the investigation can be seen at Annex 2. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) Ms A did not receive appropriate care and treatment from Hospital 1 during the period 13 September 2010 to 7 October 2010

5. Ms A had been known to the Board's psychiatric services since 2004. The Board have told us that the possibility of a diagnosis of Borderline Personality Disorder was considered between 2005 and 2007 and confirmed in 2008. Ms A was admitted to Hospital 1 on 13 September 2010 after complaining of low mood and thoughts of self-harm. She specifically said that she intended to take an overdose and burn herself to death in her car. After her admission to Hospital 1 on 13 September 2010, she was detained under a Short-Term Detention Certificate due to her unwillingness to remain in hospital, coupled with medical concern regarding her comments about taking her own life.

6. Mrs C raised a number a number of concerns about the care and treatment provided to Ms A in Hospital 1, and in particular about:

- the initial assessment when Ms A was admitted;
- Ms A's diagnosis of Borderline Personality Disorder;
- the care planning;
- Ms A's contact with staff;
- communication with her family;
- the decision to grant Ms A unescorted leave on 23 September 2010 to attend a scheduled appointment with her psychologist; and
- the delay in revoking the Short-Term Detention Certificate.

Initial assessment

7. My complaints reviewer asked Adviser 1 if staff had carried out a reasonable and appropriate assessment when Ms A was admitted to Hospital 1 on 13 September 2010. In his response, Adviser 1 said that a standardised proforma had been used to structure the assessment. He said that the Mental Health Assessment Service aspect of the assessment contained very brief notes under the various headings. Some sections contained no information at all. He also referred to notes on the reverse side of two of the pages. He said that these notes appeared to be pertinent to the assessment process. He commented that this information had not been recorded under the relevant headings on the proforma. It was not clear if they were intended as part of the clinical record or were simply reminders for the assessor.

8. In addition, the assessment summary contained no detail in relation to the nature of Ms A's needs, beyond stating that they were complex. Adviser 1 said that the overall impression was of a comprehensively designed assessment proforma being completed in a rather hurried, slipshod and casual manner. He said that it lacked relevant information and detail. He stated that the assessment, due to its brevity and incompleteness, fell below the standards expected by the Nursing and Midwifery Council in that the assessor failed to communicate necessary information effectively to colleagues.

9. At 19:00 on the day of Ms A's admission, nursing staff completed a more detailed 'risk assessment and management' proforma. Adviser 1 commented that the first page and a half had been completed appropriately, but the section for recording risk level in the event of the person absconding and other sections had been left blank. He said that a notable omission from the proforma and the

management plan was a record of Ms A's observation level, which should be an integral part of any risk management plan.

10. Nursing staff completed a 'Comprehensive Needs Assessment' proforma two days after Ms A was admitted. Adviser 1 commented that they recorded Ms A's perceptions, but failed to record the perceptions of staff as prompted by the structure of the proforma. They also failed to record any of Ms A's personal strengths that might be relevant to the care-planning process. The nursing staff recorded that Ms A had unmet needs, but no pro-active detailed plan of care to address these needs was evident in the notes. Adviser 1 stated that this again fell below the standards expected by the Nursing and Midwifery Council. Their guidance states that the nurse should, '… provide clear evidence of the arrangements you have made for future and ongoing care'.

11. Adviser 1 also commented that the Medical Assessment contained much more detail and was followed up the next day by a Senior Medical Staff Review.

Diagnosis of Borderline Personality Disorder

12. Mrs C raised concerns that Ms A's diagnosis of Borderline Personality Disorder had 'overshadowed' other potential diagnoses such as that of depressive illness. She said that Ms A was hardly sleeping despite taking sleeping medication, not eating, barely drinking, and self-harming. She said that this should this have alerted staff to the possibility of a depressive illness. She also said that Ms A's GP had been treating her with anti-depressant medication.

13. Adviser 2 said that many doctors saw Ms A and recorded their findings during her time in hospital. He said that on several occasions, they were looking in particular for a syndrome that would suggest a depressive illness on top of her personality disorder. They did not find evidence for it. Adviser 2 also said that doctors had access to the frequent nursing observations. These tend to provide evidence against a depressive illness. He said that overall, this amounted to a reasonable assessment and conclusion that Ms A did not have a depressive illness. He also said that the information recorded during the relevant period made it clear that it was reasonable to continue with the diagnosis of Borderline Personality Disorder.

