Scottish Parliament Region: North East Scotland

Case 200502096: Grampian NHS Board

Summary of Investigation

Category

Health: Community Psychiatric Services

Overview

The complainant (Mr C) raised a number of concerns regarding the treatment provided to his wife (Mrs C) by the Mental Health Directorate.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mrs C should have been assessed by a Community Psychiatric Nurse (CPN) (*not upheld*);

(b) the care/treatment package provided to Mrs C was inadequate (*not upheld*); and

(c) the Consultant failed to take appropriate action when Mr C pointed out errors in a letter which was copied to Mrs C's GP (*not upheld*).

Redress and recommendations

The Ombudsman has no recommendations to make.

Main Investigation Report

Introduction

1. On 30 January 2006 the Ombudsman received a complaint from Mr C about the treatment his wife (Mrs C) received from the Community Mental Health Team (CMHT) which is part of the Adult Mental Health Directorate of Grampian NHS Board (the Board) in 2005. Mr C complained that his wife had not been assessed by a CPN; an inadequate care package had been put in place and that the Consultant failed to take appropriate action when Mr C pointed out errors in a letter which was copied to Mrs C's GP.

2. The complaints from Mr C which I have investigated are that:

(a) Mrs C should have been assessed by a Community Psychiatric Nurse (CPN);

(b) the care/treatment package provided to Mrs C was inadequate; and

(c) the Consultant failed to take appropriate action when Mr C pointed out errors in a letter which was copied to Mrs C's GP.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and complaints correspondence between Mr C and the Board. I obtained advice from one of the Ombudsman's professional advisers, who is a consultant psychiatrist (the Adviser), on the clinical aspects of this complaint.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mr C and the Board were given an opportunity to comment on a draft of this report.

Background

5. On 3 November 2004, Mrs C's GP referred her urgently to the CMHT for assessment as Mrs C had recently lost her mother and amongst other things had trouble sleeping. Mrs C's case was discussed at a CMHT meeting on 9 November 2004. As a result of the meeting, Mrs C received a home visit on 11 November 2004 from a member of the CMHT (Officer 1) who prepared an initial report and planned to make a further visit. Both Mr and Mrs C attended a meeting with a Consultant Psychiatrist (the Consultant) on 23 November 2004. On 7 December 2004, Mrs C telephoned the CMHT and said she was happy for Officer 1 to visit. The case had been discussed at a CMHT meeting on

6 December 2004 and it was decided that either another member of the CMHT or a CPN could visit Mrs C. However Social Worker and member of the CMHT (Officer 2), saw Mrs C on 20 December 2004, 5 January 2005 and 27 January 2005. Officer 2 sent a progress report to the Consultant for his next meeting with Mrs C.

6. Mrs C saw the Consultant again on 3 March 2005. Mrs C told the Consultant that she had been showing symptoms which she had been told by other doctors were attributed to the medication which the Consultant had prescribed. It was decided to reduce some of the medication and that Mrs C would remain on his patient list for three or four months in case of a relapse but no review appointments would be sent out in the meantime. On 31 March 2005, Officer 2 wrote to the Consultant and explained that she had been in touch with Mrs C and had been told that she no longer wished to receive treatment from the CMHT. Officer 2 wrote to Mrs C to enquire whether Mrs C would consider bereavement counselling. On 13 July 2005 the Consultant discharged Mrs C as a patient from the CMHT. The Consultant wrote to Mrs C on 14 July 2005 with a detailed explanation of why he considered that it was inappropriate for her to remain on the CMHT patient list. The letter was copied to Mrs C's GP.

(a) Mrs C should have been assessed by a Community Psychiatric Nurse (CPN)

7. Mr C complained to the Board that the first contact from the CMHT was the home visit from Officer 1. Officer 1 had described herself as a member of the Psychiatrist's team and that she had experience in bereavement counselling. Mrs C only found out when Officer 1 was leaving that she was a Social Worker and not a CPN, as she had expected, and after she had explained her past medical history to her. Mr C felt that Mrs C should have had clinical care rather than social work care and that she should have been assessed by a CPN.

8. The Board's Chief Operating Officer (the Chief Officer) responded to the complaint. He said that in most cases referrals to the Psychiatric Service go to the CMHT rather than to individual professionals. Referrals are discussed at team meetings and allocated to the professional who seemed the most appropriate. In view of the fact that Mrs C's problems appeared to have been precipitated by bereavement it was felt appropriate that Officer 1 should see her in the first instance. The Chief Officer continued that although Social Work staff

are employed by local authorities, they are fully integrated members of the Mental Health Teams. He added that Social Workers' professional standards are no less stringent than those of NHS employees.

