Scottish Parliament Region: South of Scotland

Case 201005047: Ayrshire and Arran NHS Board

Summary of Investigation

Category

Health: Hospital; medical

Overview

The complainant (Mrs C) raised a number of concerns about the treatment her adult son (Mr A) received at hospital (Hospital 1) following an attempted suicide at her home on 17 August 2010. Her complaints included that Mr A was inadequately supervised in a general ward and that he had the opportunity to make a further suicide attempt. Mrs C also complained that despite her request that Mr A should remain in Hospital 1 he was transferred to another hospital (Hospital 2) which was in another health board area where Mr A normally lived.

Specific complaints and conclusions

The complaints which have been investigated are that the Board:

(a) failed to provide an acceptable standard of care to Mr A, an individual whose psychiatric problems had been highlighted to staff, who was suffering from extreme paranoia and who had recently attempted suicide (*upheld*);

(b) failed to operate an effective or flexible transfer procedure and failed to ensure that the Bed Manager acted reasonably in response to Mrs C's requests that Mr A remain in Hospital 1 (*upheld*);

(c) allowed some staff to act in a hostile way towards Mrs C after she had contacted the Mental Welfare Commission for advice (*upheld*);

(d) failed to ensure satisfactory conditions in a psychiatric ward (*not upheld*); and

(e) failed to ensure that Mr A's wounds were managed appropriately (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) share this report with the Task and Finish Group to ensure that the Adviser's concerns about mental health assessment staff training and inadequate	20 January 2012

	record-keeping are taken into account in their review of clinical processes etc;	
(ii)	review hand-over procedures to ensure an adequate level of observation is maintained during that time;	27 January 2012
(iii)	remind staff of their responsibilities under the Mental Health (Care and Treatment) (Scotland) Act 2003 in relation to transfer of patients to another hospital;	20 January 2012
(iv)	conduct an audit/review systems for safe management of non-clinical sharps;	27 January 2012
(v)	conduct an audit of wound care practice in the Mental Health Ward; and	27 January 2012
(vi)	apologise to Mrs C and Mr A for the failings which have been identified in this report.	13 January 2012

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

Main Investigation Report

Introduction

1. The complainant (Mrs C) raised a number of concerns about the treatment her adult son (Mr A) received at hospital (Hospital 1) following an attempted suicide at her home on 17 August 2010. Her complaints included that Mr A was inadequately supervised in a general ward and that he had the opportunity to make a further suicide attempt. Mrs C also complained that despite her request that Mr A should remain in Hospital 1 he was transferred to another hospital (Hospital 2) which was in another health board area where Mr A normally lived. Mrs C complained to Ayrshire and Arran NHS Board (the Board) but remained dissatisfied with their responses and contacted my office.

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

(a) failed to provide an acceptable standard of care to Mr A, an individual whose psychiatric problems had been highlighted to staff, who was suffering from extreme paranoia and who had recently attempted suicide;

(b) failed to operate an effective or flexible transfer procedure and failed to ensure that the Bed Manager acted reasonably in response to Mrs C's requests that Mr A remain in Hospital 1;

(c) allowed some staff to act in a hostile way towards Mrs C after she had contacted the Mental Welfare Commission for advice;

(d) failed to ensure satisfactory conditions in a psychiatric ward; and

(e) failed to ensure that Mr A's wounds were managed appropriately.

Investigation

3. In order to investigate this complaint my complaints reviewer reviewed all of the correspondence between Mrs C and the Board as well as documentation and statements relating to the Board's investigation of the complaint. My complaints reviewer also reviewed Mr A's clinical records and sought advice from one of my professional medical advisers in mental health (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given the opportunity to comment on a draft of this report. An explanation of the abbreviations used in this report is contained in Annex 1.

Clinical background

5. Mr A was a 45-year-old man, with no apparent previous history of self-harm, who presented at the Accident and Emergency Department of Hospital 1 on 17 August 2010 following a deliberate medication overdose and ingestion of cologne. This event occurred whilst visiting Mrs C's home. That evening Mr A was admitted to a medical ward (the Medical Ward) within Hospital 1 and the following morning, whilst on the ward, self-inflicted numerous deep lacerations which covered the full length of both inside arms with his razor. At this point (08:30) he was transferred to the Medical High Dependency Unit where his wounds were treated. He was subsequently detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCTSA) via a Short-Term Detention Certificate at 14:00 and transferred later in the day to a psychiatric ward (the Psychiatric Ward) where he was initially nursed under constant observation arrangements. At the time of transfer Mr A was felt to be acutely psychotic. In the evening the staff noted that Mr A had also made superficial lacerations to his penis. Due to the fact that (in Hospital 1) Mr A was deemed to be an out-of-area patient, transfer to his host health board area took place on 24 August 2010.

