SPSO decision report

Case: **201700463, Lothian NHS Board - Acute Division**
Sector: health
Subject: nurses / nursing care
Decision: upheld, recommendations

Summary

Ms C complained to us about the care and treatment her mother (Mrs A) had received after she was admitted to St John's Hospital with bipolar disorder (a mental health condition marked by alternating periods of elation and depression).

Ms C complained about a number of issues in relation to the nursing care provided to Mrs A. We took independent advice from a mental health nurse. We found that it had been unreasonable for nursing staff to allow Mrs A off the ward without an escort. Although Mrs A came to no harm, her safety and wellbeing were placed at undue risk as a result of this. We also found that, despite it being known that Mrs A had medication compliance issues, there was no evidence in the records of a coherent care plan designed to promote her compliance with oral medication. Neither her care needs nor her nursing care had been effectively planned or kept under review. Care plans in the records were dated four weeks after Mrs A had been admitted to hospital and we found that the manner in which the documentation had been used and completed was ineffective and unreasonable. In view of these failings, we upheld Ms C's complaint about the nursing care provided to Mrs A.

Ms C also complained about a number of aspects of the psychiatric and medical treatment Mrs A received in the hospital. We took independent advice on these issues from a psychiatric consultant. We found that there had been a delay in actioning Mrs A's electrocardiograph (ECG - a test that records the electrical activity of the heart) results and that the consultant psychiatrist had failed to make themselves aware of these results. We also found that it was unreasonable that specialist cardiology advice was not sought and that anti-psychotic drugs were prescribed to Mrs A without attention being paid to the cardiac risks or guidance being given to staff that she should be closely monitored after taking these. In addition, Mrs A received two anti-psychotic drugs at the same time, when the intention had been for staff to give Mrs A either one or the other. We also received advice that an alert should be put on Mrs A's records regarding one of the anti-psychotic drugs. We further found that the frequency of consultant review over a period of ten days had been unreasonable as adequate staff cover was not in place. Whilst it had not been unreasonable to start the application process for a compulsory treatment order for Mrs A, it was unreasonable that this had been done without a medical examination being carried out. We also found that staff failed to give Mrs A vitamin replacements that had been agreed. In view of these failings, we upheld Ms C's complaint about the psychiatric and medical treatment provided to Mrs A.

Finally, Ms C complained that the board had failed to provide a reasonable response to her complaint. We found that the board's response to her had not been reasonable, particularly that they had not informed Ms C of the outcome of their investigation into her complaints about staff behaviour. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to provide nursing care and psychiatric and medical treatment to Mrs A, and for failing to provide a reasonable response to Ms C's complaint. The apology should meet the standards

set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.
- Consider putting an alert on Mrs A's records that she should not be prescribed one of the anti-psychotic medications in future.
- Inform both Ms C and us of the outcome of their investigation into Ms C's complaints about staff behaviour in relation to Mrs A's case.

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

- Relevant staff should be fully aware of their responsibilities in relation to the application of Nurses Holding Power under the Mental Health Act.
- Template documentation introduced to ensure the quality of record-keeping should be completed in full and as intended in order that nursing care, including medication compliance, is effectively planned, documented and kept under systematic review.
- Robust systems should be in place to ensure the results of medical investigations are accessed, recorded, considered and actioned in good time.
- Prescribing clinicians should be aware of the accepted prescribing guidance, especially with regard to the use of higher risk medications (such as some anti-psychotics) in vulnerable patient groups (such as the elderly) and there should be adequate processes in place for the physical monitoring of patients when such medications are administered.
- There should be adeqaute arrangements in place to cover medical staff's leave to ensure that all reasonable requests by patients and carers for consultant review are met.
- Staff prescribing medication should ensure that they provide appropriate guidance on when and how the medication is to be given.
- All staff taking decisions under the Mental Health Act should have due regard to the principles of the Act, as they are required to do, and adequate records should be made of these decisions and the rationale for reaching them.
- Patients should be given vitamin replacements where this has been previously agreed and there is no clinical reason not to give it.

In relation to complaints handling, we recommended:

- Complaints should be investigated appropriately.

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.