Scottish Parliament Region: Lothian

Case 201200092: Lothian NHS Board - University Hospitals Division

Summary of Investigation

Category

Health: Hospitals; Accident and Emergency; admission; discharge and transfer procedures

Overview

The complainant (Mrs C), an advocacy worker, raised a number of concerns on behalf of her client (Ms A) about Ms A's detention under the terms of a Short-Term Detention Certificate and her subsequent transfer, under nurse escort by ambulance, from the Royal Infirmary Edinburgh (Hospital 1) to the mental health unit at St John's Hospital (Hospital 2) in November 2011. Specifically, Mrs C complained about the way in which Ms A was transferred and that she did not receive appropriate information in relation to the detention and transfer.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Ms A was forcibly transferred from Hospital 1 to Hospital 2 without any prior knowledge or explanation of reasons (*upheld*);

(b) Ms A was inappropriately told she was being detained under the Mental Health Act but has no recollection of being detained (*upheld*); and

(c) the manner in which Ms A was wrapped in a blanket and strapped to a trolley, causing severe bruising to her shoulders, was unreasonable (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:	*Completion date*
(i) ensure that where detention and/or transfer is being considered, the matter is fully discussed with the patient and they are informed of the options available to them and the rationale underpinning the decision;	21 October 2013
(ii) ensure that in such cases discussions in relation to the patient's care and treatment and actions taken,	21 October 2013

	including the use of medication, are clearly recorded in the clinical notes;	
(iii)	ensure that, where restraint is required during the transfer of a patient, the appropriate incident report is completed in line with Board policy and the event clearly recorded in the clinical notes;	21 October 2013
(iv)	feed back the learning from this complaint to all relevant staff in both hospitals;	21 October 2013
(v)	ensure that all staff involved in taking decisions on short term and emergency detention are aware of the requirements of the Mental Health legislation and adhere to the appropriate process when carrying out any detention; and	21 October 2013
(vi)	ensure that a physical examination is conducted on a patient on their arrival at a hospital, especially if the patient was the subject of a physical restraint en-route to the hospital; and	21 October 2013

General recommendation

The Ombudsman recommends that:	*Completion date*
(i) this report be considered at a meeting of the Lothian NHS Board.	21 October 2013

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

Main Investigation Report

Introduction

1. The complainant (Mrs C), an advocacy worker, raised a number of concerns on behalf of her client (Ms A). Ms A was seen by Accident and Emergency (A&E) staff at St John's Hospital (Hospital 2) at 07:35 on 24 November 2011. She was complaining of abdominal pain and vomiting. It was noted that she had attended A&E on a number of occasions with a history of angina and complaints of chronic pain in various areas (abdomen, hips, legs, lower back) with no confirmed cause. Following assessment on 24 November 2011, there was no evidence of acute pathology and she was subsequently discharged home.

2. Ms A was seen again in the A&E department of Hospital 2 at 18:10 the same day, claiming to have swallowed two DIY type blades in a suicide attempt. One blade was evident on abdominal x-ray. She was admitted to a surgical ward of the Royal Infirmary of Edinburgh (Hospital 1) at 02:20 on 25 November 2011 for a surgical opinion. Surgery was not required and she was subsequently seen by the Liaison Psychiatry Team at Hospital 1. She was subsequently admitted to Ward 17 (acute psychiatry) of Hospital 2 at 21:30 on 25 November 2011 under a Short Term Detention Certificate (STDC). Ms A was discharged home on 8 December 2011 with mental health and pain clinic follow-up.

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

(a) Ms A was forcibly transferred from Hospital 1 to Hospital 2 without any prior knowledge or explanation of reasons;

(a) Ms A was inappropriately told she was being detained under the Mental Health Act but has no recollection of being detained; and

(b) the manner in which Ms A was wrapped in a blanket and strapped to a trolley, causing severe bruising to her shoulders, was unreasonable.