6. In her complaint to the Board, Mrs C said Mr A had had mental health problems for many years and when he was taken to Hospital 1 he was told he would be reviewed by a psychiatrist the following day. In addition he was told that he would be transferred to Hospital 2 as the beds would be required for local residents. Mrs C contacted the Mental Welfare Commission for Scotland (MWC) for advice and although she was happy with the level of psychiatric care she felt staff then became hostile and would not speak to her. Her concerns included that there was a lack of risk assessment and observations in that Mr A was allowed to go unnoticed in a toilet for 45 minutes with a razor taken from his toilet bag. She also felt more note should have been taken of her request to delay the transfer to Hospital 2 so that she could provide more support. Mrs C also mentioned that while in the Psychiatric Ward Mr A had access to scissors in the treatment room; razors were being left in toilets and washbasins; patients played loud music and were able to smoke; and there was a general level of uncleanliness. Mrs C thought there was also poor wound care in that Mr A had to ask staff to inspect the wounds and dress them as the bandages were hanging off and that psychiatric staff had to ask medical staff to dress the wounds.

7. The Board responded to the complaint that Mr A was admitted to the Medical Ward with an overdose and the procedure was that patients undergo a psychiatric assessment when they were medically fit which was usually the following day. Staff in Accident and Emergency and the Medical Ward did not feel that Mr A was at risk of further self-harm and that he was settled overnight. The following morning, during handover, Mr A used a razor (potentially belonging to another patient) to severely lacerate his wrists. Mr A was urgently reviewed by a psychiatrist who detained him under the MHCTSA. Staff in the Psychiatric Ward allowed Mr A a few days extra on the ward before transfer to Hospital 2 but should have explored with him the possibility of extending this for a further limited period and an apology was made. The Bed Manager had apologised if it was felt that she was being officious about the transfer but she had tried to explain that it would be better if Mr A returned to Hospital 2 where the staff knew him. She also sought an opinion from a member of the medical team who agreed that return to Mr A's local area was the preferred option but failed to explore the possibility of a further one or two day stay in Hospital 1. An apology was made for the attitude of some staff members and as a result a number of improvement measures were being taken forward to develop relations with staff and patients and their families.

8. The Board subsequently reported to Mrs C that they had partly upheld the complaint about there being a lack of proactive risk assessment and risk management. Mr A was assessed by an Accident and Emergency doctor who screened the risk of self-harm and believed there was no requirement for increased supervision. On arrival in the Medical Ward Mr A was seen by another doctor who also spoke to Mrs C. The doctor reported that she felt Mr A should have been referred directly to psychiatry rather than medicine. Mr A was under general supervision and there was no record of a proactive discussion with Mr A regarding his thoughts and feelings although this would have strengthened the risk assessment process. Mr A had not told staff he planned to remain with Mrs C on discharge, however, the potential to delay transfer to Hospital 2 should have been explored to take into account the views of the family. Regarding the dressings to Mr A's wounds, there was record he refused to let the staff dress the wounds and wished to do so himself. Staff took advice from the tissue viability specialist nurse. In regard to improvements, the Board explained that staff in the Mental Health Liaison Service would provide training to staff in physical health wards regarding ongoing risk assessment and management for patients who present with mental health issues. A Task and Finish Group would review the clinical processes to provide safe, effective and

person centred care for people who present with mental health problems within the general health setting. This would include nursing risk assessment of self-harm and triggers for specialist assessment with mandatory training for nursing staff within medical wards. There would also be a review of care planning/discharge planning arrangements to ensure that patient/carer wishes inform decision making. The experiences and learning from Mrs C's complaint would feed into a Significant Adverse Event Review that related to a similar type of complaint which aimed to improve the culture within psychiatric wards and improvements on relationships between staff, patients and their families. An apology was given that staff failed to take into account Mrs C's views of Mr A's mental health status prior to admission; failed to proactively explore Mr A's thoughts and feelings as part of the risk management assessment in the medical ward; failed to take complete consideration of the expressed views of the patient and their family as part of the discharge planning process; and that staff in general hospitals had not been trained to recognise mental health problems which require urgent intervention.

