Scottish Parliament Region: North East Scotland

Case 201301359: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital; Psychiatry – Psychiatry; clinical treatment; diagnosis

Overview

The complainant (Mr C) raised a number of concerns about the care and treatment given to his wife (Mrs C), after she was admitted as a voluntary patient to Crathes Ward (Ward 1) of the Royal Cornhill Hospital, Aberdeen (the Hospital). He said that although she was experiencing suicidal thoughts, the means by which she could attempt to end her life were not removed from her. He was also concerned that she was not placed under an appropriate level of observation and that she did not receive her required medication.

Specific complaints and conclusions

The complaints which have been investigated are that the Hospital staff:

(a) failed timeously to remove Mrs C's personal belongings for safe keeping (*upheld*);

(b) failed to keep Mrs C under an appropriate level of observation (*upheld*); and

(c) failed to ensure that Mrs C had an adequate supply of medication (*upheld*).

Redress and recommendations

The Ombudsman recommends that Grampian NHS Board:	*Completion date*
(i) emphasise to staff on Ward 1 that when suicidal intent has been indicated, they must take action to mitigate the risk;	25 July 2014
(ii) ensure that action in this regard should be properly documented and timed;	25 July 2014
(iii) make a formal apology to Mr and Mrs C for their failures in this matter;	25 July 2014
(iv) take steps to ensure that their processes of risk	25 August 2014

assessment and risk assessment planning are robust and transparent; and

(v) ensure that transfer procedures take due account of medication issues, to ensure that any required medication is prescribed/given without undue delay. 25 July 2014

Main Investigation Report

Introduction

1. Following an urgent GP referral, Mrs C was admitted as a voluntary patient to Crathes Ward (Ward 1) in the Royal Cornhill Hospital, Aberdeen (the Hospital) on 22 April 2013. The reasons for her admission were noted to be Borderline Personality Disorder and Depression. It was also noted that Mrs C's presentation was complicated by suicidal thinking, and planning and preparation towards it, including the planning of her funeral. Mrs C was further noted as having a history of rheumatoid arthritis of some six years standing.

2. At the time, Mrs C said she was willing to remain in hospital and she was nursed under 'General' observation arrangements, with any time off the ward being under nurse escort. However, early in the morning following her admission (23 April 2013), Mrs C left the ward via the fire exit. She was pursued by nursing staff, who returned her, and on her return she was prescribed Zopiclone (a hypnotic) and Diazepam (a minor tranquilliser) to help her to sleep and help manage her anxiety.

3. On 24 April 2013, Mrs C was seen by a consultant psychiatrist (the Consultant) and during the interview she said that she continued to have thoughts of self-harm. Mrs C also admitted to writing suicide notes to her children and husband (Mr C) but she denied having any active plans to harm herself. She agreed to let staff know if she experienced further thoughts of self-harm. Meanwhile, she remained on General observation with escort off ward.

4. At midnight on 24/25 April 2013 Mrs C tried to strangle herself and she was found unconscious, unresponsive and cyanosed (blue) on the floor. She was sent to Accident and Emergency for assessment under a two nurse escort and at 04:30 she returned to the Hospital. At this point, her observation level was reviewed and increased to 'Special' with no time off the ward. This meant that she would remain within close proximity (within arms reach) of a designated member of nursing staff around the clock. She remained on Special observation until 9 May 2013, when it was changed to 'Constant'. Thereafter, it was further scaled down to 'General' on 16 May 2013.

5. In the meantime, on 29 April 2013, Mr and Mrs C met with the Consultant, after which Mr C made a formal complaint to Grampian NHS Board (the Board). He said that if Mrs C was thought to be suicidal any medication and sharp

objects should have been taken immediately from her; similarly, she should have been properly sedated. He was aggrieved that staff had told Mrs C that they were too busy to speak with her when she was crying and upset. Mr C was also concerned that Mrs C had not seen the Consultant until 24 April 2013 and that she was still not given an increase in sedation or anti-depressants, despite Mrs C's continued suicidal thoughts. Mr C maintained that Mrs C should have been on Special observation and that had she been listened to and looked after appropriately with the proper medication, she would not have attempted to take her life.

6. Shortly after, on 6 May 2013, Mrs C was subsequently transferred to another ward (Ward 2) due to high levels of clinical activity on Ward 1 and the records noted that she was angry and felt abandoned by her clinical team. Later, on 8 May 2013, Mr C complained again to the Board that Mrs C had to wait for a long period for analgesia (Tramadol) and an anti-inflammatory drug (Etoricoxib) for her arthritic pain and that her mattress was unsuitable.

