SPSO decision report

Case: **201604133, Fife NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained that the board unreasonably made changes to the arrangements for her to see the board's community psychiatric nursing (CPN) service. She said that her appointments with the CPN service had been changed from weekly to once every three weeks and that the appointments were held in a hospital rather than at her home. We took independent advice from a mental health nurse. We found that the board did not adequately listen to Ms C and did not take her views into account when it was decided to make these changes to her appointments. We upheld this aspect of Ms C's complaint.

Ms C also complained about the care she had received from the CPN service. We also took independent advice from a mental health nurse on this aspect of the complaint. We found that the care Ms C had received had not been of a reasonable standard. Ms C said that she had left messages on the service's answer machine, but that no one had called her back. The board's response to Ms C's complaint referred to restrictions in relation to the frequency of her phone calls, but there was no care plan or documentation within the case notes that outlined what these restrictions should be. We found that a care plan or protocol should have been in place to manage phone communication with Ms C, which could then have been followed by any member of staff. We also found that the board had failed to respond to correspondence from Ms C's GP and had failed to keep the GP adequately informed about her care. In light of these failings, we upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for not adequately listening to her and for not taking into account her views when it was decided to change her CPN appointment arrangements. Also apologise for the failings in CPN care and treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.
- Arrange a discussion with Ms C about her needs and wishes. A care plan should be created which reflects these. A mutually suitable location for visits should also be agreed between Ms C and a member of the CPN team. If Ms C does not wish to engage with this process, a care plan should still be created to guide the interventions of the team and this should be shared with Ms C.
- The care plan referred to above should be put in place and within it there should be:
- risk assessments
- agreements on phone use and any limitations around this
- what can reasonably be expected in terms of return of any messages left for staff to ensure no misunderstanding
- the frequency and location of visits
- identification of goals
- any psychological therapies.

What we said should change to put things right in future:

- To ensure that care is provided to a reasonable standard, the pathway and available interventions for people with Ms C's conditions should be reasonable, evidence-based and appropriate. The board should ensure that staff are implementing them appropriately.
- To ensure that care is provided to a reasonable standard, the arrangements for clinical and case load supervision of CPNs should be adequate and should enable staff to reflect upon their performance and discuss individual cases in depth.
- There should be regular and timely communication of any changes to care to relevant GPs and other health care providers who are part of the wider multi-disciplinary team.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.