Scottish Parliament Region: North East Scotland

Case 201102541: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital – Psychiatry; clinical treatment; communication; staff attitude; dignity

Overview

The complainant (Ms C) raised a number of complaints with Grampian NHS Board (the Board) about the care and treatment she received whilst being treated as an in-patient at Brodie Ward (the Ward) at the Royal Cornhill Hospital (the Hospital) in Aberdeen in 2010. She was dissatisfied by the Board's response to her complaints.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the care and treatment provided to Ms C on her admission to the Ward of the Hospital on 5 February 2010 was inadequate; (*upheld*)

(b) the observations levels to which Ms C was subjected and the locking of the Ward door at night were inappropriate; (*upheld*)

(c) there were communication issues during Ms C's stay on the Ward: including that she had difficulty in speaking to her named nurse; and that she was given inappropriate 'advice' on self-harming by a Staff Nurse (Staff Nurse 1); (*upheld*)

(d) inadequate care and treatment was provided to Ms C after she took an overdose on 24 February 2010; (*upheld*)

(e) it was unreasonable that on the occasions that Ms C expressed a desire to leave hospital she was 'threatened' with formal detention; (*upheld*)

(f) the action taken following the incidents on 1 and 4 March 2010 was inappropriate and inadequate; (*upheld*)

(g) staff on the Ward had an unreasonable approach to weight/body mass index (BMI) policy; (*upheld*) and

(h) the Board unreasonably delayed in responding to the complaint made by Ms C on 25 May 2010. The Chief Executive did not respond until almost four months later on 6 September 2010. (*upheld*)

Redress and recommendations

The Ombudsman recommends that the Board:		*Completion date*
(i)	provide evidence to the Ombudsman that interim care plans are developed for patients on admission to the Ward, and that all appropriate documentation within patient records is being completed;	3 October 2012
(ii)	develop a search policy to provide guidance to staff on the issues of patient dignity and safety;	3 October 2012
(iii)	review their observation policy to take cognisance of the shortcomings identified, and ensure that the observation policy leaflet for patients is finalised and distributed to all patients on the Ward;	3 October 2012
(iv)	review their policy in relation to door locking on the Ward at night to take into consideration the additional issues highlighted;	3 October 2012
(v)	provide evidence to the Ombudsman of staff training in relation to communication with mental health patients, which should include guidance on ensuring professional and appropriate record-keeping by staff in relation to patients;	3 October 2012
(vi)	develop a policy to reflect the Mental Welfare Commission's guidance in relation to short term detention, for staff use and guidance and ensure this is distributed to staff;	3 October 2012
(vii)	undertake an audit to ensure incidents are being recorded appropriately on Datix;	3 October 2012
(viii)	ensure staff are aware of their responsibilities in relation to patient confidentiality;	19 September 2012
(ix)	develop policy for staff to advise of appropriate steps to take in relation to patient measurements, in conjunction with the Quality Improvement Scotland guidelines;	3 October 2012
(x)	ensure that complainants are kept up to date in relation to the progress of their complaints, and are given full information about the options available to them;	19 September 2012

(xi)	provide evidence to the Ombudsman that the Board operates a rights and values based approach in relation to the care of patients within the Adult Mental Health Directorate;	3 October 2012
(xii)	draw this report to the attention of all the staff involved in Ms C's care; and	5 September 2012
(xiii)	provide a full apology to Ms C for all of the failings identified within this report.	5 September 2012

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

Main Investigation Report

Introduction

1. Ms C has mental health difficulties including bipolar affective disorder. In February 2010 her GP referred her to Brodie Ward (the Ward) at the Royal Cornhill Hospital in Aberdeen (the Hospital) because she was struggling to cope with thoughts of self harm. She was admitted voluntarily on the evening of 5 February 2010 and had concerns about the manner in which she was admitted.

2. Ms C remained as an in-patient at the Ward until 15 March 2010, including periods of escorted and unescorted leave. She had a number of concerns about the treatment she received at the Ward throughout this time. She felt that the various observation levels to which she was subject were inappropriate and in fact detrimental to preventing her from self harming. She raised questions about the policy of locking the Ward doors at night. Ms C also felt there was a lack of nursing support and that she was not given the opportunity to speak with her named nurse on a regular basis. Again, she felt this was detrimental to her recovery. Ms C was also concerned that on a number of occasions when she had expressed a wish to leave the Ward, she had been advised that she was 'detainable'. Ms C felt it was inappropriate that detention under the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) was seemingly used as a 'threat' to control her behaviour.

3. There were a number of incidents of Ms C self harming whilst on the Ward. On one occasion she took a Lithium overdose and had to be transferred to an Accident and Emergency Department. She complained about the way she was treated by some of the staff on the Ward following this incident. Ms C had further concerns about the way she was treated in relation to other incidents. She described how she had reported to staff that a fellow in-patient had displayed unwelcome behaviour towards her, and that this had not been taken seriously; Ms C also described an episode when she awoke to find herself lying on the bathroom floor, could not recall how she had come to be there, and again felt she had not been treated appropriately following this or had the incident taken seriously. Ms C also stated that one of the nurses on the Ward had given her 'advice' on how to use fixtures and fittings in her bedroom on the Ward for the purposes of self harm. She also complained about Grampian NHS Board (the Board)'s policy of weighing and calculating the body mass index (BMI) of in-patients.

4. Ms C complained to the Board in relation to all these matters on 25 May 2010. She received a response from the Chief Executive on 6 September 2010. Ms C remained dissatisfied and brought her complaints to my office in September 2011. She felt that the poor care she had received served to alienate her from hospital environments and resulted in a further deterioration in her mental health, to the extent that she later had to be admitted as an acute patient to another hospital within another board area.

5. The complaints from Ms C which I have investigated are that:

(a) the care and treatment provided to Ms C on her admission to the Ward of the Hospital on 5 February 2010 was inadequate;
(b) the observations levels to which Ms C was subjected and the locking of the Ward door at night were inappropriate;
(c) there were communication issues during Ms C's stay on the Ward: including that she had difficulty in speaking to her named nurse; and that she was given inappropriate 'advice' on self-harming by a Staff Nurse (Staff Nurse 1);
(d) inadequate care and treatment was provided to Ms C after she took an overdose on 24 February 2010;
(e) it was unreasonable that on the occasions that Ms C expressed a desire to leave hospital she was 'threatened' with formal detention;
(f) the action taken following the incidents on 1 and 4 March 2010 was inappropriate and inadequate;
(g) staff on the Ward had an unreasonable approach to weight/BMI policy; and
(h) the Board unreasonably delayed in responding to the complaint made by Ms C on 25 May 2010. The Chief Executive did not respond until almost four months later on 6 September 2010.

Investigation

6. In order to investigate Ms C's complaints, my complaints reviewer considered the complaints correspondence between Ms C and the Board. She obtained and reviewed Ms C's medical records and made further enquiries of the Board in relation to their observation policy (the Mental Health and Learning Disability Service In-patient Observation Policy), the proposed observation leaflet for patients, the proposed Protected Therapeutic Time, and to establish whether a policy in relation to locking the Ward door had been developed. She obtained independent psychiatric advice from one of the Ombudsman's mental

health advisers (the Adviser). She also considered relevant policies and legislation including the Act, NHS guidelines, guidance from the Mental Welfare Commission, the Nursing and Midwifery Council guidance in relation to record-keeping and the Board's complaints procedure.

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) The care and treatment provided to Ms C on her admission to the Ward of the Hospital on 5 February 2010 was inadequate

8. Ms C explained that she had been urgently referred to the Hospital by her GP on the evening of 5 February 2010, following her difficulties with ongoing anxiety and pervasive thoughts of self harm. Ms C stated that she had not been admitted to a psychiatric in-patient facility before and was terrified. She arrived at around 20:00 and stated she was seen by a duty doctor (Doctor 1) initially, who asked Ms C to sit on a chair which was attached to the floor. Ms C said this made her feel as though she was considered a threat and served to exacerbate her anxiety. She felt Doctor 1 was curt and provided no reassurance in relation to her admittance. Ms C went on to describe her first night in the Ward. She became anxious and asked to leave the Ward, but was seen by a different duty doctor (Doctor 2) who advised she should remain in the Ward overnight and would be seen by a consultant in the morning. Ms C said she had asked to be prescribed Lithium and that this request was unreasonably refused, given her consultant psychiatrist (the Consultant) had previously recommended a transition to Lithium, and was instead offered sedation which she did not want.