9. The Adviser said that he believed that Mrs C received a reasonable service. The GP's referral letter was dealt with in the conventional way by a discussion at the team meeting, and allocated to an appropriate team member, Officer 1, who had particular experience in bereavement work. She happened to be a Social Worker, and this is not uncommon. There is no indication in the referral letter that the opinion of a consultant or any other specific professional person was required. Officer 1 made a good assessment and wrote a good letter to the Consultant. Two weeks later the Consultant saw both Mr and Mrs C, and again produced a thorough assessment and a very long and detailed letter. His diagnosis and management proposals were reasonable. Another Social Worker, Officer 2, was by this time visiting and it was proposed that the Consultant would see Mrs C in just over two months time, but his appointment was unavoidably postponed for a further month. At this time a note was made asking for a CPN to visit, but this did not happen due to conflicting demands on the service and it was decided that Officer 2 should make a visit. The Adviser said that it might have been helpful to have had a further opinion from a CPN, but he did not think that CPN involvement was crucial given that Officer 2 was seeing Mrs C, and able to communicate with the Consultant.

(a) Conclusion

10. Mr C complained that Mrs C should have been assessed by a CPN rather than non-clinical staff. The advice which I have received and accept is that while there might have been a benefit in a CPN involvement it was not crucial to Mrs C's treatment. Mrs C had been assessed by Officers 1 and 2 who provided appropriate information to the Consultant which assisted him to make a diagnosis of Mrs C's condition and plan her continuing treatment. I note that CPN involvement was planned but did not materialise due to pressures on the service at that time and that appropriate apologies have been provided. I am satisfied that Mrs C's care and treatment was not compromised by the lack of CPN involvement and that the service provided by the CMHT was appropriate. Accordingly I do not uphold this aspect of the complaint.

(b) The care/treatment package provided to Mrs C was inadequate

11. Mr C complained that the Consultant had diagnosed in November 2004 that Mrs C had Bi-Polar 2 disorder. Mrs C was prescribed mood stabilisers and anti-psychotic drugs and would be seen at a later date. However, if there were any problems she could speak to the Consultant's secretary (the Secretary) or the person making a house call (i.e. CPN or social worker). Mr C said the Consultant appeared confident and explained that the drugs could cause potential side effects. Over the next two months, Mrs C suffered a drastic change in her physical health as she suffered extreme tiredness, lethargy, water retention, constipation, vaginal thrush and severe and continual bouts of vomiting. Mrs C continued taking her medication and her GP tried to manage the side effects which included hospital and on call treatment. Mr C said that when Officer 2 visited in January 2005 he told her that Mrs C had had suicidal thoughts and it was imperative her medication be reviewed or supplemented with anti-depressants. Officer 2 then contacted the Secretary and she telephoned Mr and Mrs C later that day to tell them that the Consultant was faxing a prescription for anti-depressants and to be careful about manic side effects.

12. Mr C said that the next scheduled meeting with the Consultant was not brought forward and in fact did not take place until March 2005 because the Consultant had also suffered a bereavement. At that consultation, Mr C said the Consultant was concerned that Mrs C had experienced an idiosyncratic effect from the medication and that she should stop taking Olanzapine immediately and to reduce the Carbomazapine (medications used in the treatment of manic depression). The Consultant then explained the new drug regime (Lithium) and set out the purpose and side effects. Over the next few days Mr and Mrs C reflected on the consultation, the lack of improvement in Mrs C's condition and the side effects of the medication. They decided that it might be better not to start the new medication and stop the mood stabilisers. Mr C telephoned the Secretary to see if there were alternatives to Lithium. The Consultant telephoned Mrs C a few days later and it was agreed they would take 'time out' and that the situation would be reviewed in July 2005. The Consultant told Mrs C she would still be under his care and could seek help if required. It was accepted that the Consultant gave advice about taking low doses of Carbomazapine but Mrs C declined in view of the side effects. Mrs C was then contacted by Officer 2 in June 2005 and she was told that Officer 2 would ask the Consultant if Mrs C would be suitable for Psychotherapy in view

of her continued mental health problems. Officer 2 then posted out some literature from the organisation Cruse.