Investigation

4. During my investigation I reviewed all the correspondence provided by Mrs C and Lothian NHS Board (the Board); this included all the complaint correspondence and Ms A's medical records. I have also obtained an independent report from the Ombudsman's adviser on mental health (the Adviser) and taken account of the Mental Health (Care and Treatment) (Scotland) Act 2003; Short Term Detention Certificate.

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

(a) Ms A was forcibly transferred from Hospital 1 to Hospital 2 without any prior knowledge or explanation of reasons

6. On Ms A's behalf, Mrs C raised the following issues:

- that, whilst in bed within Ward 6 of Hospital 1 and without prior warning, Ms A was approached by two nurses and two ambulance men who informed her that she was being transferred to the mental health unit at Hospital 2 (the Unit);
- that Ms A informed the nursing and ambulance staff that she was not going and a struggle then ensued;
- that she was then informed (for the first time) that she was being detained under the Mental Health Act, without appropriate explanation being provided;
- that she was advised she would be going to a locked ward at Hospital 2 without access to visitors;
- that she was then forcibly given two injections;
- that she was subsequently wrapped in a sheet and strapped to a trolley and further restrained by a nurse lying on top of her;
- that she had a bad reaction to the injections which were administered and nothing was done about this;
- that the staff were then joined by a member of security personnel, who forced her arm up her back; and
- that she heard one of the nurses say in the ambulance 'if she moves I'll sit on top of her'.

The Board's response

7. The Board responded to Mrs C on 13 February 2012. They said that the complaint had been fully investigated by the Clinical Management Team and they addressed the concerns which had been raised. They stated that Ms A was informed she was to be detained under section 44 of the Mental Health Act prior to her transfer to Hospital 2; that the doctor who completed the documentation (Doctor 1) was familiar with her case and he explained the reasons for this course of action to her; however, they advised that Doctor 1

had taken the opportunity to reflect on this aspect of his communication with his educational supervisor.

8. The Board confirmed that Ms A had received two doses of haloperidol, which they said was an attempt to calm her for her own safety prior to transfer and that she was informed at the time of the reason for this by the nursing staff involved. The nurse administering the drug had confirmed that Ms A was restrained at the time of receiving the drug. The Board confirmed that Ms A had been wrapped in a blanket after being secured with trolley belts into the ambulance trolley, which was normal practice for patients being transferred by ambulance. They advised that this procedure was not intended as a form of restraint but an essential safety step, in line with putting on a seat belt.

9. The Board further advised that Ms A had been restrained by a member of staff employing the technique of applying pressure on the individual's lower body while sedation was administered and treatment given. The period of restraint was witnessed by the nursing and security staff and at no time was any staff member seen lying on top of Ms A. It was confirmed that two guards, in addition to nursing staff and ambulance personnel, were in attendance. With regard to the complaint that Ms A's arm was held up her back, causing extreme discomfort, the Board advised that all those present had provided statements and all had commented that Ms A was restrained lying flat on her back on her bed, prior to being transferred to the ambulance trolley. They concluded that the guard would not have had the physical access to restrain Ms A in the way she described, as she was managed lying on her back. The Board apologised for threatening comments Ms A felt were made by staff in relation to restraining her further if she moved during transfer in the ambulance. They advised that this form of communication and behaviour was not acceptable under any circumstances. They said that both members of nursing staff who had accompanied her were spoken to and could not recall making comments of this nature.

10. In summary, it was acknowledged that this had been a challenging situation for both Ms A and staff; that staff had reflected on Ms A's comments and would use the feedback to improve the service they provide.

Advice received

The allegation that whilst in bed within Ward 6 of Hospital 1 and without prior warning, Ms A was approached by two nurses and two ambulance men who informed her that she was being transferred to the Unit

11. The Adviser stated that involving people in their care and treatment is the cornerstone of mental health practice and is fundamental to the delivery of effective recovery-focused care. Central to this is the provision of information about the nature of their care and treatment: what to expect; options available; and the rationale underpinning the clinical decision making. He commented that there was nothing in the clinical notes to indicate any discussion took place between medical/nursing staff and Ms A regarding detention and transfer. He noted that the STDC recorded information regarding her mental state, associated risks and unwillingness to be admitted but does not mention specifically that she was fully informed of the detention/transfer process.