9. In reply to an enquiry from my office the Board said that patients would not be allowed in the treatment room unattended although there was no recollection that this occurred. The Board advised staff were aware of the risks this could represent and also that scissors were kept in locked drawers. If staff were aware that patients were playing music too loud then they would be asked to either turn it down or off to prevent disturbing others and again there was no report of this during Mr A's stay. Similarly if patients were found to have flouted the restricted smoking policy then they are asked to attend the designated smoking room. They indicated nothing untoward was recorded at the time Mr A was a patient. The Board did accept that there were aspects of the decor and fabric of the psychiatric ward which required upgrading and this would be attended to on an incremental basis. The Board also explained that there was some slippage with the Task and Finish Group's target completion date for the improvement action plan.

(a) The Board failed to provide an acceptable standard of care to Mr A, an individual whose psychiatric problems had been highlighted to staff, who was suffering from extreme paranoia and who had recently attempted suicide

Clinical advice

10. The Adviser said that Mr A had voiced persecutory ideas and suicidal ideation in the days leading up to his self-poisoning event and it was reported

that his sleep was disturbed; that he had been anxious and under stress as a consequence of a preoccupation with self-held beliefs that people were conspiring against him. The Adviser noted that Mrs C described Mr A's mental health deteriorating over the preceding two years, particularly so in the previous six to nine months.

11. The Adviser said that Mr A denied suicidal ideation when he presented at Accident and Emergency following an overdose. Based on this it appeared to have been assumed that his risk of further self-harm was low. This is evidenced by the records which showed nothing in the plan of care at that time which addressed potential suicidality as a healthcare need. However, any assumption of low risk was contradicted by the fact that Mr A had overdosed a few hours previously and in interview expressed no regrets at doing so. It was also clear that the overdose event was precipitated by Mr A's persecutory belief that persons unknown were trying to kill him. At the point of being seen and transferred to a ward he remained acutely paranoid - the trigger for the self-harm was still, therefore, present - a crucial factor which does not seem to have been taken into account in the assessment of risk. The Adviser continued that Mrs C had accompanied Mr A to Hospital 1 and would have been able to give an account of his deteriorating mental health over a nine month period, of the events leading up to the overdose and of her ongoing concerns regarding Mr A's mental state. This would have informed the formulation of risk but the Accident and Emergency notes were silent in relation to Mrs C's views. The Adviser explained that most Accident and Emergency Departments have direct access to mental health liaison staff. These are posts which have been created specifically to deal with people presenting at Accident and Emergency who have probable ongoing mental health problems. The liaison staff are there to provide specialist input to the assessment process. In this case they did not appear to have been consulted.

12. The Adviser continued that on admission to the Medical Ward Mr A was seen by a doctor who appeared to have concluded that Mr A was inappropriately placed on a medical ward and should have gone straight to psychiatry. However, in her plan the doctor makes no reference to further potential for self-harm and merely stated that Mr A's paracetamol levels be checked; that he be reviewed by liaison psychiatry; and that he should be observed for six hours from 18:00 (presumably in relation to potential after-effects from the overdose). The Adviser said that as a mental health opinion had not been sought in Accident and Emergency, assessment by mental health

liaison staff or alternatively by mental health Advanced Nurse Practitioners (ANPs) should have happened at the point of admission to the ward or as soon as was practicable thereafter. In this case it appeared to have been decided that it was acceptable to leave this until the next morning. The Adviser did not consider this to have been a reasonable decision.

13. The Adviser noted the Patient Profile document contained no references to Mr A's mental health history, his current emotional problems or his overdose that day. The narrative nursing notes at the point of admission to the Medical Ward were extremely brief and unfit for purpose. A nurse had deemed Mr A to be 'settled'. Nothing was recorded regarding any potential for further self-harm and there was no evidence that his thoughts or feelings were discussed with him. The Adviser felt that presumably Mr A was deemed to be 'settled' because he was uncomplaining and cooperative but that should not have been taken as an indication that he was no longer harbouring thoughts of further self-harm. The Adviser felt that at no time during the Accident and Emergency or the Medical Ward clerk-in procedures was there evidence of the use of a systematic approach to the assessment of risk.