14. Adviser 1 said that it very important to consider a patient's behaviour over a lengthy period and not to put too much emphasis on current behaviour alone.

He commented that Ms A had been in touch with the Board's mental health services since 2004. In addition, the Board have told us that the possibility of a diagnosis of Borderline Personality Disorder was considered between 2005 and 2007 and confirmed in 2008.

15. Adviser 1 said that in Ms A's case, he believed that conclusions were drawn after a sufficient period of time had passed for the clinical reasoning to be deemed reliable. He did not consider that the diagnosis of Borderline Personality was one that was rushed into. On the contrary it seemed that due consideration had been given prior to this conclusion being arrived at.

16. Adviser 1 also said that symptoms such as disturbed sleep, eating disturbances and self-harm can be features of Borderline Personality Disorder. He commented that anti-depressant drugs had been shown to be effective in helping with the sadness, low mood, anxiety, and emotional reactivity often experienced by people with Borderline Personality Disorder. Adviser 1 said that previous or current treatment with anti-depressants is not necessarily indicative of depression.

Care planning

17. In his response to my complaints reviewer, Adviser 1 said that the care planning fell below the standard he would have expected in the following areas:

- There was no evidence that Ms A's Health Passport was considered in the assessment process.
- Risk assessment proformas were not fully completed.
- There was no identifiable risk management plan that matched risks to interventions.
- Indicators of an elevation in risk were not effectively responded to in terms of care planning.
- Ms A's observation status was not effectively recorded.
- There were no interventions or prescriptions of care documented to address identified health and social care needs.
- There was a lack of planned carer involvement in the assessment and care-planning process.
- The comprehensive needs assessment proforma was ineffectively completed.
- There was no evidence of interventions being effectively evaluated.

18. On 17 September 2010, after an escorted trip home to collect belongings, it was recorded that Ms A had a supply of medication in her car boot, which she would not allow staff to remove. She also refused to give up her car keys or house keys for safe-keeping on her return to the ward. These factors should have alerted staff to the possibility of her planning another self-harming event.

19. Ms A managed to abscond, albeit briefly, on the same day. Despite this potential increase in risk, no action appears to have been taken to minimise it. Adviser 1 said that he would have expected consideration to have been given to an elevation in her observation status; and, her car and house keys to have been taken from her. He commented that whilst to remove her car keys would have constituted an indirect limitation on her freedom and would have over-ridden her wishes, this would have been justifiable if the following conditions were observed:

- The risk would have to be immediate and explicitly stated.
- The measure would have to have been explicit in her care plan as the least restrictive means of managing the assessed risk.
- The situation would also have to have been kept under regular review and the conditions which would allow the measure to be discontinued would have to be clearly stated.

20. This decision could only have been justified if it had followed full discussion between all stakeholders including the patient and her named person either prior to the measure being put in place or (if there was a sense of urgency) as soon as was practicable thereafter. Ms A was a detained patient and staff had a duty-of-care towards her and the ability to override her wishes proportionately in ensuring her safety. Adviser 1 said that to remove her keys would have been reasonable and justifiable under the circumstances. If the staff were in doubt regarding where they stood, they could have sought advice from the Mental Welfare Commission.

21. There is no reference in the notes regarding Ms A's observation status being reviewed following the brief absconding event. The advice my complaints reviewer has received is that even if the decision was that it should remain the same, a note should have been made that her observation status had been considered. Ms A was again asked for her keys, but refused to hand them over. No further action was taken in this regard and there is nothing in the notes stating why her keys were not taken from her.

Ms A's contact with staff

22. Adviser 1 commented that Ms A's willingness to engage with staff tended to fluctuate and this would have affected the duration and frequency of direct therapeutic time staff were able to spend with her. However, he said that he had concerns about the lack of planning of therapeutic input. Every patient has a right to be offered and to choose from a range of available therapeutic activities. This is underpinned by the principle of reciprocity within the Mental Health Act, whereby a person who has been subject to an order under the Mental Health Act must be provided with appropriate services. Ms A had no discernible documented care plan.

23. An effective care plan should have been developed with the involvement of the patient and their named person (someone who looks after the person's interests if he or she has to be treated under the Mental Health (Care and Treatment) (Scotland) Act 2003). Such a care plan would typically include a list of health and social care needs identified from the completion of a comprehensive assessment. Each of these needs would have corresponding interventions and associated details such as the frequency of the intervention, timescales for action and the name(s) and designation(s) of the person(s) responsible for ensuring that they were delivered as prescribed. Review and evaluation arrangements should also be clearly stated.