9. Ms C said she was not provided with any orientation to the Ward and was unsure where she could go. She had been placed in an interview room after expressing her wish to leave and said that she remained there for several hours, until being asked to move by a member of the nursing staff. Ms C said she was eventually shown to her room, where she sat by her bed for the remainder of the night. Ms C explained she had her car keys with her, as well as a blade in her bag, both of which she was using to cut herself. She described that there were hourly checks of her room but the staff performing these checks did not speak with her or provide any reassurance, until around 04:30 when a student nurse attended with food and juice.

10. Ms C said she felt the care she received that evening was ‘appalling’. She believed that it tainted her whole experience of the Ward and her subsequent recovery. She described how she felt trapped in an unfamiliar environment because she had not received any orientation. She was also deeply concerned that seemingly no regard was paid to the fact she was self harming, nor to the possible reasons for this. She stated that being left on her own through the night with no reassurance was not best practice, and noted that she had since been told that her admittance experience would have been different had she been admitted during the day. Ms C said this was not reasonable, given the Hospital claimed to provide a 24 hour service.

11. The Board apologised to Ms C for the experience she described in relation to her admittance to the Ward, stating they acknowledged it was not a pleasant one. They explained that the Ward interview rooms had been designed in light of risk requirements developed by the Royal College of Psychiatrists, and that Doctor 1 had simply been following procedures for interviewing new referrals. The Board stated they appreciated this may have made Ms C feel ‘less than reassured’ but that they hoped she could understand there were standard operating procedures in relation to new referrals. They stated that Ms C’s comments about the manner of Doctor 1 had been conveyed to her. The Board also stated that the Consultant’s plan in relation to the prescription of Lithium had been for her to begin taking this on 8 February 2010, as stated within the Consultant’s letter to Ms C of 1 February 2010, and that the referral letter from Ms C’s GP had not contained a reference to Lithium. The Board also noted Ms C was started on Lithium when she was reviewed by the duty consultant the following morning.

12. The Board accepted Ms C’s position that she had not received orientation, and accepted that this should happen no matter what time of day or night a new in-patient is admitted. They acknowledged this was a potentially stressful experience for Ms C and said that they were ‘sure [Ms C] would understand that there are fewer staff on night duty’; that staff had not been sure whether Ms C intended to stay in the Ward overnight or not; and said that the Ward Manager (the Ward Manager) had reinforced with staff the importance of all patients receiving orientation to the Ward on arrival.

13. In relation to the attitude of the nursing staff towards Ms C throughout the night, the Board stated the Ward Manager had discussed this with those on duty that evening. The Board referred to one staff member (Staff Nurse 1) as

having a 'joking approach' and another (Staff Nurse 2) as having 'at times a blunt manner' but that it was 'never their intention to come over in an uncaring way' and that they apologised for any distress which they had caused Ms C. The Board also stated that the Ward had been busy that evening with two patients under constant observation, and that through the night only two trained nurses plus one healthcare assistant had been on duty plus a 'twilight' trained nurse until midnight. The Board stated this meant there was not as much time as during the day for staff to spend on one-to-one time with patients, but that nevertheless the staff on duty that evening had been made aware of her feelings and that the Ward Manager had reiterated to his staff it was 'important to check regularly on how someone is feeling'.

Advice obtained

14. The Adviser explained that according to guidelines[1], all individuals admitted to hospital should receive verbal and written information which orientates them to the hospital environment and a ward's internal geography. He examined Ms C's medical records and stated they noted that orientation to the Ward had in fact been carried out and that a ward information booklet had been given. This entry in the records was initialled within the records checklist by one of the nurses on duty. The Adviser commented that despite this, the Board had not countered Ms C's position that the orientation had not been carried out, and that this could suggest that those investigating the complaint had not adequately explored this issue. On the other hand, he noted this could indicate that the issue had in fact been explored and it had been concluded either that the record-keeping was inaccurate, or that the checklist was seen by staff as a 'paper exercise' only and not as an aide-memoire to ensure consistency and quality of care. The Adviser went on that if orientation was in fact carried out, the Board had clearly failed to adequately investigate this aspect of Ms C's complaint, thereby leaving staff open to unwarranted criticism. If it was not carried out, the Adviser said the fact that there were fewer staff on duty at night, cited by the Board as a reason for the failure to orientate, was not a valid excuse for failing to execute such a basic and fundamental responsibility; and nor was the Board's reasoning that staff did not know whether Ms C was staying or not. The Adviser said that even if there was initial doubt in this regard, it became clear in due course that Ms C was staying, and the orientation should have been provided at that point if not before.

[1] NHS Health Improvement Scotland: *Admissions to Adult Mental Health In-patient Services – Best Practice Statement*: Edinburgh [2009]

15. The Adviser said a failure to carry out orientation would have conveyed a lack of respect towards Ms C and would have no doubt heightened her sense of apprehension. The Adviser said it was unlikely this was the intention of the Ward staff, but that as mental health professionals they should have been more aware of how their actions would have impacted upon an already distressed individual. On this issue, the Adviser concluded that it was uncertain whether orientation took place, but if Ms C's and the Board's position was accepted then the Board's responses did not adequately convey an apology about this, nor did they indicate the steps being taken to avoid a repetition in the future, nor did they address the significant matter of potentially false record-keeping.

16. In commenting on a draft of this report, the Board explained that the issue of orientation had in fact been fully investigated, and it had been confirmed with duty staff that some orientation had been carried out, but had not included a comprehensive physical orientation of the Ward. They further explained that a verbal ward orientation had been carried out and a ward information booklet had been provided, but that because no comprehensive physical orientation to the Ward's layout had taken place they considered that full orientation was not completed. The Adviser noted that this information had not been provided in the initial response to Ms C nor in the Board's response to my office's enquiries during our investigation.

17. The Adviser considered the matter of Ms C self harming during the night of her admission. He explained that one of the major service ambitions of the NHS was patient safety. He noted that Ms C had been admitted due to a perceived high risk of self harm, but despite this the risk screening tool within Ms C's records had not been completed at the point of admission (nor at any time thereafter). He referred to guidelines in relation to risk assessment and management[2] and said these stated that 'risk assessment and management is integral to every stage of the admission process; accurate risk assessment helps reduce the risk of ... deliberate self harm ...' The Adviser said he would have expected this to be completed on admission as part of a structured approach to the assessment of risk and to inform clinical judgment and decision making, which could have led to the development of an interim plan to manage the risk of self harm. The Adviser noted no interim plan was developed for

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[2] NHS Health Improvement Scotland: *Admissions to Adult Mental Health In-patient Services – Best Practice Statement*: Edinburgh [2009]

Ms C, which may typically have included the restriction of access to harmful implements. He commented that the fact Ms C was able to retain possession of her car keys was a patient safety issue, and that as part of the admission process Ms C could respectfully have been requested by staff to surrender any items she had in her possession that might have been reasonably considered to offer a means of inflicting self harm.

18. The Adviser commented that the admission checklist within Ms C's records did note that Ms C was asked about sharp items in her possession, and that the patient information sheet indicated that a 'belongings policy' was explained to her, but he said that this may simply have related to the safekeeping of valuables and monies. The Adviser concluded that neither of these courses of action resulted in either the car keys or the blade in her bag referred to by Ms C being surrendered to staff. The Adviser noted that whilst staff may not have wished to compromise Ms C's dignity by asking permission to search her belongings, such concerns for dignity must be subordinated to those for safety when patients are deemed to be vulnerable or at risk. The Adviser concluded that risk assessment and management fell below the standard reasonably expected, and that it was not clear if the Board maintained a search policy to provide guidance to staff dealing with issues of privacy, dignity and safety.

