SPSO decision report

Case: **201104846, Grampian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Mrs C complained on behalf of her son (Mr A), who was admitted to hospital on a voluntary basis to try to address his obsessive-compulsive disorder (OCD - an anxiety disorder where a person has obsessive thoughts and displays compulsive behaviour). Among other things, Mr A found it very difficult to share toilet facilities with other people, including his family. He was admitted to a mixed-sex dormitory-style ward, where there were only a few single rooms with private toilets. These rooms were allocated on the basis of clinical necessity. Although at times one or more of these rooms was vacant while Mr A was on the ward he was not allocated one, despite his and his mother's requests. Mr A became dissatisfied with his care and treatment, and discharged himself against medical advice. Mrs C later complained that her son did not receive appropriate care and treatment while he was on the ward. She said that he was not allocated a single room with private facilities, so instead he used bedpans, which were not emptied frequently enough; a doctor did not listen to Mr A during a review; and, when Mr A discharged himself, he was told that he would not get his medication.

When we investigated, the board told us that they decided to place Mr A on the ward on the basis of a clinical assessment that providing him with access to private facilities would not help him address his OCD. Our investigation, which included taking independent advice from one of our medical advisers, found that this was a reasonable decision. However, the adviser considered that allowing Mr A unlimited and unsupervised access to bedpans was in fact counter-productive. We found no evidence that the disposable bedpans used were not regularly disposed of, but noted that the board also said that Mr A sometimes hid used bedpans or would only accept assistance to dispose of them from certain staff and would wait until they were on duty.

Similarly, we found no evidence that the doctor involved in the review talked over, or would not listen to, Mr A. Where versions of events differ, and without truly independent evidence to support either version, we cannot prefer one version over another. We did find evidence that Mr A was very keen to discuss certain issues, mainly to do with dissatisfaction with some staff members, but that the doctor did not pursue these. It is possible that Mr A may have perceived this as not being listened to or being talked over. On the matter of medication, a series of appointments with a psychologist had been made, the first of which was to be on the day after Mr A discharged himself. He was issued with only 24 hours worth of his regular medication, in the hope that this would encourage him to keep the appointment. Unfortunately, he did not. Our adviser considered, however, that it was reasonable to only dispense a limited amount of medication in these circumstances. There was no evidence that Mr A was refused medication or only proved with medication on condition that he signed the discharge form.

Overall, however, as we found little evidence of the type of structured, supportive and focused care plan that we would have expected to address Mr A's complex condition and behaviours, we upheld Mrs C's complaint and made recommendations to address the failings our investigation found.

Recommendations

We recommended that the board:

- provide appropriate training to enable multi-disciplinary team working to be supported by cohesive and structured care plans that are appropriately recorded in a patient's notes;
- monitor the implementation of the 'Ten essential shared capabilities for mental health practice' training to ensure that relevant rights-based and recovery-focused care is being provided; and
- apologise for the failings identifed.