12. The Adviser noted that Ms A had stated that, without her prior knowledge, four people (two nurses and two ambulance personnel) arrived at her bedside to remove her to Hospital 2. The Board's response indicated that two security personnel were also involved. The Board's restraint policy (Restraint Policy; Consideration and Alternatives) clearly stated (at paragraph 13.5) that 'the minimum number of competently trained staff required for restraint is two. Three staff are required if the patient is to be restrained on the floor (four is best practice)'. The Adviser stated that such guidance is consistent with recognised good practice, such as that contained within the Royal College of Nursing's 'Let's talk About Restraint' document published in 2008. However, he commented there was no information in the records in relation to how the escorting team approached Ms A. A person's sense of distress could be heightened by the appearance of uniforms and he would have expected her to be approached in a compassionate manner by nursing staff, employing de-escalation techniques. Four or perhaps six people presenting themselves at her bedside without warning would have been an inappropriate way to handle the situation

The allegation that Ms A informed the nursing and ambulance staff that she was not going and a struggle then ensued

13. The Adviser said that the Board indicated that Ms A was physically aggressive and resisted attempts to calm her down. He could not say definitively how she was restrained because there was nothing recorded in the clinical records in relation to the use of restraint, the transfer process or Ms A's

behaviour prior to transfer or en-route. He commented that the absence of records in relation to this care event was concerning. He would have expected the use of restraint, the techniques used and the rationale to be clearly recorded and for an incident report to be completed. He considered it was so unusual for such events not to be carefully recorded that it may be possible that some clinical records were missing.[1]

The allegation that Ms A was then informed (for the first time) that she was being detained under the Mental Health Act, without appropriate explanation being provided

14. The Adviser noted the Board had stated that Doctor 1 (who detained Ms A) was familiar with her case and that: (a) he advised her of his intention to detain her; and (b) he provided a verbal explanation of his reasons for doing so. The Adviser commented that although communication with Ms A regarding her detention had not been contemporaneously recorded and, as stated above, the STDC does not mention that she was informed of the transfer, he thought it unlikely that a doctor would detain a patient without fully discussing this with them.

The allegation that Ms A was advised she would be going to a locked ward at Hospital 2 without access to visitors

15. The Adviser stated he could find nothing in the Board's response (or clinical records) which covered this aspect of the complaint. However, it would be inappropriate to make such a statement unless the patient did not wish to have access to visitors.

The allegation that Ms A was then forcibly given two injections

16. The Adviser said that the Board stated that Ms A was kicking and punching staff and required to be restrained. They had confirmed that the drug haloperidol was administered on two occasions, due to a sense of urgency and the need to try to calm her prior to the transfer by ambulance. The Board said this was done in the interests of Ms A's personal safety and that of staff. The Adviser commented that he could find nothing in the clinical notes which referred to Ms A being physically aggressive and having to be restrained. Nothing was noted in narrative fashion in relation to the use of medication to manage aggression, although the administration of the drug had been noted in

[1] In subsequent correspondence, the Board confirmed that the SPSO had been provided with all the clinical records.

the drug recording sheet and a note made the following day that Ms A had received 12mg of haloperidol the previous evening. He commented, however, that the use of the drug was not unreasonable in the circumstances ie on the basis that a valid STDC was in place (see paragraph 30).

The allegation that Ms A was subsequently wrapped in a sheet and strapped to a trolley and further restrained by a nurse lying on top of her

17. The Adviser stated that it was appropriate to wrap a blanket around someone being moved on a stretcher or trolley to prevent the blanket trailing and forming a trip hazard. Patients in stretchers should always be strapped in, whether the stretcher is moving or at rest (this is considered in detail under complaint c). He confirmed that a nurse would be acting in line with the Board's management of aggression techniques by lying across a patient's lower body as a means of stopping their legs kicking in such a situation.