19. The Adviser considered whether it was reasonable for the duty doctor not to commence Ms C on Lithium on the evening of her admission as she had requested. The Adviser said he had not seen a copy of the letter referred to by the Board from the Consultant dated 1 February 2010, which the Board said stated that Lithium should be commenced on 8 February 2010. The Adviser considered both of the duty doctors' notes in relation to this aspect of Ms C's admission. He said that the decision not to prescribe Lithium for the first evening appeared reasonable, because it would not be for a more junior doctor to deviate from a plan for medication prepared by a consultant. The Adviser noted that Doctor 2 had reviewed Ms C at 22:30 and had made contact with an on-call registrar, who had advised that Ms C was not to be given Lithium that evening because she had only been on 150 milligrammes Venlafaxine for four days, and that more time was needed to allow this dosage of that medication to take effect. The Adviser also noted that Ms C was commenced on Lithium the following morning by the duty consultant. The Adviser considered the offer of sedation to Ms C and explained that this should only occur as an adjunct to

compassionate support and engagement and not as a substitute for verbal reassurance.

20. In relation to the nursing care, the Adviser said that whilst there were many notes for the admission process, there was no discernible nursing care plan for the immediate post-admission period. He said that the evidence in the notes described the situation as Ms C had described it, with her spending the evening sitting in a chair by the bed with her jacket on, clearly anxious and agitated, and that as a result of the hourly checks it was discovered that Ms C's hand was bleeding. The Adviser reiterated he would have expected an interim plan to minimise the risk of self inflicted harm, which should have included the need to offer reassurance and emotional support. The Adviser said it appeared that some reassurance was offered but that this was reactive and minimal rather than planned and proportionate to need. He explained that such an interim risk management plan can be developed in collaboration with a patient and can help to make them feel safe. The Adviser said he was conscious the Board had commented the Ward was busy with limited numbers of staff on duty, and that the deployment of nursing power can be a 'difficult juggling act', but nevertheless it remained unreasonable that this resulted in Ms C receiving a demand-led service during her first night on the Ward.

(a) Conclusion

21. Ms C was concerned that the care she received on the night of her admission to the Ward was inadequate and in fact served to set back her recovery. My investigation has identified a number of concerning aspects about this period of Ms C's care: first, from their initial response to this complaint and our investigation, it was unclear whether the Board chose not to accept the position of the written records in relation to orientation or whether their investigation was simply not carried out thoroughly. This in itself was unsatisfactory. I note the Board's explanatory comments on this issue following their opportunity to review the draft report. I find the fact that full orientation did not take place to be a basic failing in care, particularly with regard to a vulnerable individual who was attending a psychiatric facility for the first time as an in-patient, a no doubt extremely difficult experience in itself.

22. It is also unsatisfactory to note the advice given to me that no interim care plan (including risk management) was established and that nursing care was reactive and intermittent. I acknowledge that there will be less staff on duty throughout the night time period, but nevertheless it is of particular concern that

Ms C was self harming throughout the night with items in her possession, and no discernible care plan had been prepared to prevent this from occurring. I am also critical of the Board's apparent excusal of the manner of some of their staff which they described as 'joking' and 'blunt at times', to explain why they may have acted in the way they did – I find this to be inappropriate and unprofessional.

23. I acknowledge that Ms C's experiences on the night of her admission to the Ward were distressing, and a different approach to her care could have helped to reduce or prevent this. I uphold this complaint. I have two recommendations to make.

(a) Recommendations

24. I recommend that the Board:	*Completion date*
(i) provide evidence to the Ombudsman that interim care plans are developed for patients on admission to the Ward, and that all appropriate documentation within patient records is being completed; and	3 October 2012
(ii) develop a search policy to provide guidance to staff on the issues of patient dignity and safety.	3 October 2012

(b) The observations levels to which Ms C was subjected and the locking of the Ward door at night were inappropriate

25. Ms C described that throughout her time on the Ward she was subject to various observation levels for varying times. She noted that at the beginning of her stay she was subject to what she described as 'close' observation, and that this involved a nurse sitting outside her room observing her, although this did not happen through the night. Ms C found this to be antagonistic and served to increase her self harm rather than prevent it. She also described how she was able to leave the Ward for periods of unescorted leave to spend time with her family, and to return to close observation was unnecessary and degrading. Ms C described an incident where one of the staff nurses (Staff Nurse 3) would not allow her to go to reception without an escort, to pick up some flowers which had arrived for her, despite her having spent that day at home and some of the time on her own. She said Staff Nurse 3 would not contact medical staff to ask for the observation level to be reduced. Ms C described that she felt 'the level of observation should be for the least restrictive [period] for the shortest period of time and frequently reviewed'.

26. Ms C also said she had at some stage been reduced to 'general' observation, and that she had asked what that meant and had allegedly been told by one of the nurses (Staff Nurse 4) that 'she was a grown up and should know what it meant'. Ms C described how under this level of observation she would frequently leave the Ward as she did not like to be there, and would spend hours outside, often upset and crying because she felt 'guilty for running away'. She said the term 'general' observation was not described to her until towards the end of her time on the Ward, and that she only understood then that it was in fact 'encouraged' for patients under this level of observation to leave the Ward if they wanted to do so. Ms C said it should not have been presumed that the different terms to describe observation would be understood without explanation.

27. Ms C also referred to the Board's policy of locking the Ward doors at 22:00 each night until the day staff arrived in the morning. She noted that on three occasions in March 2010 (when under 'general' observations) she had asked to go outside after 22:00 for fresh air and was not allowed to do so. Ms C felt this was excessive and unnecessary, and again exacerbated her anxiety and prevented her access to a distraction from self harm, ie, walking in the grounds or sitting in the garden.

28. The Board noted that Ms C had attended a meeting in relation to her complaints with the Ward Manager and the Clinical Nurse Manager for the Adult Mental Health Directorate (the Clinical Nurse Manager) on 30 July 2010, and that during this 'both agreed it would be useful to have a short leaflet explaining what the various levels of observation are'. The Board had advised this would be produced.

29. The Board noted the incident with the flower collection at reception and said they appreciated this seemed something of a contradiction, given that when Ms C was at home she was able to come and go as she pleased, but that she was still on 'general observation with escort' whilst on the Ward and Staff Nurse 3 had no option but to follow the appropriate procedure. The Board said the Ward Manager had raised the comment allegedly made by Staff Nurse 4 to her, and that Staff Nurse 4 did not recall 'saying anything in a way that meant to come over as being unhelpful or dismissive'.

30. In relation to the policy of locking the Ward doors at night, the Board said this was 'largely at the discretion of the night staff', and 'it would appear that some night staff are more willing than others to open the door'. They said this was something that would be discussed by the Ward Manager with the night staff. The Board later expanded upon this response (see paragraph 40).

Advice obtained

31. The Adviser noted that at the point of admission, Ms C was placed under general observation arrangements with time off the Ward permissible with a nurse escort. He said this was a valid observation level under the Board's observation policy, the Mental Health and Learning Disability Service In-patient Observation Policy. He said this meant staff would not need to keep Ms C within sight at all times on the Ward but should know her 'general whereabouts', and that time off the Ward would only be permissible if she was accompanied by a member of staff or a relative or friend, by agreement with the medical staff. The Adviser noted that the Board's policy in relation to general observation stated that during the night, staff should have confirmed her whereabouts by sight on an hourly basis and that such checks should be noted on a standardised form. The Adviser noted that there was no evidence of such a form in Ms C's records.

32. In commenting on a draft of this report, the Board said that Observation Prescription Sheets are only completed for patients on constant observation, and as such would not be included in Ms C's notes for the times that she was on general observation. The Adviser said, however, that this statement was in fact contrary to the Board's observation policy, which stated that 'nursing staff should note the presence in the Ward or be aware of the whereabouts of all patients on general observations at intervals of at least two hours … such checks should be noted on a standardised form'.

33. The Adviser went on that the Board's observation policy said that the reason for the initial level of observation had to be agreed with medical staff, and that 'this must be indicated on the Observation Prescription Sheet and signed by the clinical staff involved in the discussion'. The Adviser noted there was no evidence of the Observation Prescription Sheet in Ms C's records (he noted that Observation Forms were referred to within the Admission Checklist and regarded as integral to the admission process), and that there was also nothing in the records to indicate a discussion regarding appropriate observation levels or the reasons under-pinning the decision. The Adviser

concluded that the outcome of these apparent deviations from organisational standards and recording practices meant that the rationale for deeming general observation to be proportionate to Ms C's degree of vulnerability at the point of her admission was unclear, and meant that the decision lacked transparency. He commented that he did not suggest that this meant the decision was wrong, but rather that the failure to explain it breached the Board's policy.

