Scottish Parliament Region: North East Scotland

Case 200600040: Grampian NHS Board

Summary of Investigation

Category

Health: Hospital

Overview

The complainant (Mr C), through his Advocacy Worker (the Advocacy Worker), raised a concern about the circumstances which led to him discharging himself from hospital.

Specific complaint and conclusion

The complaint which has been investigated is that staff failed to take into account Mr C's mental health problems and as a result he discharged himself from hospital *(not upheld)*.

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 3 April 2006 the Ombudsman received a complaint, from the Advocacy Worker, on behalf of Mr C. Mr C complained about the circumstances which led to him discharging himself from Aberdeen Royal Infirmary (the Hospital). Mr C complained to Grampian NHS Board (the Board) who have administrative responsibility for the Hospital but remained dissatisfied with their responses to his complaint and subsequently complained to the Ombudsman.

2. The complaint from Mr C which I have investigated is that staff failed to take into account Mr C's mental health problems and as a result he discharged himself from hospital.

Investigation

3. In writing this report I have had access to Mr C's clinical records and the complaints correspondence from the Board. I also made a written enquiry of the Board. I obtained clinical advice from one of the Ombudsman's professional nursing advisers (the Adviser).

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

Complaint: Staff failed to take into account Mr C's mental health problems and as a result he discharged himself from hospital

Clinical History

5. Mr C was admitted to the Acute Medical Assessment Unit from the Accident and Emergency Department at 04:50 on 28 October 2005. The presenting symptoms were a history of left sided chest pain and a provisional diagnosis of acute coronary syndrome (condition which mimics a heart attack such as unstable angina) was made. According to the Patient Admission Record, Mr C's brother was his next of kin. It was also noted that Mr C had a social worker; home help; and support workers assisted twice a day. Mr C's past medical history included depression, anaemia, alcoholism, type 2 diabetes and he had a left ankle plate due to a broken ankle. Mr C was assessed as being anxious and distressed and that he needed minimal assistance with personal hygiene. It was recorded that Mr C appeared anxious at 19:40 on

28 October 2005. Mr C remained in hospital and on 31 October 2005 it is recorded '09:30 … [Mr C] is intent on leaving the ward… 10:15 has discussed his problems with both medical and nursing staff and is now feeling as though he will manage to stay on the ward'. Mr C was then transferred to Ward 39. On 1 November 2005 it was recorded '11:30 received a telephone call from x-ray. Patient is refusing to have echo [cardiograph] done. Being abusive towards staff. Doctors went down to x-ray department. Patient has not had echo and refuses to wait or get another one. ?plan if patient refusing investigation doctors will review in the afternoon. 16:35 Patient has discharged himself against medical advice. Has signed the correct forms … '.

6. Mr C complained to the Board on 11 November 2005 about the circumstances which led to him discharging himself from the Hospital. Mr C said that while he was shaving a surgical boot and other items went missing and he had to go home in his stocking soles. Mr C said he was heavily sedated at the time.

7. The Board's Chief Operating Officer (the Chief Officer) wrote to Mr C on 21 December 2005 and said that he was sorry that some items had gone missing. The Clinical Nurse Manger (the Manager) had investigated the matter but had not been able to locate the missing items. The Chief Officer said the Manager had told him that Mr C had left the ward against medical advice and was verbally abusive to staff who tried to help him. If staff had had the opportunity to plan the discharge then they would have arranged for a replacement surgical boot to be provided.

8. The Advocacy Worker subsequently wrote to the Board and said that Mr C refuted that he was abusive to staff. Mr C was anxious at the time because he had been seen by a doctor and a number of students prior to his discharge and Ward 39 staff had not explained what treatment was planned for him. Mr C has memory difficulties and needed to have information repeated to him. The Advocacy Worker said Mr C's Key Worker had been concerned that as Mr C had had a number of past admissions to the Hospital she thought that staff would be aware of Mr C's mental health history and medication. Mr C felt that staff may not have been aware of his mental health difficulties and that he would never intentionally be abusive towards staff. Mr C also maintained that his Key Worker should have been contacted to inform her that he had self discharged.

9. The Chief Officer responded on 16 February 2006 and explained that the clinical notes made reference to Mr C's attitude and that he was not willing to wait for advice.

10. The Advocacy Worker complained to the Ombudsman that Mr C felt the onus for the problems which occurred had been placed on Mr C and that he wished an apology.

11. The Adviser had some concerns that if staff had been aware that Mr C had a Key Worker then it would have been prudent to have advised her of his irregular discharge.

12. In response to my enquiry the Chief Officer told me that Mr C was in the x-ray department where he became abusive to staff and refused to have a procedure carried out. The medical staff from the ward were contacted and went down to x-ray to speak to Mr C without success. Mr C discharged himself from the ward at 16:35. The Chief Officer said that there is no record that a Key Worker was contacted or that Mr C had requested this and that the member of staff who dealt with his admission to the ward has since left the Board.

(a) Conclusion

13. Mr C believes that he was due an apology from the Board because their response to the complaint inferred that he was responsible for the incident prior to his self discharge and that staff should have done more to assist him with his lost surgical boot and contact his Key Worker. Mr C's clinical records do not indicate that Mr C reported the loss of the surgical boot to staff or that he had made staff aware that he had a Key Worker who was to be contacted on discharge. It is clear that Mr C had concerns about being in hospital and staff had already spent time with him the day prior to his discharge and persuaded him to remain in hospital for treatment. It was Mr C's decision to discharge himself from hospital and that he signed the appropriate form which set out that he accepted full responsibility for his actions. I am also conscious that Mr C discharged himself some five hours after the incident in the x-ray department rather than on immediately returning to the ward. On balance I am persuaded that staff dealt with Mr C in an appropriate manner and accordingly I do not uphold the complaint.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Advocacy Worker	The Advocacy Worker who assisted Mr C with his complaint
The Hospital	Aberdeen Royal Infirmary
The Board	Grampian NHS Board
The Adviser	The Ombudsman's professional nursing adviser
The Chief Officer	The Board's Chief Operating Officer
The Manager	The Clinical Nurse Manager