SPSO decision report

Case: **201910080, Highland NHS Board**
Sector: Health
Subject: Clinical treatment / Diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment that their adult child (A) received from the board over a two year period. A had previously suffered an acquired brain injury and since then had developed obsessive compulsive disorder, post-traumatic stress disorder and anxiety, as well as experiencing delusional thinking and periods of psychosis (a mental disorder in which thought and emotions are so impaired that contact is lost with external reality). C raised a number of concerns, including that the board claimed A was reviewed regularly when they were not, that no psychological support was provided for A, that there was a lack of support from the local mental health team, that there was no clear local treatment plan and that in the care programme approach, needs identified were not met, matters were not escalated and no solution was found.

We took independent advice from a consultant psychiatrist (a medical practitioner specialising in the diagnosis and treatment of mental illness). We found that A's records showed that they received regular reviews during the period in question and that the letters on these showed a high level of clinical input. However, the evidence showed that there was a delay of over five months from the date of A's discharge from psychiatric hospital and the issuing of the discharge letter, which we found was unreasonable and, for a patient with less clinical/multi-professional input and family interaction, would likely have resulted in significant clinical risk.

We found that the overall level of support A received was reasonable. However, we found that there was a lack of focus by the board on the organic elements of A's presentation and how these may have contributed to their psychosis and we were critical of the board's failure to utilise locally available specialist advice which resulted in a lack of psychology and neuropsychiatric input in A's case. We found that these failings were significant and, on balance, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C and A for failing to focus on the organic elements of A's presentation and failing to utilise locally available specialist advice on psychology and neuropsychiatry in A's case. 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:

- In cases such as this, the board should consider organic elements of patients' presentations and utilise locally available specialist advice on psychology and neuropsychiatry.
- The board's patient discharge letters should be issued in a timely fashion.

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.