34. The Adviser noted that the Board's policy said 'patients undergoing observations should be kept informed of their observation status'. He said this meant all patients should have their level of observation explained to them, and that there was no evidence from Ms C's records of her having these explained nor of receiving written information in this regard.

35. The Adviser said that there was evidence in Ms C's records that her observation levels were subject to reasonably regular review (for example, Ms C was placed under 'constant observations' following an incident of self harm on 17 February 2010), and there was no sense of the implementation of the policy being overly restrictive, but what was not clear was Ms C's involvement in the decision-making process. The Adviser noted that the policy acknowledged that elevated levels of clinical observation can compromise dignity and privacy, and have a detrimental effect on self esteem and mood. The Adviser explained that the Millan Principles underpinned the Act, and that these stated the least restrictive means necessary must be used to manage risks. He said that in the spirit of the Act and in line with recovery-focused care, individuals have a right to expect that they will be involved in the observation decision-making process as far as they are able to participate. He concluded that there was no evidence that Ms C, as an informal in-patient, had been appropriately involved in this regard.

36. In relation to the policy itself the Adviser noted this seemed outdated; it was dated May 2009 and stated that it should be 'reviewed within six months'. He also commented that the policy contained stigmatising language such as 'level of freedom to be granted', 'attempted escape' and relatives being involved in 'handing patients back'. He said the policy did not prompt patient and carer involvement in the decision making process, which was contrary to the principles underpinning the Act. He noted the policy lacked clarity in relation to when and how written information would given to patients and relatives; it simply stated written information was 'available'.

37. In relation to the Board's position on the locking of the Ward doors at night, the Adviser noted the 'least restrictive alternative' principle as defined in the Act, and stated that the level of restriction should be proportionate to the presenting level and nature of risk. The Adviser noted the conflicting benefits and adverse effects of locking the Ward doors, such as obvious safety reasons, ie, to prevent crime and for reasons of personal safety, compared to the creation of feelings in patients of being trapped and confined which could escalate feelings of disrespect, social exclusion and stigmatisation. He also commented that adversely, open doors could result in a sense of anxious vigilance on the part of staff, who may find this tension-provoking, particularly during busy periods or when staffing numbers were limited. The Adviser said in order to address all of these issues, a clear, documented policy to ensure an ethically sound approach which appropriately balanced concerns for safety with the need to maintain dignity and a sense of personal autonomy was necessary.

38. The Adviser went on that it was not acceptable to simply state that it was the Ward's policy to lock the door at night, or to state that the locking of the door was at the discretion of the nurse-in-charge without stating clearly (in the form of written policy or good practice guidance) the conditions and circumstances when it would be acceptable for the nurse-in-charge to take that decision and be able to justify it. He said the Board's response to Ms C's complaint on this issue had been vague, indecisive and conveyed a lack of managerial leadership. He explained that staff needed to be confident that they understood the Board's expectations in relation to risk management. The Adviser noted the more recent information provided by the Board to my office in this regard, which included that a garden area was now accessible to patients up until 23:00 (this had not been case at the time of Ms C's treatment). He said the Board's more recent response indicated a more cohesive and consultative approach, but that it still did not address the question of whether an ethical locked door policy was in place.

39. The Adviser suggested a policy should describe in detail the conditions and circumstances when it would be reasonable to lock the Ward door, how this would be kept under transparent review to ensure doors were locked for a minimum necessary period of time, and how the policy would relate to individual risk assessment, care planning and recovery. He also suggested a number of potential practical solutions to the requirement of a door being locked in a general acute mental health ward, such as a key pad on the outside of the door to prevent access but allow egress, a keypad on the inside preventing access

and impeding egress but not preventing it, or the use of double handles or an electronic slow release door opening device.

40. In commenting on a draft on this report, the Board explained that in fact locking of the doors was not at the discretion of ward staff, and that it was Adult Mental Health Directorate policy for all ward doors to be locked at 22:00, primarily for safety reasons. They said the 'discretion' they had mentioned in their response letter to Ms C was in relation to allowing patients to leave the Ward after 22:00 for fresh air. The Adviser commented that this position had not been clear from the response to the complaint nor the Board's response to my office's enquiries during the investigation.

(b) Conclusion

41. In determining this complaint, although I take into account the advice given to me that the observation levels to which Ms C was subject were valid under the Board's observation policy, I have a number of concerns about the manner in which these levels were decided upon and documented. It appears that, as per the risk assessment documentation in relation to the previous complaint, little or no regard was given to observation level recording and explanation in Ms C's notes. It is of concern to me that copies of necessary records such as the Observation Prescription Sheet appeared to be routinely overlooked in Ms C's case. I note that the Board commented on this, having considered a draft of this report, but it is of additional concern to me that these comments are contrary to their observation policy. I am also critical of the failure of the Ward staff to involve Ms C in decision making and discussions in relation to observation levels. Good practice advises this should occur when the patient is able to have involvement; and the failure to give Ms C information about observation levels or allow her the opportunity to be involved in the process, as an informal patient, is not acceptable. I do note that the Board have taken some steps in this regard and have provided my office with a copy of their new information leaflet for patients and relatives in relation to observation levels. I note that this is currently out for consultation.

42. The advice given to me about the use of stigmatising language in the Board's observation policy gives me further cause for concern. I would anticipate that the Board would seek to ensure their polices and guidelines are up to date and in keeping with contemporary mental health care standards – for such language to be considered appropriate for Board policy is unacceptable.

43. In relation to the issue of door locking on the Ward, I accept that this can be a challenging issue with conflicting principles and outcomes in play. However, I agree with the Adviser that the Board's initial response in this regard was vague; it did not allow confidence in the Board's position. I note again that the Board have since taken some steps to address this issue and have since provided my office with a copy of their policy in relation to the locking of ward doors. I find this policy should be reviewed to give consideration to the issues raised by the Adviser. I also note the additional information the Board have provided when commenting on a draft of this report, and that this was not clear from the initial response either to Ms C or my office. In all of the circumstances, I uphold this complaint. I have made two recommendations to address the failings identified within this complaint, and would also anticipate that recommendation (i) made in relation to complaint (a) would also seek to address the failings in relation to record-keeping.

(b) Recommendations

44. I recommend that the Board:	*Completion date*
(i) review their observation policy to take cognisance of the shortcomings identified, and ensure that the observation policy leaflet for patients is finalised and distributed to all patients on the Ward; and	3 October 2012
(ii) review their policy in relation to door locking on the Ward at night to take into consideration the additional issues highlighted.	3 October 2012

(c) There were communication issues during Ms C's stay on the Ward: including that she had difficulty in speaking to her named nurse; and that she was given inappropriate 'advice' on self-harming by Staff Nurse 1

45. Ms C felt that the support from nursing staff on the Ward was inadequate. She described that at first she had had opportunities to talk with her named nurse, which she said she found mostly supportive, although she referred to an occasion when she said she had been described (by Staff Nurse 3) as 'dishonest, untrustworthy and rude', and another when she said she had been told she was not making enough effort to integrate with the other patients. Ms C said that after some time she noticed her interactions with nursing staff had dwindled – she found the decrease in this support made it more difficult for her to cope. Ms C said she raised this with the Consultant during a consultation on 5 March 2010, and that thereafter a mental health recovery plan was developed which stated she should have half an hour time with her named nurse everyday.

Ms C said this worked for a day or so until Staff Nurse 4 was her named nurse. Ms C said Staff Nurse 4 did not approach her to arrange a time to talk, and Ms C attempted to arrange this herself but felt like she was 'pestering' Staff Nurse 4. Thereafter, Ms C said she 'did not push' to talk to her named nurse.

46. Ms C explained that talking with a trained professional helped her with her feelings of low self esteem and insecurity, which had worsened with her increasing anxiety. She said she found it very difficult to approach the nurses to ask to talk, and felt disappointed that the nurses did not generally approach her for this purpose nor appear able to give her time to talk. Ms C said she felt there should have been a greater awareness across the Ward of a depressed patient and their needs.