24. Adviser 1 said that within the context of an effective care plan as described above, one-to-one therapeutic contact between the person and nursing staff would be negotiated and explicitly recorded in terms of time, duration and frequency. No such arrangements were in place for Ms A. One-to-one therapeutic time seems to have been ad-hoc and irregular.

Communication with Ms A's family

25. NHS Education for Scotland have produced a framework for acute mental health care in Scotland, which includes clear statements pertinent to the involvement of relatives and carers. This states that nurses are expected to:

- gather, exchange and act on information to help make early assessment and care planning possible, including any immediate needs, risks, and concerns service users and families may have;
- demonstrate a values base that recognises the key role of relatives and carers in the recovery of service users, values their involvement in the recovery process, and is able to provide appropriate information and support while respecting confidentiality and the choices of the individual;

- form relationships with service users, carers and others, which support people to explore and make sense of their distress and their experiences of acute mental health services.

26. Hospital 1 contacted Mrs C when the Short-Term Detention Certificate was completed at 20:00 on the day of admission. She had been worried about Ms A's potential for suicide and agreed with the Short-Term Detention Certificate.

27. There are notes in Ms A's records of two telephone conversations between a doctor and Mrs C on 16 September 2010. The content of these discussions was relevant to the ongoing assessment and care-planning process. Adviser 1 commented that whilst it appeared that it was Mrs C who telephoned Hospital 1 on both occasions as opposed to staff contacting her, it was clear that the doctor took these conversations into account when formulating his plan for Ms A.

28. There are nine telephone conversations with Mrs C recorded in the third party information section of Ms A's notes. However, only one of these conversations was initiated by hospital staff. Mrs C was Ms A's named person and should have been proactively provided with a range of support and information to ensure that she was able to participate as fully as possible in decisions about Ms A's care as indicated in NHS Education for Scotland's framework . Hospital 1 should have been contacting her and not leaving it to her to initiate contact.

29. My complaints reviewer asked Adviser 1 if Hospital 1 should have contacted Ms A's family for comment as part of the assessment. In his response, Adviser 1 said that it is good practice to involve carers in the assessment process whenever this is practicable. However, Ms A was coherent in interview and her previous records contained a lot of valuable information, which in other circumstances might have had to be obtained from relatives.

30. Adviser 1 did not consider that there were any glaring information gaps in Ms A's case that required urgent attention at the point of admission, therefore, it was not absolutely necessary for staff to telephone her relatives to gather essential details or to fill knowledge gaps. However, it would have been good

practice to telephone relatives to inform them of her admission and to ascertain and allay any anxieties they may have had.

31. Adviser 1 commented that there was nothing in Ms A's records to indicate that the involvement of Ms A's family was either cohesive or planned. Although there clearly was contact between staff and Mrs C, it was almost all instigated by her.

Decision to grant Ms A unescorted leave on 23 September 2010 to attend a scheduled appointment with her psychologist

32. Adviser 1 stated that Ms A's scheduled meeting with her psychologist on 23 September 2010 appears to have been discussed within the care team appropriately on 22 September 2010. The rationale behind the clinical judgement was noted in her records. There is nothing in the record to suggest that nursing staff felt that the decision was unsafe at that point in time. Adviser 2 said that the decision by the consultant to grant Ms A unescorted leave was reasonable. He also said that it was in accordance with current practice on the basis that Ms A was not ill with depression, but had a personality disorder and the risks were acknowledged. However, no one contacted Mrs C to discuss the decision with her.

33. Ms A's friend telephoned Hospital 1 later that day to express her concerns after Ms A had contacted her to say that she had been granted unescorted leave. The friend said that Ms A had told her that she intended to get a taxi to take her to her car and drive somewhere to kill herself. It is recorded in the notes that she also related this plan to a fellow patient.

34. Later that evening, Mrs C telephoned the ward again to say that Ms A had telephoned a friend to say that she was not going to see her psychologist and intended to kill herself. Mrs C asked that the consultant telephone her the following day prior to Ms A being allowed to leave the ward. Mrs C telephoned again at 07:50 on the following day, the day on which Ms A's unescorted leave was to take place, to say that Ms A had sent a text message to the friend stating that she intended to kill herself that day. Ms A's brother then telephoned at 08:50 to again stress the family's concerns.