14. The Adviser saw that the medical doctor clearly felt that referral to a medical ward was inappropriate in Mr A's case, however, it was probably not wholly unreasonable given that he had recently ingested an excessive quantity of prescription drugs and swallowed an unknown quantity of cologne. A period of medical observation was indicated in this regard and, although probably not essential, it could be reasonably argued that this could be more effectively undertaken in a medical ward than in a specialist mental health facility. However, a more in-depth mental health assessment should have been carried out and a mental health opinion should have been sought which would have more effectively informed the formulation and management of risk and the decision regarding the most appropriate clinical setting.

15. The Adviser had no concerns regarding the clinical observation practice in the Psychiatric Ward. The decision making process was transparent; multi-disciplinary; informed by effective risk assessment; and in line with national guidelines. The national guidelines specifically relate to engagement with, and observation of, people living with acute mental health problems. They clearly state that raised levels of formal clinical observation should be introduced where risk assessment has identified increased concerns regarding a patient's mental state. The Adviser continued that people presenting at general hospitals

following self-harm events is reasonably commonplace. While he would not expect general hospital staff to be fully up to date with all national guidelines in respect of mental health care he would have expected them to have knowledge of the existence of both national and local guidelines relating to clinical observation for this client group and for this to prompt the seeking of specialist input. Had a mental health opinion been sought timeously it was likely that the assessment of risk would have been more robust and an appropriate level of observation and other safety measures would have been prescribed. The Adviser said that mental health staff would also have highlighted the importance of Mr A not being given access to potentially dangerous objects such as razors and scissors and other means of self-harm. Staff seemed to have taken no action in relation to preventing Mr A having access to potentially dangerous items.

16. The Adviser said that in the Medical Ward, not only did Mr A not receive an appropriate raised level of observation, staff failed to provide a reasonable level of general observation. This was evidenced by the fact that staff were unaware of his whereabouts for approximately 45 minutes. The Adviser would expect ward staff to be at least aware of the general whereabouts of all patients at all times. Forty five minutes was too long for someone to be out of sight or sound in any ward. It was acknowledged that shift hand-overs are particularly vulnerable times in relation to the observation of patients as there is a potential for increased risk caused by the number of staff who can be involved in the hand-over procedure and also because of ineffective communication. It is the responsibility of the oncoming nurse-in-charge to ensure that all patients being transferred into his/her care are accounted for and safe and that their levels of observation are clearly understood and documented. The responsibility for observation during the handover period should lie with the outgoing shift and they should only be released from that duty when relieved by a colleague from the oncoming shift. In this case observation during the hand-over period seemed to have been ineffective.

17. The Adviser explained the advice of specialist mental health liaison staff or mental health ANPs should have been sought either in Accident and Emergency or at the point of admission to the Medical Ward. As a minimum, admitting personnel should routinely enquire about any history of previous self-harm / suicide events and depressive / suicidal states and should include a statement regarding their presence or absence in their report. Prior, recent or current suicidal behaviour should be described in sufficient detail including date,

method, and context. The potential for further self-harm should be evaluated and recorded. Precautionary measures and staff duties responsibilities designed to minimise the risk of a recurrence should be explicit. Obtaining and recording these details is as important in general hospital settings as it is in a mental health setting.

18. The Adviser said aspects of the care plan compiled in the Psychiatric Ward lacked detail. The needs and goals of care are clear, as is the achievement date and person(s) responsible. However, the planned care and support contains only general statements such as 'crisis and contingency planning daily' / 'education and health promotion' and 'employing protective environmental precautions' – these phrases do not provide details of the actions expected. The lack of detail is particularly obvious for the care goal which states: - 'Nursing staff will work in partnership with [Mr A] in reducing the risk of him taking his own life' – the associated planned care and support merely states 'Prescribed observation daily'. For the purposes of providing an example, the Adviser would have expected detail around aspects of care such as: how the level of risk would be monitored; how Mr A's thoughts, feelings and expectations would be discussed and explored; how Mr A's personal strengths and resources might be capitalised upon; and how harmful drinking might be influencing Mr A's moods and impulse control.