47. Ms C also described an occasion during which she was feeling increasingly distressed by her urges to self harm, and had approached Staff Nurse 1 to talk about this. Ms C said that Staff Nurse 1 had come to her room and had explained to her what other patients in her situation had used. She said Staff Nurse 1 had described how some of the screws in the walls were loose and could be used for harm, and that some patients had chipped bits of wood off the skirting boards for the purposes of self harm. Ms C said at the time she 'felt pleased' to be given this information, and found a screw in the bathroom wall which she used to cut herself that night and several subsequent nights. Ms C said in hindsight she thought it was 'horrendous' that one of the nurses had provided assistance to her in this manner.

48. The Board said that Staff Nurse 3 could not recall making the negative comments described to Ms C and felt that she 'had always tried to do her best in any interaction with [Ms C]'. In relation to Staff Nurse 4, the Board said that she had 'done her best to spend time with [Ms C] but acknowledges this could have been more'. The Board also said the staff said they were trying to give Ms C some time to manage on her own but that it was not their intention to 'back off'. The Board apologised to Ms C for how staff had come across during their interactions with her. The Board advised that the Ward was working to introduce Protected Therapeutic Time, which two of the Board's other wards had done. This involved one member of staff being available for one or two hours per day to deal with calls or queries so that all the other members of staff were free to interact with patients in either a one-to-one or group situation. The Board said this should help to ensure that planned time with patients was easier to achieve.

49. The Board provided additional information to my office which advised that Protected Therapeutic Time was now available on the Ward as of April 2012, and that initially this would operate for three days per week at one hour per day. They said this time would be used as far as possible to ensure one-to-one interactions with patients. The Board also advised that it was planned to introduce a Recovery group in the near future which would also run during this time.

50. In relation to Ms C's position regarding the incident with Staff Nurse 1, the Board said that due to the potentially serious nature of this issue, Staff Nurse 1 had been asked to provide a statement about what had happened on that evening. Staff Nurse 1 had stated he remembered approaching Ms C himself to ask how she was getting on, and that he did not recall her being distressed or stating that she was going to harm herself. He said he remembered Ms C asking about observation levels and 'how staff prevented patients from self harming if they were not on close observations or being closely monitored'. Staff Nurse 1 said he had tried to explain this in detail by describing risk assessment, and that Ms C had then mentioned that on several occasions during the day she could have left the Ward to buy sharp objects without staff noticing. Staff Nurse 1 had said that to 'provide further reassurance, he had described a theoretical scenario and explained how the risk assessment process would apply to it'. He said that at no time had he advocated or encouraged self harm; that the tone of the conversation had been 'light hearted at times'; that Ms C appeared reassured and satisfied by the responses he gave; and that he had made it clear that help and support was always available from the staff on the Ward. The Board said they had made Staff Nurse 1 'fully aware of how [Ms C] felt about what was said that night, and [he] has reflected on how any similar future situations might be handled differently'.

Advice obtained

51. The Adviser explained that the purpose of a named nurse was to ensure consistency in the planning and delivery of care, and to provide individuals with a named healthcare professional who would be primarily responsible for spending planned and unscheduled one-to-one time as part of a cohesive programme. He noted the Safety Plan developed on 9 February 2010 indicated that staff should spend time with Ms C daily, but that it was not specific regarding a named nurse nor when and for how long the daily time should occur. The Adviser said that from Ms C's records he could only identify seven

planned one-to-one sessions taking place with Ms C in the 27 days she was on the Ward prior to 4 March 2010. The Adviser then noted the Recovery Plan within Ms C's records which was developed on 5 March 2010; he said this indicated that structured daily 30 minute one-to-one time should took place, and that staff should approach Ms C to offer this engagement. There was also provision for Ms C contacting staff over and above the daily agreed time should she feel anxious at any time. The Adviser noted that following the development of the revised plan, it appeared that scheduled one-to-one sessions took place every day apart from those days Ms C spent off the Ward on pass (ie eight sessions in ten days). The Adviser concluded that the amount of planned one-to-one contact between staff and Ms C prior to 4 March 2010 fell below an acceptable standard and did not comply with the care plan, but that the renewed care plan was much more specific and Ms C's records indicated sessions took place as appropriate. The Adviser said the Board's additional response in relation to Protected Therapeutic Time was a welcome development which sought to ensure that nursing staff time was devoted to the delivery of patient care.

52. Additionally the Adviser considered the allegations Ms C had made about staff being disrespectful. He noted that there was evidence in Ms C's notes of judgemental language being used, such as 'drama this morning', 'dramatically stormed off to bed', 'contradicting herself over and over' and 'irritable and truculent'. The Adviser said these entries suggested a lack of compassion, and was something the Board seemed to acknowledge when they had previously described staff members as being 'blunt' or having a 'joking approach'. He said that mental healthcare staff should be aware of the sensitivities of vulnerable people in their care, and that they may feel judged and distressed by staff attitudes and actions, even where no ill will was intended. The Adviser stressed that uncaring and/or stigmatising language should be avoided at all times in interactions with patients. He also noted that many of the staff were no doubt very caring in their approach, but that the impressions of a service 'will only ever be as good as that service's weakest link'. The Adviser stated that training could assist with discouraging judgmental attitudes, and that input from service users could in fact assist with this, as some staff would be unaware of how their behaviour could negatively impact on those in their care.

53. In relation to the discussion Ms C described she had with Staff Nurse 1, the Adviser stated it was difficult to scrutinise Ms C's records to assist with this as the staff did not print their names and designations below their signatures.

He noted there were some entries that could reasonably be judged to be by Staff Nurse 1 from the signature, but that none of the entries reflected the circumstances described by Ms C. The Adviser noted, however, that neither the Board nor Staff Nurse 1 had denied that a conversation took place with Ms C that related to risk assessment and self harm, and it seemed from the Board's response that that conversation had involved a 'theoretical scenario' relating to self-harm. The Adviser said the Board's response was ambiguous in this respect because it did not confirm or deny whether Staff Nurse 1 had described to Ms C how fixtures and fittings in a patient's bedroom might be used to inflict self-injury. The Adviser noted the Board's comment that Staff Nurse 1 would 'reflect on how the situation might have been handled differently' implied that he might have been inappropriate, but did not confirm it. The Adviser said if it had in fact been the case Staff Nurse 1 had given such information to Ms C then this was very inappropriate, ill judged and unprofessional, particularly as it was reasonable to conclude that Ms C may have used this information to deliberately harm herself. The Adviser concluded the Board's response in this regard was inadequate because it neither upheld nor refuted Ms C's allegations, nor stated whether there was insufficient evidence to come to a definite conclusion. He commented this would have been dissatisfactory for Ms C.

(c) Conclusion

54. I have considered the communicative aspects of Ms C's care according to the written records available, the information from Ms C, the Board's responses and the advice given to me. I find that the initial plan for Ms C's time with a named nurse was inadequate as it did not give any details of how this contact would occur. It was not acceptable that it was seemingly left to Ms C to initiate contact, particularly given her vulnerable and depressive state and self esteem difficulties. I do note the Board thereafter took steps to improve this plan, and that thereafter this aspect of Ms C's care was generally handled satisfactorily, but this only appeared to occur after Ms C had raised the issue herself with the Consultant.

55. I was disappointed to read the highlighted excerpts from Ms C's records as recorded by various members of the nursing staff. The use of such stigmatising and judgemental language is entirely inappropriate in a professional environment, and I am critical of the Board that at the time of Ms C's in-patient stay there appeared to be a general acceptance that describing patients in a derogatory manner within their records was acceptable.

56. Finally, I am concerned by the alleged discussion that took place with Staff Nurse 1 and the Board's response to this. It is not certain to me what the Board did or did not accept of Ms C's recollection of the discussion with Staff Nurse 1; for there to be uncertainty and ambiguity in relation to such a serious incident is not reasonable. I cannot reach a definitive conclusion about this incident from the evidence available to me, but do take into account the Board's comments that Staff Nurse 1 would be 'reflecting' on the incident. In all the circumstances, I uphold this complaint. I would expect the Board to learn from the comments made within this section of the report to ensure continual improvement of staff attitudes and interactions with vulnerable patients, and have one recommendation to make.

