SPSO decision report

Case: **201400595, Lothian NHS Board**
Sector: health
Subject: admission / discharge / transfer procedures
Outcome: not upheld, recommendations

Summary

Ms C complained about the appropriateness of her late son (Mr A)'s discharge from a clinic at the Royal Edinburgh Hospital and also the adequacy of his follow-up care and treatment in the community. Mr A had a diagnosis of schizophrenia and also had alcohol and drug problems. He died of a drug overdose five weeks after discharge. Ms C complained in particular that community psychiatric nurses (CPNs) did not get help for Mr A, or alert her, when they visited him the day before his death and found him in an intoxicated state.

We took independent medical advice from a consultant psychiatrist and a mental health nurse. We were advised that Mr A was no longer suffering from the symptoms of his mental illness at the time of discharge. It was highlighted that his hospital detention could not have been prolonged solely on account of his drug taking behaviour. The advice we received indicated that the decision to discharge was reasonable and that it followed detailed risk assessment and appropriate multi-agency planning. We therefore did not uphold this complaint.

We were also advised that an intensive package of care was arranged, with multi-agency involvement, and we therefore did not uphold Ms C's complaint that adequate support was not in place for Mr A for his return to the community. However, we were advised that all relevant paperwork was not fully completed and distributed prior to discharge and so we made some recommendations to try to prevent a similar future omission.

In relation to the actions of the CPNs the day before Mr A's death, it was noted that it was not an unusual scenario for them to find him in an intoxicated state when they visited him. We were advised that there was no evidence to suggest that the level of risk was increased on this occasion or that it represented an emergency situation. As the CPNs did not perceive the circumstances to represent an emergency situation, they were required to respect Mr A's confidentiality. We therefore did not consider there to be an unreasonable failure to involve Ms C. We concluded that there was no unreasonable act or omission on the part of the CPNs that directly contributed to Mr A's death. However, with the benefit of hindsight, we noted that there were additional steps the CPNs might have considered taking and we made a recommendation about this.

Ms C also complained that mental health and addiction services staff did not work together to support Mr A the day before, and on the day of, his death. However, we were advised that addiction services had no acute role over these particular days and we did not uphold this complaint. In terms of their longer-term role, we were advised that they were appropriately involved in Mr A's care. However, as the addiction psychiatrist appeared not to have been invited to one particular meeting, we made a recommendation about this.

Finally, as we were unable to determine that the board's incident review report contained factual inaccuracies, we did not uphold Ms C's complaint in this regard. However, we considered that a report written by one of the CPNs could have been more clearly worded and we made a recommendation about this.

Recommendations

We recommended that the board:

- take steps to ensure that Care Programme Approach documentation is brought fully up to date prior to discharge and is circulated to all relevant parties;
- remind staff to ensure that standardised documentation, such as the Discharge Checklist, is completed fully and accurately;
- consider providing field management guidance to community staff who, in the course of their duties, are likely to encounter patients significantly under the influence of harmful drugs;
- remind staff to ensure that all relevant parties are invited to attend key multi-disciplinary meetings; and
- take steps to remind nursing staff that clinical reports should be factual and unambiguous in order to ensure that the meaning is clear and in line with Nursing and Midwifery Council record-keeping guidance.