35. At 09:30 on 23 September 2010, two nurses spoke to Ms A and she told them of her intent to take an overdose rather than to go to see her psychologist. Nursing staff contacted the consultant about this, but he did not change the

decision to allow Ms A to go out. Staff contacted Mrs C to inform her of this decision. At 10:00, a staff nurse expressed concerns to a charge nurse. Despite this, Ms A was allowed to leave the ward at 10:05 on an unescorted pass scheduled to last three hours.

36. Ms A did not attend the scheduled appointment. Mrs C telephoned the ward at 13:35. She said that she had spoken to Ms A and believed that she had taken an overdose. Mrs C told us that she also alerted the police to her concerns about Ms A's safety. It was only then that staff tried to contact the psychologist to check if Ms A had attended her appointment. Ms A was later admitted to the toxicology ward at the Royal Infirmary of Edinburgh (Hospital 2), as she had taken an overdose. She was re-admitted to Hospital 1 on the following day.

37. Adviser 1 said that his first observation was that Ms A contacted someone to tell them of her intention to harm herself rather than to go to see her psychologist. He said that this may have been interpreted as a lack of intent to cause herself serious harm. Staff may have asked themselves why she would tell someone who might be able to prevent her from harming herself if she intended to do so. However, Adviser 1 stated that there were signs that Ms A intended to do something harmful to herself.

38. Adviser 1 listed a number of concerns that he had:

- It was known that Ms A had a supply of drugs in her car at home, yet she was allowed to go out with her car keys in her possession. Adviser 1 said that they should have been taken from her. He stated that by not doing so, staff failed to take reasonable precautions to minimise risk.
- Ms A was not given a specific time to return, despite the fact that she made it common knowledge that she was not going out for the reasons the pass was granted. Although Ms A knew that her pass was for three hours, an explicit and specific return time would have given staff an alert time to work to. Adviser 1 said that again staff failed to take a reasonable precaution to minimise risk.
- Mrs C had asked that the consultant contact her prior to Ms A being allowed to leave the ward. As Ms A's named person, Mrs C wished to discuss the matter. No such telephone call was made. Adviser 1 commented that perhaps the consultant felt that he had a clear understanding of Mrs C's views from the information passed on by the nursing staff. Adviser 1 considered, however, that this was discourteous

and denied Mrs C the opportunity to discuss matters such as risks and contingency plans with the person she presumably viewed as being the principal decision-maker. Although nursing staff telephoned her at 09:00 on the day Ms A was allowed out, this was to inform her that the decision was unchanged. It was not to involve her in the decision-making process. Adviser 1 stated that in his view, Mrs C's status as a named person and a carer was not afforded sufficient respect.

- Despite the family's concerns and the staff nurse's reservations about Ms A's safety, there is nothing in the notes about why the nurse in charge still allowed her to go out unescorted. Nurses are accountable for their personal acts and omissions regardless of advice or instructions given by other professionals. If it was considered that taking the risk was justifiable, the rationale for letting Ms A leave in the face of concerns from staff and family should have been recorded.
- Staff failed to contact the psychologist to check if Ms A had attended the appointment until Mrs C telephoned Hospital 1 to say that she had spoken to Ms A and thought she had taken an overdose.
- Staff should have put a contingency plan in place to take specific actions in the event of Ms A failing to return. Adviser 1 said that although it might have been felt that the consequences of any potential risk were unlikely to be significant, the probability of something untoward occurring was high.

Delay in revoking the Short-Term Detention Certificate

39. In her letter to my office dated 20 December 2010, Mrs C asked why Ms A had been left on the Short-Term Detention Certificate after it had been agreed that this was not warranted.

40. On 22 September 2010, a doctor recorded that Ms A had no impairment of decision-making (a necessary criterion for detention) as a consequence of mental disorder. To test this conclusion the consultant told Ms A that she could leave the ward the following day on unescorted leave to see her psychologist. In his response to my complaints reviewer, Adviser 1 commented that Ms A's failure to negotiate the period of leave successfully presumably informed the consultant that her decision-making remained impaired because she remained a detained patient thereafter. Adviser 1 said that he did not believe this decision to continue to detain Ms A to have been inappropriate under the circumstances.

41. On 24 September 2010, the consultant explained to Ms A that he would review the detention the following week. He said that Ms A and a Mental Health

Officer would be involved in this. Adviser 1 said that this also seemed to have been an appropriate course of action.