7. The Board replied on 5 June 2013. They took the view that Mrs C had been appropriately seen and assessed on her admission and that she had not been given her anti-inflammatory drugs or analgesia because they had not been in stock. Consequently, there had been a delay in providing them, for which they apologised. The Board also explained that it had been for clinical reasons that Mrs C had moved wards but that she had subsequently been moved back to Ward 1.

8. Mrs C remained in the Hospital during this time and, despite wanting to leave, she was persuaded to stay until effective arrangements were put in place to facilitate her discharge. She was eventually discharged on 10 June 2013.

9. The complaints from Mr C which I have investigated are that the Hospital staff:

(a) failed timeously to remove Mrs C's personal belongings for safe keeping;
(b) failed to keep Mrs C under an appropriate level of observation; and
(c) failed to ensure that Mrs C had an adequate supply of medication.

Investigation

10. The investigation of this complaint involved obtaining and reading all the relevant documentation, including the complaints correspondence and Mrs C's relevant clinical notes. Independent advice has been obtained from a

consultant psychiatrist (Adviser 1) and from a senior mental health nurse (Adviser 2) and this has also been taken into consideration. The Board's Safe and Therapeutic Clinical Observation Policy (the Policy) has been taken into account.

11. While this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Mr C and the Board were given an opportunity to comment on a draft of this report.

(a) Hospital staff failed timeously to remove Mrs C's personal belongings for safe keeping

12. Mr C said that on Mrs C's admission, as it was known that she was suicidal, any drugs in her possession and any sharp objects should have been removed. He said that this did not happen until some eight hours later. The Board's letter of response to Mr C dated 5 June 2013 said that Mrs C's possessions had been checked but that no specific time was indicated in the notes to say when this had happened. However, they added that it was the usual operating procedure on Ward 1 and other Adult Mental Health Wards, on admission, for a member of staff to check patients for any money, valuables, medication or items that could be used for self-harm. They said that on the day of Mrs C's admission (22 April 2013) Ward 1 had been very busy with a full complement of 28 patients, three of whom required constant observation. As a consequence, they said that it may not have been possible for all aspects of the admission procedure to have been undertaken as timeously as usual. The Board acknowledged Mr C's concern and apologised.

13. My complaints reviewer asked both Adviser 1 and Adviser 2 to consider Mrs C's clinical records and to confirm what had happened on her admission. Adviser 1 said that it was his view, from the information available to him, that it was not clear whether a search had been conducted and whether sharp objects and medication had been removed. He said that no time was indicated of this having taken place, nor was anything itemised as having been removed from Mrs C's possession. Adviser 1 went on to say that in his view, it was, therefore, unlikely that a search took place which resulted in the removal of hazardous items. Adviser 1 said that this was in the face of information at the time of admission which suggested an increased risk of self-harm and/or suicidal behaviour. He went on to say that good practice would have dictated that steps should have been taken to minimise the known risks.

14. Adviser 2 agreed but added that there was no evidence to support the use of a systematic screening tool to support the risk assessment process, aid clinical judgement and inform multi-disciplinary discussion about risk management.

(a) Conclusion

15. The available evidence does not support the Board's contention that Mrs C's possessions were checked in accordance with their usual practice. Both advisers said that there was no evidence to confirm a time when this happened or to confirm what had been removed from Mrs C's possession. It was not in doubt that, on admission, Mrs C had spoken about taking her life and yet it seemed that no action was taken to reduce the risk of this. Adviser 1 said that this was not good practice.

16. Given the advice above, I uphold Mr C's complaint. I note the apology already made to Mr C, however, the Board should also emphasise to the staff on Ward 1 that when suicidal intent has been indicated they must take action to mitigate the risk. Their action should also be properly documented and timed.

(a) Recommendations

17. I recommend that the Board:	*Completion date*
(i) emphasise to staff on Ward 1 that when suicidal intent has been indicated, they must take action to mitigate the risk; and	25 July 2014
(ii) ensure that action in this regard should be properly documented and timed.	25 July 2014

(b) Hospital staff failed to keep Mrs C under an appropriate level of observation

18. Mr C was of the view that had Mrs C had been placed under a proper (higher) observation level, as he said her admission records seem to have indicated that she needed, she would not have been able to leave Ward 1 unattended nor attempt to take her life. In replying to this, when responding to Mr C's complaint, the Board confirmed that Mrs C had indeed attempted to leave Ward 1 in the early hours of the morning of 23 April 2013 but that this had happened during an emergency situation in Ward 1. They said that Mrs C's previous behaviour had not indicated that there was any cause for concern about her safety and they were satisfied that the level of risk posed by Mrs C had been adequately assessed by the clinical team looking after her. The

Board added that circumstances had made it difficult for staff to spend as much time with Mrs C as they would normally have done.

