SPSO decision report

Case: **201508568, Forth Valley NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C complained to us on behalf of his constituent, Ms A. He said that on being transferred from a mental health unit outside Scotland to Forth Valley Royal Hospital, Ms A was not provided with reasonable mental health care and treatment, in particular that the diagnosis of personality disorder she had been given did not fit her symptoms. Mr C also complained that Ms A was not provided with reasonable out-patient treatment when she was discharged from the hospital, and that the board did not take reasonable steps to change incorrect information on her discharge documents.

We took independent psychiatric advice. We found that the in-patient care and treatment provided to Ms A was not reasonable. Whilst we found that the treatment strategies offered to her were appropriate, the diagnosis of personality disorder was not sufficiently evidenced and documented. We found that no valid diagnostic assessment tool was used to assess Ms A and that her diagnosis was given without sufficient consideration of her previous diagnoses. We also found that the way this diagnosis was communicated was inconsistent, sometimes being reported as a provisional diagnosis and sometimes as confirmed. We found that there was a lack of documentation surrounding decisions taken about Ms A's care, including the decision not to implement the recommendations of a clinician who gave a second opinion, not to trial certain medications and the decision to change Ms A's lead clinician. We therefore upheld this aspect of Mr C's complaint.

In terms of Ms A's out-patient mental health care and treatment, we found that it was reasonable for the staff involved to provide care on the basis of Ms A's diagnosis of personality disorder, and that out-patient care and treatment had been planned in a collaborative way with Ms A in line with treatment for personality disorders.

When considering whether the board had taken reasonable steps to remove incorrect information from Ms A's records, we saw evidence that when the board became aware of this incorrect information, they apologised and arranged for the documents to be replaced with amended versions. We also saw evidence that they took steps to ensure all incorrect electronic records were amended. We considered the steps the board took to have been reasonable in this regard.

Recommendations

We recommended that the board:

- apologise to Ms A for the failings identified in this investigation;
- remind relevant staff of the caution advised when assessing personality disorder traits in patients with prominent mood or anxiety symptoms;
- consider using a valid diagnostic assessment tool (not just a screening tool) to aid diagnosis and formulation of personality disorders;
- remind the relevant staff of the importance of being clear and consistent in documenting any diagnoses and whether such diagnoses are provisional or confirmed;
- remind the relevant staff of the importance of, in cases where clinicians have sought second opinions, the

recommendations made being fully considered before being implemented, and, if not implemented, the reasons why not being clearly documented and explained to the patient;

- remind the relevant staff of the importance of ensuring prescribed medication is regularly reviewed; and
- remind the relevant staff of the importance of documenting changes of responsible medical officer or consultant psychiatrist, and the reasons for these changes.