42. The Mental Health Officer met Ms A on 27 September 2010. She recorded that Ms A did not seem to have impaired decision-making and that detention in hospital was not particularly helpful for her. The Short-Term Detention Certificate was revoked two days later following further review of Ms A's mental health state.

43. Adviser 1 commented that given Ms A's history of fluctuating emotions and impulsivity, a demonstrable period of stability would have been necessary prior to her becoming an informal patient. He said that in light of this, he did not believe that there was any unnecessary delay in revoking the detention.

(a) Conclusion

44. I do not consider that Hospital 1 carried out a satisfactory assessment when Ms A was admitted on 13 September 2010. There was no evidence of a clear documented care plan. They also failed to provide Mrs C, as Ms A's named person, with a range of support and information to ensure that she was able to participate as fully as possible in decisions about Ms A's care. Hospital 1 should have been contacting Mrs C and not leaving it to her to initiate contact with them. In addition, no one contacted Mrs C to discuss Ms A's unescorted leave on 23 September 2010.

45. While I have received advice that the decision to grant unescorted leave on 23 September 2010 was reasonable, given that the consultant who made the decision did not contact Mrs C, as Ms A's named person, to discuss her concerns, I am unable to conclude that the consultant's actions overall in allowing Ms A unescorted leave were reasonable. I am critical of the failure to discuss the decision with Mrs C and the failure to review the decision in light of all the concerns expressed by the family and nursing staff.

46. Hospital 1 failed to take reasonable action to minimise Ms A's risk of self-harm and there is no evidence that they reviewed her observation status after she tried to abscond. Staff also failed to take reasonable precautions to minimise risk when Ms A went on unescorted leave to attend an appointment with her psychologist on 23 September 2010. These were extremely serious failings. The consequences of this for Ms A could have been much more serious.

47. I have received and accept advice that the diagnosis of Borderline Personality Disorder was reasonable as was the time taken to revoke the Short-term Detention Certificate. However, in view of the serious criticisms I have made above, I have concluded that Hospital 1 did not provide appropriate care and treatment to Ms A during the period she was an in-patient. I, therefore, uphold this complaint.

(a) Recommendations

48. I recommend that the Board:	*Completion date*
(i) undertake an external peer review in Hospital 1, to include: the assessment of patients on admission; care-planning practice; the completion of risk management plans and proformas; and communication with the named person and relatives and their involvement and participation in decision-making. Practices in these areas should be audited against relevant professional body expectations; national standards, policies and codes of practice; and existing local policy intentions;	17 February 2012
(ii) provide me with details of the findings and the action plan created as a result of the above recommendation; and	16 March 2012
(iii) ensure that the findings in this report are communicated to the staff involved in Ms A's care and treatment.	16 December 2011

(b) The Board have failed to provide satisfactory answers to Mrs C's questions about the matter

49. Mrs C submitted her complaint to the Board on 26 September 2010. In the complaint letter, she asked the Board a number of questions. The Board issued a response to her on 24 November 2010.

(b) Conclusion

50. I have carefully considered Mrs C's letter and the Board's response. Mrs C asked the Board a number of questions in her letter about the care provided to Ms A. In particular, she asked questions about the decision to grant Ms A unescorted leave on 23 September 2010.

51. I consider that the Board did try to answer the questions that Mrs C asked in her letter of 26 September 2010. Mrs C also asked some additional questions in the letter that she sent to Ms A's MP. These additional questions were not in the letter she sent to the Board and this may have caused some confusion. However, the Board's investigation into the complaints failed to identify many of the problems that our investigation has uncovered. It was, therefore, understandable that Mrs C considered that the Board's answers to her questions were unsatisfactory. In view of this, I uphold the complaint.

(b) Recommendation

52. I recommend that the Board:	*Completion date*
(i) apologise to Mrs C and Ms A for the failures identified in this report.	30 November 2011

53. 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.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Ms A	The aggrieved – Mrs C's sister
Hospital 1	The Royal Edinburgh Hospital
The Board	Lothian NHS Board
Adviser 1	The Ombudsman's Mental Health Adviser
Adviser 2	The Ombudsman's Psychiatric Adviser
Hospital 2	The Royal Infirmary of Edinburgh

Annex 2

List of legislation and policies considered

The Nursing and Midwifery Council: Record keeping: Guidance for nurses and midwives (2009)

NHS Education for Scotland: A Capability Framework for Working in Acute Mental Health Care (2008)