19. The Adviser continued that nursing records should contain clear evidence of the arrangements made for ongoing care. Nurses should use their records to facilitate full and effective communication with colleagues by ensuring that they have all of the necessary information to enable them to effectively and safely care for each and every patient. Nursing interventions may be psychosocial or physiological; they may be for treatment / prevention of illness or for health promotion. However, regardless of their aim, when recorded they should clearly describe the nature of the actions and therapeutic approaches to be performed by nurses within a particular clinical setting for a specific individual. They should include details such as how the patient will be enabled to participate; the frequency of the actions; and how/when intervention will be evaluated. The documented interventions in Mr A's case lacked this level of detail.

(a) Conclusion

20. Mrs C had concerns that Mr A did not receive an acceptable level of care on admission to Hospital 1. The advice which I have received, and accept, is that following admission to the Psychiatric Ward there is evidence that Mr A

received appropriate care and treatment in relation to the assessment and management of risk. However, this was not matched by the treatment which was provided in Accident and Emergency and in the Medical Ward. Mr A had been admitted following an overdose a few hours previously and was acutely paranoid and there was a delay in staff seeking a psychiatric opinion on his mental health state. Staff did not seek specialist mental health advice in either Accident and Emergency or the Medical Ward. There was no record that staff had attempted to elicit important medical history information from Mrs C. I am also concerned that medical staff also believed that admission to a medical ward was inappropriate but still no urgency was shown to obtain a psychiatric assessment for Mr A. Had the assessment been undertaken earlier it would have formulated a management plan to address the risks associated with Mr A and would have ensured that he be cared for in the most appropriate setting. While there could not be a guarantee that Mr A would not have made a further attempt at self-harm, at least he would have been subject to an increased and more appropriate level of observation by suitably experienced staff. I uphold this complaint.

(a) Recommendations

21. I recommend that the Board:	*Completion date*
(i) share this report with the Task and Finish Group to ensure that the Adviser's concerns about mental health assessment staff training and inadequate record-keeping are taken into account in their review of clinical processes; and	20 January 2012
(ii) review hand-over procedures to ensure an adequate level of observation is maintained during that time.	27 January 2012

(b) The Board failed to operate an effective or flexible transfer procedure and failed to ensure that the Bed Manager acted reasonably in response to Mrs C's requests that Mr A remain in Hospital 1

22. The Adviser felt that from the time of Mr A's arrival in the Psychiatric Ward the clinical team's mindset seems to have been that he be transferred to his host hospital (Hospital 2) at the earliest possible opportunity. All mental health hospitals operate with the minimum number of beds required for their respective catchment areas. Transferring out-of-area patients to their host hospital is commonplace and it is usually done as soon as is practicable and following full consultation with all stakeholders. This makes perfect sense in relation to

ensuring availability of beds for people who do live in the transferring hospital's catchment area. Mr A appeared to have stated that he had no intention of staying locally even on a temporary basis; therefore, it made sense that he be transferred to the services in his home area which would be responsible for planning his follow-up care. This would also have helped ensure that he did not become disengaged from services post-discharge which could have been a risk if things had been co-ordinated locally.

23. The Adviser continued that as Mr A's Named Person under the terms of the MHCTSA Mrs C had a right to express these views and for her views to be respected and taken into consideration. However, she did not have an automatic right for her wishes to be conformed to. She should, as a matter of courtesy, have been given advance notice as far as was practicable of the precise date and time that the transfer was scheduled to take place. [Note: Chapter 6 (125) of the MHCTSA states that where a decision has been taken that a patient is to be transferred to another hospital (other than the State Hospital) then the patient or the patient's named person may appeal to a Tribunal]. The Adviser believed that the Board were within their rights to transfer Mr A, there is evidence in the notes to suggest that they took his views and that of Mrs C at least partly into consideration before doing so. However, perhaps staff showed some evidence of inflexibility and insensitivity by raising the issue of transfer almost immediately on his arrival on the ward. As things turned out the transfer was postponed for a few days but when it did happen communication with Mrs C was ineffective. Mrs C may have been more amenable to the transfer if it had been postponed a few days more by which time Mr A presumably would have shown further evidence of sustained stability in his mental health state thereby reducing her level of concern.