The allegation that Ms A had a bad reaction to the injections which were administered and nothing was done about this

18. The Adviser stated that the Board said nothing was recorded in the clinical record in relation to Ms A experiencing an adverse reaction to the administered injections. However he noted, from the records covering the period immediately following Ms A's transfer, that she was showing some evidence of side effects (pain in jaw, excessive saliva and protruding tongue) and she was prescribed medication to counteract this. He considered the side effects were not unusual and were appropriately controlled with medication.

The allegation that the staff were then joined by a member of security personnel, who forced her arm up her back

19. The Board said that, due to Ms A's aggressive presentation and in anticipation of her transfer, support was sought from Hospital 1's security team and two guards attended the situation. The Board provided independent statements, taken at the time from those involved, which indicated that Ms A was restrained whilst lying on her back and that nothing within those statements corroborated her allegation that her arm was forced up her back.

20. The Adviser commented that, as there was nothing recorded in the clinical records, it was difficult to say what happened. This was also the case in relation to the threatening comments Ms A felt were made in the ambulance.

(a) Conclusion

21. Ms C complained that Ms A was forcibly transferred from Hospital 1 to Hospital 2 without her prior knowledge or explanation.

22. I have very carefully considered all the documentation I have been provided with regarding this complaint. I have noted that there is nothing in Hospital 1's notes which records that any discussion took place between medical or nursing staff and Ms A about her detention and transfer. There is also no specific mention of this in any part the STDC form, nor is there any mention in the clinical records of the use of restraint prior to and during the transfer process. The advice I have received is that the absence of recording this care event in the clinical records, including any discussion which took place with Ms A regarding detention and transfer, is concerning. In addition, an incident report in relation to the use of restraint, techniques used and rationale should have been completed. I am critical of these failures.

23. The Adviser has stated that it is unlikely a doctor would detain a patient without fully discussing this with them. However, had such a discussion taken place I would have expected it to have been fully documented in the clinical records. I therefore do not consider that the Board have been able to demonstrate that the appropriate discussions took place with Ms A about her detention and transfer and I regard this as a significant failing in care.

24. In addition, the absence of clinical records in relation to the restraint used means I am unable to say with certainty that this was appropriate or that the Board's restraint policy was appropriately followed. Again, I am critical of this.

25. The advice I have received is that the administration of haloperidol would be reasonable in the circumstances, of a valid STDC being in place (complaint (b) considers this point in detail) and the side-effects were not unusual; also, that the treatment of the side effects experienced by Ms A was appropriate. However, again I note that there is nothing in the clinical notes to explain the use of the drug (albeit its use has been noted in the drug recording sheet), the reasons for its use as an emergency to ensure personal safety or any discussions with Ms A.

26. In conclusion, I am unable to confirm with certainty that appropriate discussions took place with Ms A regarding her transfer and detention and that appropriate restraint techniques were used. Nor am I satisfied that the

administration of haloperidol was properly undertaken (please also see reference to this under complaint (b)). I am extremely critical of this care event and at the overall lack of record-keeping. In these circumstances, I uphold the complaint and make the following recommendations.

(a) Recommendations

27. I recommend that the Board:	*Completion date*
(i) ensure that where detention and/or transfer is being considered, the matter is fully discussed with the patient and they are informed of the options available to them and the rationale underpinning the decision;	21 October 2013
(ii) ensure that in such cases discussions in relation to the patient's care and treatment and actions taken, including the use of medication, are clearly recorded in the clinical notes; and	21 October 2013
(iii) ensure that, where restraint is required during the transfer of a patient, the appropriate incident report is completed in line with Board policy and the event clearly recorded in the clinical notes.	21 October 2013

(b) Ms A was inappropriately told she was being detained under the Mental Health Act but has no recollection of being detained

28. Mrs C complained that Ms A was advised, without explanation, that she was being detained under the Mental Health Act. Mrs C said that Ms A saw a consultant psychiatrist the following day, who informed her that she was not detained, that it sounded like her treatment had been like something from the 'olden days' and that she had cause for complaint in this regard.

