SPSO decision report

Case: **201803447, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained on behalf of their sibling (A) following A's contact with a health board's mental health service when they were in crisis. C was concerned about the standard of care and treatment provided to A. C's concerns were wide-ranging and covered numerous aspects of the provision of care and treatment. C said this included repeated, unreasonable, failures by staff to recognise and diagnose A with psychosis and paranoia, to prescribe appropriate medication, to communicate adequately with A or their family or both, adequately supervise A, to agree a care plan and put in place appropriate discharge care, and to admit A as an in-patient at each emergency department attendance.

We took independent advice from a consultant psychiatrist and from a mental health nurse. We found that the diagnosis was appropriately assessed and reasonable conclusions reached on management and treatment of A. However, we also noted some concerns about aspects of communication with A and their family and found significant shortcomings in relation to record-keeping about a discharge from one hospital admission in particular. We upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failings identified in this investigation. 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:

- Ensure relevant clinical staff at Wishaw General Hospital are aware of their responsibility to document patient management decisions in relation to General Medical Council Good Medical Practice Guidelines.

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.