(c) Recommendation

57. I recommend that the Board:	*Completion date*
(i) provide evidence to the Ombudsman of staff training in relation to communication with mental health patients, which should include guidance on ensuring professional and appropriate record-keeping by staff in relation to patients.	3 October 2012

(d) Inadequate care and treatment was provided to Ms C after she took an overdose on 24 February 2010

58. On 23 February 2010 Ms C took an overdose of Lithium. She was taken to an Accident and Emergency Department, and the following morning was deemed fit for discharge. She described that the Deputy Ward Manager (the Deputy Ward Manager) came to collect her along with another nurse (Staff Nurse 5); Ms C said that the Deputy Ward Manager was abrupt, gave no greeting to her and neither her nor Staff Nurse 5 spoke to her at any time between the journey from the Accident and Emergency Department back to the Ward. Ms C said no care or compassion was shown to her by either individual. On arrival back at the Ward, Ms C said the Deputy Ward Manager told her to go to her room, where she remained for the rest of the day. She stated no one came to speak with her except the Consultant. She explained she was given food at 17:00 but was sick. Thereafter she was given juice with her night medication at 22:00, but was again sick. Ms C described that as she came out of the bathroom at this time, Staff Nurse 1 came into her bedroom, 'sat on a chair with his feet on [her] bed and his arms crossed, smiled and stated 'there are easier ways to not take medication, you could just refuse the Lithium''.

59. Ms C stated she found the way she was treated by the Ward staff on this day emotionally distressing. She explained she had ‘incredible feelings of guilt’ about what she had put her parents through as a result of the overdose, but that no one had asked her how she was feeling, and even after being sick no one had asked her if she was alright. Ms C said this made her feel ‘worthless’ and not deserving of support. She also said she felt ‘threatened’ by the manner of Staff Nurse 1 in her bedroom.

60. The Board said the Ward Manager had made the Deputy Ward Manager aware of Ms C’s comments in this regard, and that the Deputy Ward Manager felt ‘embarrassed that she did not behave in a friendly or welcoming manner’. She acknowledged she ‘should have handled the situation differently and apologised for how she was that day’. The Ward Manager also said he had spoken with Staff Nurse 1, who had advised he did not recall sitting with his feet on Ms C’s bed, felt that he had a good relationship with Ms C and would not have said anything intended to make her feel uncomfortable. Again, Staff Nurse 1 had said he would be ‘more aware of how he came across in the future’. The Board said there was certainly no policy of leaving patients alone after an incident like an overdose, and that as Ms C’s parents had been visiting for a couple of hours, the Ward staff had not felt Ms C had been alone.

Advice obtained

61. The Adviser noted that the Board had acknowledged the Deputy Ward Manager’s lack of compassion for Ms C and passed on her apologies in this regard. He considered Ms C’s records for 24 February 2010, the day she returned to the Ward following the overdose. He noted that the clinical notes showed a one hour session with the Consultant and a nurse. It was also recorded that Ms C’s parents had been visiting throughout the afternoon, and that this would have inhibited direct staff contact with Ms C. It was also recorded that when the night staff came on duty, Ms C was asleep. The incident of Ms C vomiting at 22:00 was recorded by Staff Nurse 1, but there was nothing in the notes which detailed any interaction with Ms C. The Adviser also noted that the records stated Ms C was placed under constant observation arrangements.

(d) Conclusion

62. In considering whether the care Ms C received following her Lithium overdose was inadequate, I have taken into account the position of the Board in

relation to the attitude of the Deputy Ward Manager as described by Ms C – it appears that the Board accepts Ms C's recollection in its entirety, and apologises for this. I am critical that at a time when a patient was extremely vulnerable and no doubt would have benefited from a display of care and compassion, a senior member of staff failed to recognise this and act appropriately.

63. I note the Adviser's consideration of the written records and find that the limited time nursing staff spent with Ms C can be reasonably explained by Ms C's time with the Consultant, her parents, and her time spent sleeping. However, I can appreciate that Ms C would have expected staff to enquire after her wellbeing, particularly given she was under constant observations and had been sick twice during the evening. I also note that the Board have again stated (as with complaint (c)) that Staff Nurse 1 would be 'reflecting how he comes across'. This again suggests a possible acceptance that Staff Nurses 1's behaviour or comments may not have been entirely appropriate for the situation. On balance, I uphold this complaint. I would anticipate the recommendation made in relation to complaint (c) for staff training in relation to communication with patients would also seek to address the issues identified in this complaint.

(e) It was unreasonable that on the occasions that Ms C expressed a desire to leave hospital she was 'threatened' with formal detention

64. Ms C described that on many occasions she had voiced a wish to leave the Ward and to return home. She stated that on one occasion Staff Nurse 4 had told her that in order to leave, she would have to see the duty doctor, who would detain her under the Act, and on another occasion Staff Nurse 3 had told her she had three choices – to have sedation, to have the duty doctor called to detain her or she could go to bed and wait to speak with the Consultant in the morning. Ms C said she did not feel this was 'best practice interpretation' of the Act, that staff on the Ward were using verbal control to effectively detain her, and that detention should not have been used as a threat to control her behaviour. She suggested that staff should have spent more time talking with her to establish her reasons for wanting to leave the Ward.

65. The Board said the Ward Manager acknowledged these situations could have been handled differently, and that detention should never be used as a threat. The Board acknowledged this was something the Mental Welfare Commission was very clear about, and that they had made the staff involved

aware of this, as well as staff across all four wards of the Adult Mental Health Directorate. The Board also mentioned that the Hospital was one of the 'lowest users of the Nurses Holding Power', which enables mental health nurses to detain an informal patient in their care for up to two hours until a medical examination can be carried out. The Board said staff did try to avoid detaining patients in line with the principle of the 'least restrictive option', one of the principles of the Act.

Advice obtained

66. The Adviser referred to the Mental Welfare Commission's report on short term detention[3], which said they had noted staff had written 'detainable if wishes to leave' or similar, on some records, and that this type of statement was not acceptable because it increased the risk of a patient's rights being overlooked to such an extent that they became 'de facto detained', ie without legal authority and without the safeguards of the law. The Adviser said that statements such as this were written in Ms C's records on four separate dates by both nursing and medical staff. He said this was wholly inappropriate, and it had been acknowledged by the Board that such practice was contrary to the Mental Welfare Commission's guidance and was to be drawn to the attention of staff across all relevant wards. The Adviser noted, however, that the Board had not explicitly apologised for this, and it was also not clear how staff awareness would be raised. He noted it would be reasonable to expect to see written guidance for staff which reflected the Mental Welfare Commissions' guidance, which could provide examples of how to deal with situations where the Registered Medical Officer considered that compulsion may not be immediately warranted, or they wished to avoid continued use of the Act, but where there remained concerns that the person's compliance may not be sustained. The Adviser said that in such situations a written plan should be in place detailing what should happen if such a patient expressed the wish to leave.

(e) Conclusion

67. The Board accepts Ms C's position that she was effectively threatened with formal detention, and the advice given to me states that the records reflect this with the inclusion on a number of occasions of inappropriate comments about Ms C being 'detainable'. On that basis, I uphold this complaint. I note the

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[3] The Mental Welfare Commission: *Short-Term Detention: Monitoring the Care and Treatment of Individuals Receiving Care and Treatment on Short-Term Detention Certificates*: Edinburgh [2010]

Board have acknowledged this was not acceptable, and I make the following recommendation to help ensure that the Board demonstrate they are committed to eradicating this type of practice in the Ward and throughout their other mental health facilities. I would anticipate that the recommendation made in relation to complaint (c) for ensuring appropriate and professional record-keeping would also seek to address the issues identified in this complaint.

(e) Recommendation

68. I recommend that the Board:	*Completion date*
(i) develop a policy to reflect the Mental Welfare Commission's guidance in relation to short term detention, for staff use and guidance and ensure this is distributed to staff.	3 October 2012

(f) The action taken following the incidents on 1 and 4 March 2010 was inappropriate and inadequate

69. Ms C explained that on a certain type of medication she experienced graphic and terrifying nightmares. On the night of 1 March 2010, Ms C explained she had had a nightmare about 'creatures being in [her] room', and as a result ran out of her room. She said she was told by one of the nurses (Staff Nurse 6) to return to her room, and did not receive any reassurance. Ms C said she was too frightened at that time to return to her room, so went to the Ward's day room to make some tea and to calm down. Ms C explained that a fellow patient sat opposite her and offered her a 'kiss and cuddle' to make her less upset. Ms C said she tried to ignore the patient but that he persisted and moved closer to her; Ms C said she felt threatened, and that the patient repeated his offer to 'give her a kiss' and then began to run his hand up and down her leg. Ms C said that at this stage she was so frightened she ran to the nurses station to report the incident, but was told the patient was 'harmless' and that she should just return to bed.