Advice obtained

29. As stated above, the Adviser has commented on the need to involve individuals in their care and treatment (to the extent that their individual capabilities allow). He said that the General Medical Council had produced guidance for doctors in relation to the provision of information to patients: 'The General Medical Council Consent: Patients and Doctors Making Decisions Together'; London (2008). Part 2 paragraph 9 states that a doctor must give patients the information they want or need about a diagnosis and prognosis and any uncertainties about the diagnosis or prognosis.

30. The Adviser confirmed that Ms A was transferred to Hospital 2 on 25 November 2011 under a STDC. He advised that this detains a person in hospital for up to 28 days for assessment and treatment. However, the certificate was invalid as no Mental Health Officer (MHO) consent had been secured at the time the STDC was invoked.

31. The Adviser commented that the inappropriateness of this detention in effect meant that the escorting team had no legal authority to remove Ms A to Hospital 2 against her will. He would have expected the escorting nurses to have checked the documentation, to ensure that it was completed appropriately and that they were acting in line with the Mental Health Act. Equally, he confirmed that he would have expected someone with appropriate knowledge within the clinical team to check the detention paperwork on Ms A's arrival at Hospital 2 to ensure its validity but again that did not seem to have happened. He considered that if detention was required urgently at the time of transfer this should have occurred under an Emergency Detention Certificate (EDC), which permits detention, for assessment only, for a period of 72 hours without MHO consent. He considered that Ms A had been illegally detained even although she may have met the criteria for detention under an EDC.

32. The Adviser continued that Ms A arrived on the ward at Hospital 2 at 21:30 on 25 November 2011; that her legal status was noted as being detained under a STDC; and the accompanying letter from Doctor 1 clearly stated that detention had taken place without MHO consent.

33. On 28 November 2011 it is recorded at 23:00, 'continues on STDC - I'll rescind this therefore she will be an informal patient'. The Adviser stated that it appeared from this entry in the notes that the STDC was revoked because Ms A's mental state had improved to the point that she was no longer detainable. However, the notes were silent on this being explained to her and it was not until 30 November 2011 that medical records brought the inappropriate detention to the attention of the Responsible Medical Officer (RMO).

Mental Welfare Commission (the Commission) involvement

34. It was noted in the clinical records that when the RMO became aware of the invalid detention on 30 November 2011 he then contacted the Commission, who advised him to inform the patient of this and the legal recourse she may wish to pursue. It was subsequently noted in the clinical records that this was

discussed with Ms A, who indicated she may wish to make a complaint and seek legal advice.

35. Subsequently, the Commission wrote to the RMO on 8 December 2011, advising that they had been alerted to the fact that a STDC appeared to have been completed for Ms A without MHO consent. They asked for written details of the circumstances leading to this situation and confirmation that Ms A had been alerted to the position and made aware of her legal rights. In response, the RMO accepted that the detention was not valid and that he had made Ms A aware of her legal rights with regard to this.

36. In further correspondence with the Commission, Doctor 1 stated that he fully recognised his error in terms of the legal process, as he had used the STDC paperwork in error when he should have completed the paperwork for the EDC. However, he stated that, under the strict clinical criteria, Ms A had required admission to Hospital 2 as she had attempted suicide by swallowing razor blades, expressed on-going suicidal attempts and had clear depressive symptoms; however, she had refused admission.

(b) Conclusion

37. It is clear from the advice I have received, and from the clinical records, that Ms A was inappropriately detained against her will and that the clinician involved failed to follow the correct legal process, thereby rendering the STDC invalid. The advice I have received is that the escorting team had no legal authority to remove Ms A, nor had the receiving team to detain her under an STDC. Ultimately, only a court could determine the legality of the situation, however, I am clear that there was a complete failure to follow due process; and that was compounded by a failure to check the detention certification by both the escorting nurses and the clinical team at hospital 2. I am equally concerned that the situation was only identified by medical records five days after the STDC was issued and following its revoking. This also has implications regarding the administration of haloperidol. Under an STDC, a patient can receive treatment, including medication, without consent. In the circumstances, given the STDC was invalid, it is the case that haloperidol should not have been administered without the patient's consent. These are significant failings and I uphold the complaint. I make the following recommendations.