19. Adviser 1 pointed out that the Board's Policy (see paragraph 10) set out the guidance in existence at the time Mrs C was admitted to Ward 1. He said that it stated that General observation was suitable for 'service users posing no immediate safety risk to themselves or others'. Also, that:

> 'Constant observation should be used for service users who have been clinically assessed as being particularly vulnerable thus posing a significant safety risk to self or others. A designated member of staff must be continuously aware of the precise whereabouts of the service user through visual observation.'

Adviser 1 said that there was sufficient evidence clearly documented by the referring GP, admitting doctor and nurse to suggest a clear intent on Mrs C's part to self-harm. He added that, in his view, the appropriate level of observation for Mrs C on admission would have been Constant observation.

20. Adviser 1 went on to say that after Mrs C tried to leave Ward 1 it was noted that she was very distressed and that '… if she was to leave the ward she would jump off something high …'. He said this was a clear indication that Mrs C was at a very high risk of impulsive self-harm and that she appeared to be asking to be kept safe and watched. Adviser 1 said that it was only after the attempted hanging that Mrs C's level of observation was changed and, while it was appropriate to do so, it was a reaction to what had occurred. He said that good clinical practice would have anticipated the need for a higher level of observation.

21. Adviser 2 commented on the situation in some detail. He said that the use of enhanced levels of clinical observation should have been informed by multi-disciplinary risk assessment and the default position should always have been to use the least restrictive measures possible to promote safety and manage prevailing risks. He acknowledged that this could present challenges for clinical teams who were expected to ensure people’s safety on the one hand while not be overly controlling on the other.

22. Adviser 2 said that risk assessment should not simply be left to the clinical judgement of an experienced single clinician. It should be a structured process which utilised evidence from multiple sources; it was important to ensure that

risk assessment was not simply based upon intuition or feeling. The aim should be to combine evidence-based risk factors with individual bio-psycho-social assessment and to use that information to formulate the seriousness of the presenting risk and develop a risk management plan. Structured risk assessment promoted transparency of decision-making. He said that it often involved the use of risk screening tools but that where such tools were used they should not be seen as an end in themselves, as this merely encouraged a 'tick-box' mentality. He said that they should be used as part of routine bio-psycho-social assessment, not as a separate unrelated exercise.

23. In Mrs C's case, Adviser 2 said he could see no evidence in the records of a structured approach to risk assessment (see also paragraph 14). The initial assessment was carried out on admission and followed up by the Consultant's review on 24 April 2013. He said that neither of these assessments adequately covered historical factors related to the risk of suicide such as: history of self-harm; seriousness of previous suicidality (if any); family history of suicide; childhood adversity; past psychiatric history; and previous hospitalisation. He added that, in considering precipitating risk factors, the presence of feelings of hopelessness, low self-esteem and impulsive personality traits, all of which Mrs C disclosed to nursing staff, had not been addressed.

24. Adviser 2 said that it was recorded that Mrs C presented with the following self-harm risk factors:

- persistent low mood
- personality disorder traits
- prominent suicidal ideation - more so in the preceding week
- intent to self-harm should opportunity present itself
- planning and preparing for suicide
- psycho-social stress
- loss of interest
- flattened affect
- lack of spontaneity
- loss of appetite

25. And, in relation to potential protective factors, it was noted that she:

- was willing to remain in hospital to get better
- denied any recent acts of self-harm
- denied having active suicidal plans
- agreed to seek out the support of nursing staff should suicidal ideation increase
- had solid friendships

- derived support from her church

26. Adviser 2 explained that determining the correct level of observation for a person was not an exact science. Rather, it was a clinical judgement based upon the assessment of risk as part of a wider holistic assessment process. Ensuring accuracy and quality of information was critical to the formulation of risk. It allowed factors which were known to heighten risk to be balanced against factors which might mitigate the risk. Adviser 2 said that in Mrs C's case, the initial and follow-up assessments highlighted a number of known risk factors (as highlighted in paragraph 24) but they failed to consider some important aspects of risk assessment – most notably the presence/absence of impulsive traits and feelings of hopelessness and details in relation to previous acts of self-harm. Adviser 2 said that the opportunity to gather this important information was missed at the point of admission and in the subsequent 24 hours.