(b) Conclusion

24. Mrs C complained that the transfer to Hospital 2 was carried out with undue haste and that insufficient weight was apportioned to her request that Mr A remain at Hospital 1 so that she could provide additional support. From a clinical viewpoint the transfer from Hospital 1 to Hospital 2 in Mr A's home area was appropriate as he would be known to the community mental health staff there. Such arrangements are normal practice nationally, however, the Board have accepted that perhaps more notice should have been taken of Mrs C's views that Mr A should remain in Hospital 1 for a few more days. There is evidence that staff had formed the opinion that Mr A was not going to be at Hospital 1 for any length of time and that transfer to Hospital 2 would occur

shortly. I am concerned that there is no evidence that staff advised Mrs C about her right to appeal to a Tribunal under MHCTSA and while there was no guarantee about the outcome at least proper procedures would have been followed. While it is recorded that Mrs C had concerns, I have not seen evidence that the staff gave this due consideration and as such I uphold this complaint.

(b) Recommendation

25.	I recommend that the Board:	*Completion date*
(i)	remind staff of their responsibilities under the Mental Health (Care and Treatment) (Scotland) Act 2003 in relation to transfer of patients to another hospital.	20 January 2012

(c) The Board allowed some staff to act in a hostile way towards Mrs C after she had contacted the Mental Welfare Commission for advice

26. Mrs C said that when staff knew the MWC had been contacted their attitude changed as they would have to explain their actions and that a nurse refused to speak to Mrs C as he was now off duty. Staff became abrupt and hostile and this caused Mr A great upset. The Board apologised for the attitude of the staff and explained that the service was already aware of a number of issues relating to staff attitude and that action was being taken to develop staff relations with patients and their families.

(c) Conclusion

27. Mrs C maintains that relations with staff deteriorated when it was mentioned the MWC had been contacted. The Board have accepted that staff attitude was a recognised problem and that action is being taken to improve relations between the staff and patients and families. Normally issues about attitude are difficult to substantiate, however, in this instance it appears that the Board has already identified a problem and were seeking to resolve matters. I uphold this complaint.

(d) The Board failed to ensure satisfactory conditions in a psychiatric ward

28. The Adviser said that while unsupervised access to items such as scissors is unacceptable in respect of patients at risk of self-harm there is no evidence in the records to support the view that Mr A had access to scissors in any of the clinical settings he received care and treatment in. Clearly Mr A had access to

razors in the Medical Ward and this was unacceptable in the case of someone who had very recently self-harmed. It arises from ineffective assessment of his mental state and risks and a failure to seek specialist advice and support. In relation to systems; the Activities of Living Assessment Form begins with a section headed 'Maintaining a Safe Environment'. However, it provides no prompts to assist in identifying risk of self-harm which seems like a glaring omission in a service which probably sees its fair share of people who have recently self-harmed. Mr A was subsequently assessed as having no needs in relation to the maintenance of a safe environment, which was clearly inaccurate. Effective assessment would probably have resulted in potentially harmful objects being removed from his possession. The Psychiatric Ward's care-plan clearly indicates the need to 'continuously assess the ward environment ensuring that implements that could cause potential risk are eradicated'.

(d) Conclusion

29. Mrs C complained about unsatisfactory conditions in the Psychiatric Ward in that Mr A had access to scissors. There were also other issues such as other patients playing loud music and smoking. The Board have stated that there were no reports of that kind when Mr A was a patient but have explained that staff would take steps to resolve such matters once they had been brought to their attention. The Adviser has already pointed out that the inadequate assessment in the Medical Ward meant that Mr A was wrongly assessed as having no needs in regards to the maintenance of a safe environment. However, in regards to the Psychiatric Ward I have not seen any evidence to support that concerns were raised with staff during the time Mr A was a patient. I do not uphold this complaint.

(d) Recommendation

30. I recommend that the Board:	*Completion date*
(i) conduct an audit/review systems for safe management of non-clinical sharps.	27 January 2012

(e) The Board failed to ensure that Mr A's wounds were managed appropriately

31. The Adviser noted the Wound Management care plan developed at the time of Mr A's transfer to the Psychiatric Ward indicated the need for daily observation and cleansing of his wounds and the need to document any evident changes. It did not specify how the wounds should be cleaned and dressed.