13. Mr C said that Mrs C then telephoned the Secretary to see if she could assist and there was a discussion about psychological help and whether Mrs C could have medication to help her sleep at night. The Secretary suggested that Mrs C should contact her GP. The Secretary also enquired what Mrs C wanted to do about remaining on the CMHT list as the Consultant had stated if Mrs C would not continue with a mood stabiliser regime then there was nothing else he could do. Mr C had indicated his wife was not thinking straight and she said if nothing else could be done then she might as well come off the patient list. Mr C was angered to learn that the CMHT were not considering further treatment options and he and his wife again spoke to the Secretary. The following day they were told by the Secretary that the Consultant had typed a letter himself and that they would receive it soon. The letter duly arrived and it said that as Mrs C no longer wished to take a mood stabiliser there would be no benefit in continuing with members of the CMHT as their role would be to supervise the commencement of an alternative mood stabiliser regime. Mr C felt that the letter intimated that medication was a requirement or else no other concurrent treatment would be considered. Mr C thought his wife had been isolated from care because of her ability to judge rationally about benefits versus side effects. Mr C felt the Consultant failed to monitor Mrs C's care effectively. The Consultant had made a diagnosis and prescribed strong medication without putting in place an adequate support package (Officer 2's lack of medical knowledge); he had left Mrs C for three months without a follow-up and this had affected Mrs C's physical health and caused the family great distress. Mr C felt that had Mrs C been treated by clinical team members then they could have managed the mood levellers in a better manner.

14. The Chief Officer responded that the Consultant had commenced Mrs C on low doses of mood stabiliser medications. He had provided written information about side effects and of the importance of seeking medical attention should these become troublesome. He had not been made aware that Mrs C was having problems with side effects until he saw Mrs C on 3 March 2005. Prior to this he had been advised by Officer 2 that Mrs C had become depressed and had obsessive thoughts about death. The Consultant arranged for a prescription of anti-depressants and asked the Secretary to make an earlier appointment for him to see Mrs C. He also arranged for a CPN to visit (Note: the CPN did not actually visit because of conflicting demands on

the service and it was decided that Officer 2 should make the visit). The Consultant was told in February 2005 that Mrs C was feeling better and he advised that the anti-depressant be increased. The Chief Officer continued that the Consultant expressed sympathy with Mrs C on 3 March 2005 about the side effects of the medication and advised that she should continue with the Olanzapine only if required and to discontinue the Carbamezapine.

15. The Chief Officer said the Consultant informed him that Mrs C said at the appointment on 3 March 2005 that she did not wish further appointments with him or any other members of the CMHT. The Consultant agreed to keep her case open for three or four months. The Consultant then received a telephone message on 12 July 2005 from Mrs C who stated that she had been doing well in the previous months and that she did not wish to recommence medication. Mrs C had also said that she would remain in contact with her GP. Mrs C also understood that should she become unwell in the future then she could go back to her GP and seek referral to the Psychiatric Service. The Chief Officer had been assured by the Consultant that he had explained to Mr and Mrs C the importance of mood stabiliser medication on several occasions. The Chief Officer said it was quite correct that mental health care should involve more than medication. Mrs C had been offered contact with two mental health practitioners (Officer 1 and Officer 2) who were able to offer non-medical care. Both these practitioners have specialist training and expertise in mental health care.

16. The Chief Officer continued that the Consultant acknowledged that Mrs C did go for three months without a follow-up appointment. This was caused partly by the fact that the Consultant himself suffered a bereavement. However, he felt adequate provision had been made by providing written information for any side effects from the medication to be picked up and managed by Mrs C's GP. The Consultant would have been more than willing to provide assistance but he was not informed that Mrs C was experiencing problems. In addition the various members of the Consultant's team are able to review his patients between appointments. The Consultant still felt that Mrs C would benefit from a mood stabiliser. There are alternatives available which might achieve the desired effect without significant side effects. The Consultant had acknowledged that there is a place for psychotherapy in the absence of medication although, in his opinion, the absence of medication would reduce any benefits.

17. The Adviser commented about whether Mrs C should have been referred for psychotherapy in March 2005. He said psychotherapy broadly encompasses a great range of psychological treatments, and bereavement counselling might well be considered to come under this heading. On the other hand, psychotherapy may be used in a strict sense for a clearly defined programme of treatment following some theoretical model, such a cognitive behavioural therapy. The Adviser did not believe that this specialised psychotherapy should have been proposed for Mrs C in March 2005. On the other hand, supportive psychotherapy or specific bereavement counselling were proposed, and considered many times, by Officer 1, by the Consultant on his first consultation, by Officer 2, and when Mrs C saw the Consultant on 3 March 2005. However, Mrs C told him that she did not want any more appointments with him or his team. This obviously excluded what psychotherapy broadly considered could be provided by them. Then, in June 2005, Officer 2 sent Cruse material (Cruse is a charity which offers help to bereaved people) to Mrs C in case she now wanted to pursue this line of action. The Adviser noted that as the complaint progressed the Board's Associate Medical Director (the Director) prepared the way for a possible specialist psychotherapy referral by the GP. This would not have been suitable at an earlier stage, because of the temporary disturbance caused by Mrs C's bereavement. Overall, the Adviser felt that the management of this case by the Consultant and the CMHT was reasonable, except for the lost referral to the CPN, which has been apologised for, and which the Adviser believed would not have made any difference to treatment.

