SPSO decision report

Case: **201802643, Borders NHS Board**
Sector: Health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment their relative (A) received from the board; in particular, about the mental health care they received at Borders General Hospital following an impulsive overdose and their subsequent community health care.

The board's investigation found that A's care and treatment was appropriate and timely. However, the board suggested exploring possible improvements in information sharing between public and private sector professionals.

We took independent advice from a consultant psychiatrist and a mental health adviser. We found that the hospital care and treatment, including changes to A's medication were reasonable and appropriate. We considered that there was a shortcoming in care as there was no follow-up out-patient hospital appointment after the discharge from hospital to assess A, despite a significant change in their medication and a new diagnosis. However, we did not consider this was an unreasonable failing given there was a plan for care by community psychiatric nursing who would have had access to psychiatric advice as and when required. We did not uphold this complaint.

In terms of the community mental health care, we were critical that A did not receive a face-to-face assessment even though multiple concerns were raised by various individuals about A's deteriorating behaviour; and particularly given A had not made themselves available to be seen. For this reason, we upheld this complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to A for failing to carry out a face-to-face assessment following concerns that were raised by multiple individuals. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

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

- Patients with Community Mental Health Team follow-up who show evidence of a significant deterioration in mental state or social circumstances, or where a significant deterioration in mental state is indicated by the expressed concerns of family or significant others, consideration should be given to having a face-to-face review and screening for presenting clinical risks/vulnerabilities.

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.