70. Ms C said she felt belittled during this incident, and felt staff should have taken the time to talk with her and reassure her. She was concerned that her complaint against the other patient had not been taken seriously and was not raised with him at any point, and was 'appalled' to learn later that the incident was not recorded in her notes; she said this meant she had to persuade other staff later that the incident had in fact occurred. Ms C said this incident resulted in her feeling unsafe within the Hospital.

71. Ms C said that on 4 March 2010 she awoke lying on the bathroom floor with her head in the shower tray, and that she had no recollection of how this had occurred. She explained she had a severe headache from banging her head and was nauseated. She said that the Deputy Ward Manager had attended her room at 08:00 with her morning medication, that Ms C had described the incident to her, and that the Deputy Ward Manager had responded that it was 'Ms C's fault for not eating enough in the preceding days'. Ms C said the Deputy Ward Manager did not enquire as to whether Ms C was alright.

72. Ms C said she was upset by this interaction and tried to speak with the Deputy Ward Manager later. Ms C said the Deputy Ward Manager told her she was 'too busy' to talk further, that Ms C should know she 'called a spade a spade' and that Ms C would 'have to deal with this'. Ms C explained she became increasingly distressed by the Deputy Ward Manager's uncaring attitude towards her and the duty doctor (Doctor 3) was contacted. Ms C said she was further upset by Doctor 3 then stating the incident she had described with the other patient on 1 March 2010 'might not have occurred as it was not witnessed'. Ms C also stated that her mother had happened to telephone the Ward at this time and was given information over the telephone about what was happening with Ms C. Ms C said she left the Ward shortly thereafter on a pass given she was so upset, and did not return until 20:00 that evening.

73. Ms C said the Deputy Ward Manager's attitude was not appropriate for dealing with sensitive and vulnerable people. She was concerned that Doctor 3 had implied she had 'made up' the incident with the other patient, and that it should not be assumed that because something was not witnessed it did not occur. Ms C was also concerned that her mother had been given information about her over the telephone, in particular that she was refusing medication from Doctor 3, as this caused additional anxiety and distress to her mother. Ms C also felt there was very little support given to her on her return to the Ward in the evening.

74. In relation to the events of 1 March 2010, the Board said that Staff Nurse 6 was 'relatively new to nursing and whilst enthusiastic, can come across at times as lacking a degree of tact'. They explained the importance of coming across as approachable and understanding was an area that would be addressed via her Personal Development Plan. The Board assured Ms C that they took incidents such as that she described with the other patient very seriously. They

said Ms C should not have been subject to anything like this whilst in the Hospital, and apologised. They said although the incident was not recorded in Ms C's notes, it had been discussed with the Ward Manager at the following morning's handover and the patient concerned had been made aware that the behaviour described was not acceptable. The Board said they had made the staff involved aware of the importance of recording such incidents as well as the need to spend time with someone after such an alarming experience.

75. In relation to the incidents on 4 March 2010, the Board reiterated that they had raised with the Deputy Ward Manager Ms C's comments and feelings about the way she had interacted with her and her lack of empathy, and that the Deputy Ward Manager had acknowledged that she could have handled the situation in a more friendly and approachable way. They noted that the nurse who had spoken with Ms C's mother on the telephone had been doing so 'with the best of intentions' and apologised for the anxiety caused. The Board acknowledged it would have been more appropriate for Ms C to have been invited to speak with her mother over the telephone herself.

Advice obtained

76. The Adviser noted it was appropriate that the manner in which Staff Nurse 6 spoke to patients had been identified as a professional development issue within her Personal Development Plan, as was the Board's apology for the lack of tact shown by Staff Nurse 6 following Ms C's distressing nightmare. He also noted that the Board had apologised for the inappropriate behaviour of the other patient, as well as the failure of staff to treat this incident seriously and to offer appropriate reassurance. The Adviser said the fact that the Board felt there was a need to remind staff to spend time with people who had had an alarming experience was concerning and may be evidence of a 'disrespectful and untherapeutic culture' existing in the Ward.

77. The Adviser noted the Board had apologised the incident had not been recorded in Ms C's notes nor logged on their incident reporting system (Datix), and that he found this failure to record the incident concerning. The Adviser noted it could not be certain whether this was a 'one-off' failure or a regular occurrence in relation to incidents on the Ward. The Adviser explained Datix is incident reporting software which feeds into the Board's risk register, enabling it to assess and prioritise its risks as a comprehensive approach to patient safety and governance. He said the failure to record incidents and 'near misses' would significantly compromise the Board's patient safety strategy.

78. The Adviser noted there were a number of elements to Ms C's complaint about events on 4 March 2010. He said that Ms C's records did not contain a record of the fact she had awoken on the bathroom floor having hit her head and was nauseous as a result. What was recorded within the nursing notes was that Ms C had declined her morning medication due to nausea. He noted that Ms C had again raised concerns about the Deputy Ward Manager's attitude towards her and that these concerns had been accepted by the Board. The Adviser said this issue 'rang alarm bells' regarding how well practice in the Ward was aligned with a rights and values based approach to mental health care. He said that this was not the first time the Deputy Ward Manager had been mentioned in the context of a negative attitude towards Ms C, and given her clinical leadership role this was concerning. He commented that a deputy ward manager should be able to demonstrate compassionate, respectful practice and to promote the maintenance of patient dignity.

79. The Adviser also noted the Board's response failed to address several issues raised by Ms C, including her potential fall in the bathroom, (the Adviser noted he would have expected Ms C to be physically examined if she had come to be on the bathroom floor as a result of a fall, and for the incident to be recorded in Ms C's notes and on the Datix system), Ms C's allegation that a member of medical staff had implied that the incident of sexual harassment did not take place, and Ms C's position that staff had not enquired about her welfare on her return to the Ward that night. The Adviser commented that the nursing notes on this last point were very brief and did not state whether Ms C had been asked how she was on her return to the Ward.

80. The Adviser stated that the fact that a telephone conversation with Ms C's mother had taken place was recorded, but the nature of the information passed on was not. The Adviser highlighted the Mental Welfare Commission's position in relation to confidentiality[4] which was that 'if information is disclosed that could personally affect the patient, he or she must give express consent to the disclosure'. The Adviser said this report also noted that it was a statutory requirement for practitioners and service managers to keep personal information confidential. He commented that this incident raised further questions in relation to care on the Ward being ethical and appropriately rights-

[4] The Mental Welfare Commission: *Cares and Confidentiality – Developing Effective Relationships Between Practitioners and Carers*: Edinburgh [2006]

based, and of staff being aware of their responsibilities in this regard. The Adviser also noted that according to her records Ms C was very clear at the point of her admission that no information should be shared with third parties.

(f) Conclusion

81. This complaint raises a number of different concerns about the practices of the Ward, in relation to fundamental issues including the appropriate recognition and recording of serious incidents, attitudes of senior staff, patient confidentiality and an apparent failure to adopt suitable rights and values based care or to advise staff of their responsibilities in this regard. I express my serious concern that it appears these important aspects of mental health care were not adhered to appropriately in Ms C's case. I share the Adviser's concern that the failings identified may be indicative of a wider cultural problem within this Ward.

82. In particular, I am critical of the seemingly dismissive attitude of the staff following Ms C reporting to them the behaviour of her fellow patient, which was no doubt a distressing experience in itself, and the failure to record this incident, which may have had wider risk management implications. I am also critical of the attitude seemingly displayed by the Deputy Ward Manager towards Ms C on 4 March 2010; usually, it is difficult for my office to consider complaints relating to staff attitude. However, in this instance, the Board are accepting of Ms C's position of the Deputy Ward Manager's attitude towards her. Finally, it is unclear from the Board's response whether or not they accepted Ms C's position that she had awoken lying on the bathroom floor. This again was a serious incident, and if the Board's position was that they fully accepted Ms C's position on this matter, then there were significant failings in terms of a lack of appropriate care being given to Ms C immediately following this incident. For all of the reasons given I uphold this complaint. Once again, I expect the Board to learn from Ms C's experiences to improve the care within the Ward for future patients. I have two recommendations to make. Again, I would anticipate that the recommendation made in complaint (c) in relation to staff communication with patients will be relevant to this complaint. I also have a general recommendation to make at the end of this report which I suggest will address some of the concerns raised in this complaint.