(b) Conclusion

18. Mr C complained that the care package provided by the CMHT to Mrs C was inadequate and that the Consultant should have monitored Mrs C more closely. The advice which I have received and accept is that the management of Mrs C by the CMHT was appropriate in that members of the CMHT were in contact with Mrs C and that she was advised to discuss any concerns with her GP. It should be noted that CMHTs consist of multi-disciplinary team members whose backgrounds are clinical and non-clinical. While the Consultant remained responsible for Mrs C's overall care and treatment he had to rely on other team members to provide him with information so that an appropriate care plan could be put in place. I am also conscious that Mrs C intimated that she did not wish to continue with CMHT involvement and that she was prepared to deal with her concerns herself and to communicate with her GP if she needed additional support. I have also taken into account that there was a delay in the

review appointment by the Consultant due to unforeseen circumstances, however, this did not mean that Mrs C did not have access to other members of the CMHT if she so wished. Accordingly I do not uphold this aspect of the complaint.

(c) the Consultant failed to take appropriate action when Mr C pointed out errors in a letter which was copied to Mrs C's GP

Guidance

19. In April 2005 Health Rights Information Scotland produced an information leaflet relating to *'How to see your Health Records'* on behalf of the Scottish Executive Health Department. The information applies to all Health Boards in Scotland. The leaflet states:

> If you think information in your records is incorrect, first talk to a member of NHS staff providing your care. What will be done depends on whether or not NHS staff decide the information is correct.
>
> - If they decide that the information is incorrect they will score through it so that people can still read the information but can see that it has been corrected. They will also attach a note to your records explaining why the information has been scored out.
> - If they decide that the information is correct, they will not change it. However, you can choose to have a note attached to your records explaining why you think the information is incorrect.

20. Mr C complained that the letter from the Consultant dated 14 July 2005 was incorrect in that the Consultant believed Mrs C had made the complaint where in fact it was Mr C. Mr C felt the letter caused more anguish for Mrs C and should be removed from her medical records and an apology issued with a copy going to the GP. Mr C felt it was clear from his letter that he was making the complaint. He thought that if the letter remained on Mrs C's clinical records it could lead a clinician in the future to assume that Mrs C's symptoms were psychosomatic. In further correspondence with the Board, Mr C said that the letter would have a major impact on Mrs C's future health care and was akin to libel and that Mrs C had not made the complaint.

21. The Chief Officer responded that the Consultant did not believe his letter was ill-advised and was an attempt on his part to set out in a polite manner the importance of medication. In further correspondence the Director said he had spoken to the Consultant who had produced a note of a conversation in which he had recorded Mrs C expressed some dissatisfaction with the treatment she

had received but it was acknowledged that the main impetus for the complaint was from Mr C. The Director gave an assurance that a copy of the correspondence would be kept in Mrs C's case notes so that anyone who reads them in the future is made aware of Mr and Mrs C's interpretation of events.

22. The Adviser told me that in his opinion the letter was reasonable. It is firm, and explains why the Consultant acted as he did. The letter offers some explanations also for Mrs C's own behaviour, in terms of the illness that the Consultant believed her to be suffering from. Mr C also insisted that it was he that complained and not his wife, but there is evidence that his wife had also expressed dissatisfaction, as set out in the letter. The Adviser thought that the proposal to retain the letter in the records and place Mr C's version alongside was reasonable.

(c) Conclusion

23. Mr C felt aggrieved that the letter from the Consultant which was copied to Mrs C's GP would remain in Mrs C's clinical records and could, in the future, lead a clinician to believe that Mrs C was psychosomatic and give the impression that it was Mrs C who had made a complaint. The Board have acknowledged that the main impetus for the complaint came from Mr C although it is recorded that Mrs C had expressed some dissatisfaction with her treatment. The Board had offered to place Mr C's correspondence alongside the Consultant's letter in the clinical records so that both versions would be available for clinicians to consider in the future.

24. The guidance referred to in paragraph 19 clearly sets out the action to be taken when there is a disputed entry in the clinical records. I am satisfied that the Board have acted in accordance with the guidance and, therefore, I do not uphold this aspect of the complaint.

27 March 2007

Annex 1

Explanation of abbreviations used

Mr C	The complainant
Mrs C	The complainant's wife
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
The Board	Grampian NHS Board
The Adviser	The Ombudsman's professional medical adviser
Officer 1	A member of the CMHT who prepared an initial report
The Consultant	The consultant psychiatrist responsible for Mrs C's treatment
Officer 2	Social worker and member of CMHT who first saw Mrs C on 20 December 2004
The Secretary	The Consultant's secretary
The Chief Officer	The Board's chief operating officer
The Director	The Board's Associate Medical Director
Cruse	National Charity set up to help bereaved persons