27. Adviser 2 said that the statement in the Consultant's assessment that Mrs C still had 'thoughts of self-harm (if opportunity presents)', allied to the other risk factors identified, was a combination which should have been considered as an alert in relation to the potential need for enhanced observation. The fact that she had agreed to stay in hospital 'to get better', had denied indulging in any recent self-harming acts or having active suicidal plans and agreed to self-report increasing suicidal thoughts to nursing staff may have been given too much weight in the face of the presenting known risk factors.

28. He said that, overall, there was a lack of structure to the risk assessment process and some important known risk factors did not appear to have been considered. Insufficient weight had been given to Mrs C's statement that she would think about self-harm if the opportunity presented itself. Adviser 2 did not consider the assessment of risk to have been reasonable. It was his view that general observation as a means of minimising the risk of self-harm was, on balance, inadequate.

(b) Conclusion

29. The Board said that Mrs C's level of risk had been adequately assessed but neither of my advisers agreed with this. Given the evidence and advice presented to me, I uphold the complaint. The Board have a responsibility, as far as possible, to maintain the safety of their patient. They have procedures to assist them to do so. In this case they were not followed. The Board should

now make a formal apology to Mr and Mrs C for their failures in this matter. It had been my intention to make a recommendation concerning the application of their policy (paragraphs 10 and 19) but the Board advised me when commenting on a draft of this report that they had since introduced an updated version with an intention to formally review it in May 2015. In these circumstances, I make no further recommendation about this. Nevertheless, the Board should take steps to ensure that their processes of risk assessment and risk assessment planning are robust and transparent.

(b) Recommendations

30. I recommend that the Board:	*Completion date*
(i) make a formal apology to Mr and Mrs C for their failures in this matter; and	25 July 2014
(ii) take steps to ensure that their processes of risk assessment and risk assessment planning are robust and transparent.	25 August 2014

(c) Hospital staff failed to ensure that Mrs C had an adequate supply of medication

31. Mr C said that during Mrs C's stay in the Hospital she did not receive the medication or sedation she required. In their reply to his complaint, the Board said that Mrs C received some Diazepam following the incident when she left Ward 1 during the night and that she received sedation on the evening of 23 April 2012. Other changes in her medication were dependent upon the Consultant's review. However, when Mrs C was moved from Ward 1 to Ward 2, the Board said that Ward 2 did not hold a stock of the anti-inflamatory she required. This was then ordered from the pharmacy and Mrs C received it when it became available. The Board added that a number of patients on Ward 2 required Tramadol but that this drug ran out and also had to be re-ordered from the pharmacy. The Board apologised for these delays.

32. When commenting on this complaint, Adviser 1 said that wards should not run out of commonly used drugs. He said that to do so suggested poor stock control and poor clinical practice. He noted that the Board said that Mrs C had been without Tramadol for about three hours and that this was unacceptable and would have caused pain and associated distress.

33. Adviser 2 was similarly critical and said that the relevant drug prescription sheet indicated that Tramadol was out of stock when Mrs C was due to receive

it at 08:00 on Ward 2 but that it was administered at midday. He said that there seemed to be a 24 hour delay in administering Etoricoxib. Adviser 2 said that the fact that both these drugs were out of stock showed evidence of a lack of forward planning at the time of Mrs C's transfer between wards.

(c) Conclusion

34. It does not appear to be in question that when Mrs C was transferred between wards, the Board ran out of the drugs she needed. Both advisers said that this was unacceptable and showed a lack of forward planning. In the circumstances, I uphold the complaint. While the Board have already made apologies for this, they should also ensure that transfer procedures take due account of medication issues to ensure that any required medication is prescribed/given without undue delay.

(c) Recommendation

35. I recommend that the Board:

	Completion date
(i) ensure that transfer procedures take due account of medication issues, to ensure that any required medication is prescribed/given without undue delay.	25 July 2014

Annex 1

Explanation of abbreviations used

Mrs C	the complainant's wife
Ward 1	Crathes ward
the Hospital	The Royal Cornhill Hospital, Aberdeen
the Consultant	a consultant psychiatrist
Mr C	the complainant
the Board	Grampian NHS Board
Ward 2	another hospital ward
Adviser 1	a consultant psychiatrist adviser
Adviser 2	a senior mental health nurse adviser
the Policy	Safe and Therapeutic Clinical Observation Policy

Annex 2

Glossary of terms

Analgesia	pain killing medication, for example, Tramadol
Anti- inflammatory drugs	medication to reduce inflammation, for example, Etoricoxib
Diazepam	tranquillising medication
Zopiclone	a hypnotic drug

Annex 3

List of legislation and policies considered

NHS Grampian. Safe and Therapeutic Clinical Observation Policy