(f) Recommendations

83. I recommend that the Board: *Completion date*

(i)	undertake an audit to ensure incidents are being recorded appropriately on Datix; and	3 October 2012
(ii)	ensure staff are aware of their responsibilities in relation to patient confidentiality.	19 September 2012

(g) Staff on the Ward had an unreasonable approach to weight/BMI policy

84. Ms C explained she did not like to discuss her weight or BMI with anyone as she had issues regarding this. She explained that on 21 February 2010 Staff Nurse 3 told her that she had to have her height and weight measured and her BMI calculated. Ms C said she explained she did not want this to happen and had 'protested clearly and distinctly', but that Staff Nurse 3 put her under 'great psychological pressure' to have these measurements taken, by stating that the Consultant would want it done and that it was Ward policy. Ms C said that eventually she was 'verbally forced' along the corridor and had the measurements taken. Ms C said this incident caused her a huge amount of distress both at the time and over subsequent weeks, that she was aware other patients had been treated differently when they requested not to have these measurements taken, and that she felt that excessive persuasion techniques had been used to control her behaviour.

85. The Board said that they had spoken with Staff Nurse 3 who had advised she had been 'trying to do the right thing' and was following the NHS Quality Improvement Scotland guidelines in relation to Food, Fluid and Nutrition Standards. The Board accepted that these guidelines allowed for exceptions when a patient was clear about not wanting their weight recorded, and they said that Staff Nurse 3 had acknowledged that there was no need on that occasion to insist that Ms C's weight was recorded.

Advice obtained

86. The Adviser said the Board were correct to refer to the Quality Improvement Scotland guidelines, and that there was a tool within Ms C's records which was the prescribed model for complying with these guidelines (the Must tool). He noted the Board had also acknowledged there was no requirement for staff to insist that weight and BMI measurements were taken. The Adviser said that simply advising someone it was 'ward policy' that such measurements be taken as a means to ensure compliance was inappropriate, and denied the person the right to the information which might allow them to make an informed decision. He described the Board's response as somewhat

cursory, although they seemed to have upheld Ms C's complaint. However, he noted they had not detailed any action taken to clear up any wider staff misconceptions about the weight screening policy versus patient rights, which could help to avert a recurrence.

87. The Adviser also noted that the Quality Improvement Scotland standards also stated that 'all patients should have the opportunity to discuss and be given information about their nutritional care, food and fluid. Patient views should be sought to inform decisions made about the nutritional care, food and fluid provided'. He stated that nothing in Ms C's notes indicated that verbal or written information in this regard was provided to Ms C, and that he would have expected this to be covered at the point of admission as part of the Ward orientation.

(g) Conclusion

88. It appears that a failure to communicate appropriately with Ms C resulted in this complaint; if the member of staff involved had advised Ms C of her rights in this regard, or had accepted Ms C's position that she did not want these measurements taken, the distress caused to Ms C could have been avoided. On that basis I uphold this complaint. I make one recommendation to ensure the Board make staff aware of their responsibilities in this regard.

(g) Recommendation

89. I recommend that the Board:	*Completion date*
(i) develop policy for staff to advise of appropriate steps to take in relation to patient measurements, in conjunction with the Quality Improvement Scotland guidelines.	3 October 2012

(h) The Board unreasonably delayed in responding to the complaint made by Ms C on 25 May 2010. The Chief Executive did not respond until almost four months later on 6 September 2010

90. Ms C felt that the time taken by the Board to respond to her letter of complaint was excessive at almost four months. She explained that the stress involved in waiting for a response had further contributed negatively to the state of her mental health.

91. My complaints reviewer asked the Board whether they wished to make any specific comment about this complaint, but they did not provide any

additional information. The Board's complaints file demonstrated that Ms C's letter of complaint had been received by the Board on 28 May 2010, an acknowledgment letter was sent on 31 May 2010, a meeting between Ms C and staff at the Board was offered and held on 30 July 2010, and that thereafter the response was issued on 6 September 2010. In the letter offering Ms C the meeting, the Board apologised for the delay and stated this was due to staff being on annual leave (this letter was dated 14 July 2010).

(h) Conclusion

92. In order to reach a conclusion on this complaint, I have considered the Board's complaint procedure. This states that formal responses must be sent out within twenty working days of a complaint being received, and if this is not possible 'escalation measures' are to be initiated. Ms C's complaint was not dealt with within twenty days; I recognise this was a complex and lengthy complaint and acknowledge the Board's position that it was received during a period of annual leave for staff, but nevertheless I would have expected to see evidence of escalation measures being implemented, and for Ms C to be contacted earlier about the offer of a meeting. The Board's procedure also states that if a response is not received within forty working days, the Board are obliged to advise the complainant that they could contact my office for a review. I do not see any evidence of Ms C having being contacted in this regard. I understand the unexplained delays will have compounded Ms C's distress. On that basis, I uphold this complaint.

(h) Recommendation

93. I recommend that the Board:	*Completion date*
(i) ensure that complainants are kept up to date in relation to the progress of their complaints, and are given full information about the options available to them.	19 September 2012

General Recommendations

94. I recommend that the Board:	*Completion date*
(i) provide evidence to the Ombudsman that the Board operates a rights and values based approach in relation to the care of patients within the Adult Mental Health Directorate;	3 October 2012
(ii) draw this report to the attention of all the staff	5 September 2012

	involved in Ms C's care; and	
(iii)	provide a full apology to Ms C for all of the failings identified within this report.	5 September 2012

95. 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

Ms C	The complainant
The Ward	Brodie Ward, a psychiatric in-patient ward at the Hospital
The Hospital	The Royal Cornhill Hospital in Aberdeen
The Act	The Mental Health (Care and Treatment) (Scotland) Act 2003
The Board	Grampian NHS Board
The Adviser	The Ombudsman's independent mental health adviser
Doctor 1	The first duty doctor who saw Ms C on the night of her admission
Doctor 2	The second duty doctor who saw Ms C on the night of her admission
The Consultant	Ms C's consultant psychiatrist
The Ward Manager	The Ward Manager at Brodie Ward
Staff Nurse 1	One of members of the nursing team on the Ward
Staff Nurse 2	One of members of the nursing team on the Ward
Staff Nurse 3	One of members of the nursing team on the Ward

Staff Nurse 4	One of members of the nursing team on the Ward
The Clinical Nurse Manager	The Clinical Nurse Manager for the Adult Mental Health Directorate
The Deputy Ward Manager	The Deputy Ward Manager at Brodie Ward
Staff Nurse 5	One of members of the nursing team on the Ward
Staff Nurse 6	One of members of the nursing team on the Ward
Doctor 3	A duty doctor who saw Ms C on 4 March 2010

Annex 2

Glossary of terms

Bipolar affective disorder	A condition also known as manic depression; the sufferer experiences episodes of mania and/or depression which can vary in frequency
Body mass index (BMI)	A measure of body fat based on height and weight
Datix	Incident reporting software which feeds into the Board's risk register, enabling it to assess and prioritise its risks
Lithium	A mood stabilising medication used to treat bipolar affective disorder
Venlafaxine	An anti-depressant medication for the treatment of anxiety and depressive illnesses

Annex 3

List of legislation and policies considered

NHS Health Improvement Scotland: *Admissions to Adult Mental Health In-patient Services – Best Practice Statement*: Edinburgh [2009]

The Mental Welfare Commission: *Short-Term Detention: Monitoring the Care and Treatment of Individuals Receiving Care and Treatment on Short-Term Detention Certificates*: Edinburgh [2010]

The Mental Welfare Commission: *Cares and Confidentiality – Developing Effective Relationships Between Practitioners and Carers*: Edinburgh [2006]

NHS Quality Improvement Scotland: *Food, Fluid and Nutrition Standards*