(b) Recommendations

38. I recommend that the Board:	*Completion date*
(i) feed back the learning from this complaint to all relevant staff in both hospitals; and	21 October 2013
(ii) ensure that all staff involved in taking decisions on short term and emergency detention are aware of the requirements of the Mental Health legislation and adhere to the appropriate process when carrying out any detention.	21 October 2013

(c) The manner in which Ms A was wrapped in a blanket and strapped to a trolley, causing severe bruising to her shoulders, was unreasonable

39. Mrs C stated that the manner in which Ms A was wrapped in a blanket and strapped to a trolley, causing severe bruising to her shoulders, was unreasonable.

Advice received

40. The Adviser has stated that it was appropriate to wrap a blanket around a person being moved on a stretcher or trolley to prevent the blanket trailing and forming a trip hazard. He also said that patients on stretchers should always be strapped in, whether the stretcher is being moved or is at rest.

41. He noted that no physical examination was carried out on Ms A's arrival at Hospital 2 and that no complaint of bruising as a consequence of the use of stretcher straps was recorded in the few days post-transfer to Hospital 2.

42. The Adviser stated that Ms A was not inappropriately restrained by mechanical means during the process of transfer to Hospital 2. However, he said that she should have had a physical examination on her arrival at Hospital 2, especially as it appeared she was subject of a physical restraint en-route to Hospital 2.

43. The Board's response stated that Ms A was wrapped in a blanket to keep her warm and the straps were a safety measure similar to car seat belts used in line with health and safety guidelines. They stated that the straps were not a form of mechanical restraint.

(c) Conclusion

44. I have carefully considered this issue, as with complaints (a) and (b). In doing so, I have not seen evidence to support the view that the manner in which Ms A was wrapped in a blanket and strapped to a trolley was inappropriate. The advice I have received is this was appropriate in terms of patient safety. While I appreciate Ms A has complained that she sustained bruising as a result, I have not seen definitive evidence of this. Had Ms A been examined following her transfer then any bruising would have been detected, however, I also note that, given there is no record in the clinical notes of the need for restraint en-route, the receiving hospital may not have been fully aware of this on her arrival. For all these reasons, I do not uphold this complaint.

45. However, I make the following recommendation.

(c) Recommendation

46. I recommend that the Board:	*Completion date*
(i) ensure that a physical examination is conducted on a patient on their arrival at a hospital, especially if the patient was the subject of a physical restraint en-route to the hospital.	21 October 2013

Complaint Handling

47. While this was not part of the complaint Mrs C raised with SPSO, I remain concerned that the Board's response in February 2012 to her complaint on behalf of Ms A failed to acknowledge that the detention was invalid and that there had been a failure to follow the correct process. Nor did it confirm any legal recourse open to Ms A, as requested by the Commission. It is a matter of fact that by the time Mrs C raised the complaint (in December 2011) and the Board responded (in February 2012), they were aware of the situation; they had drawn it to the attention of the Commission and corresponded with them on it. I am concerned that, in these circumstances, and given the significance of the failings, Mrs C and Ms A did not receive formal notification of the position at this time.

48. Given these concerns and, in light of the patient rights issues raised by this complaint, I am recommending that a copy of this report be considered at a meeting of the Lothian NHS Board.

General recommendation

49. I recommend that:	*Completion date*
(i) this report be considered at a meeting of the Lothian NHS Board.	21 October 2013

50. 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 advocacy worker who raised the complaint on behalf of Ms A
Ms A	The aggrieved
A&E	Accident and Emergency
Hospital 2	St John's Hospital
Hospital 1	Royal Infirmary of Edinburgh
STDC	Short term detention certificate
The Board	Lothian NHS Board
The Unit	The mental health unit at Hospital 2
The Adviser	The Ombudsman's adviser on mental health
Doctor 1	The doctor who completed the short term detention documentation
MHO	Mental Health Officer
EDC	Emergency detention certificate
RMO	Responsible Medical Officer
The Commission	The Mental Welfare Commission