The records showed on 18 August 2010 that Mr A would not allow staff to cleanse his penile laceration – preferring to do so himself. He was given the necessary wound-care products and utensils to do this. However, it was unlikely that his technique would have been appropriately aseptic (free from infection). Due to the potential complexities of the wound-site it was arranged for Mr A to be seen by a surgical registrar as a precautionary measure. On 19 August 2010 it was recorded that necessary wound-care was carried out on both of Mr A's arms. On 20 August 2010 it was recorded that the tissue viability specialist nurse was contacted for advice regarding Mr A's wound-care. The advice was that staff should continue care as previously planned. On 21 August 2010 (early pm) it was recorded that Mr A reported to staff that his dressing had come off and that his wounds were slightly painful. Staff noted possible infection and medical intervention was sought. The medical advice was to continue monitoring the wounds every second day and monitor Mr A's temperature. The wounds were then cleaned and redressed using 'Jelonet' (a paraffin impregnated gauze) and dry dressings and bandages. On 23 August 2010 it was recorded that Mr A's wounds were inspected and cleansed by a doctor who advised the use of dry dressings to prevent Mr A from interfering with the wounds – although the Adviser saw that nothing was recorded to indicate that he had been doing so prior to that point in time.

32. The Adviser continued that the tissue viability nurse specialist was contacted and his/her advice was to continue with current care ie dry dressings and bandages. On 23 August 2010 the doctor noted that some of Mr A's wounds seemed to be overgranulating. On 23 August 2010 it is recorded that Mr A's wounds were swabbed for laboratory investigation into potential infection and Mr A was pro-actively commenced on the antibiotic co-amoxislav. On 26 August 2010 the microbiology lab report of the arm swab showed that Mr A's wounds were infected with a heavy growth of Staphylococcus Aureus which was sensitive to his prescribed anti-biotic. The Adviser said the Board's response letter stated that on more than one occasion Mr A refused to let staff dress his wounds. As far as the Adviser could ascertain from the records this happened twice. The first time being immediately following the self-harming event itself whilst Mr A was still psychotic and distressed - which the Adviser thought was understandable. The second time being when Mr A reported that he had also cut his penis. On this occasion he preferred to dress the wound himself, therefore, the refusal was probably founded in a sense of personal embarrassment rather than it being an indication of a lack of co-operation which the response seems to infer. There was nothing in the electronic nursing notes

to indicate that Mr A objected to his wounds being cleansed and dressed during his stay on the Psychiatric Ward although it is recorded on 23 August 2010 that dry dressings and bandages should be applied to 'prevent him from interfering with his wounds'. The Psychiatric Ward staff sought advice from the tissue viability nurse specialist on two occasions but the Adviser could find nothing in the notes written by him/her which confirmed that he/she visited the ward and personally inspected the wounds. Neither could the Adviser find a wound-care plan prescribed and signed by the tissue viability nurse which, again, he would have expected to see. However, the Adviser noted that staff may have been acting in line with a local wound care protocol designed to effectively deploy a scarce resource.

(e) Conclusion

33. Mrs C has raised issues that Mr A's wounds were not managed appropriately. The Board have said that Mr A was reluctant to allow staff to change his dressings but that advice was sought from the tissue viability nurse. The advice which I have received is that there is evidence that staff dealt with Mr A's wounds and although contact was made with the tissue viability nurse the wound care interventions were not clear in the care plan. I am not convinced that it was fair to say that Mr A was deliberately obstructive to allow staff to care for his wounds but rather his concerns were due to distress and embarrassment. It is on the basis of the inadequate documentation in the wound care plan and the Board's contention that Mr A was reluctant to allow staff to manage his wounds that I uphold this complaint.

(e) Recommendations

34. I recommend that the Board:	*Completion date*
(i) conduct an audit of wound care practice in the Mental Health Ward; and	27 January 2012
(ii) apologise to Mrs C and Mr A for the failings which have been identified in this report.	13 January 2012

35. 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
Mr A	Mrs C's adult son
Hospital 1	Hospital situated within Mrs C's home area
Hospital 2	Hospital situated within Mr A's home area
The Board	Ayrshire and Arran NHS Board
The Adviser	The Ombudsman's professional mental health adviser
The Medical Ward	The medical ward Mr A was transferred to from Accident and Emergency Department
MHCTSA	Mental Health (Care and Treatment) (Scotland) Act 2003
The Psychiatric Ward	The psychiatric ward Mr A was transferred to from the Medical ward
ANP	Advanced Nurse Practitioners
The MWC	The Mental Welfare Commission for Scotland