Scottish Parliament Region: Mid Scotland and Fife

Case 200602930: Forth Valley NHS Board

Summary of Investigation

Category

Health: Mental Health Services

Overview

The complainant Mrs C raised a number of concerns about the care and treatment provided to her daughter (Ms A) who had mental health problems. Ms A's treatment was provided by Clinical Psychologists and was then transferred to a Community Psychiatric Nurse.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Ms A's treatment from the Clinical Psychologists was withdrawn inappropriately (*not upheld*); and

(b) explanations provided to Mrs C and Ms A were inadequate (*upheld*).

Redress and recommendations

The Ombudsman recommends that Forth Valley NHS Board (the Board):

(i) apologise to Mrs C and Ms A for the failures identified in this report;

(ii) remind staff that clinical decisions should be documented and of the importance of doing this; and

(iii) remind staff that adequate explanations of clinical decisions need to be provided to patients.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Ms A's GP diagnosed her with depression in August 2003. The following year her GP referred her to Clackmannan County Hospital (the Hospital) where Ms A was treated until her discharge in December 2006. In November 2006 Mrs C wrote to the Board asking for an explanation of her daughter's care. The Board's Director of Nursing (the Director) responded but Mrs C remained dissatisfied and on 10 January 2007 she complained to the Ombudsman.

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

(a) Ms A's treatment from the Clinical Psychologists was withdrawn inappropriately; and

(b) explanations provided to Mrs C and Ms A were inadequate.

Investigation

3. In order to investigate this complaint I have had access to Ms A's clinical health records and the correspondence relating to the complaint. I have received advice from the Ombudsman's professional medical adviser who is a Consultant Psychiatrist (the Adviser). An explanation of the abbreviations used in this report is contained in Annex 1 and a glossary of terms is in Annex 2. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

4. Adult Mental Health Services within the Board area are located within the Clackmannanshire Community Health Partnership. There are three Community Mental Health Teams which include Consultant Psychiatrists, Community Psychiatric Nurses, Psychologists, Occupational Therapists and Art Therapists.

(a) Ms A's treatment from the Clinical Psychologists was withdrawn inappropriately

5. Mrs C said that events, including the premature death of Ms A's father, had affected her to the extent that on 4 August 2003, when Ms A was 25 years old, her GP diagnosed her as suffering from depression. Several months later her GP referred her to the Hospital where she was initially treated by a community psychiatric nurse (CPN 1) but Mrs C said that there was no improvement. In December 2004 a consultant psychiatrist (the Consultant) accordingly referred Ms A to a clinical psychologist (the Psychologist) who met

with Ms A regularly until the Psychologist went on maternity leave in February 2006 at which time Ms A's care was transferred to an assistant clinical psychologist (the Assistant Psychologist). Mrs C said that Ms A was making slow but steady progress with the support of the Psychologist and the Assistant Psychologist.

6. The Assistant Psychologist left the Board area in July 2006 and following this a letter arrived to say that a community psychiatric nurse (CPN 2) would visit Ms A on 21 August 2006. At that visit Mrs C said that CPN 2 told Ms A that she would not be able to see another clinical psychologist and her care had been transferred to CPN 2. Mrs C said that CPN 2 said that she was unable to continue with the work begun with the psychologists and required Ms A to begin again using similar material to that used by CPN 1 who had treated Ms A previously. Mrs C said that once Ms A was aware that she was unable to continue the programme she had embarked upon with the psychologists she began to deteriorate. She suffered an increase in panic attacks and her medication required to be increased in an effort to control them, her eating disorder became worse as did her obsessional behaviour and anxiety. She was reluctant to venture out alone and her self harming had increased. Ms A's physical condition had also worsened with skin, bowel and stomach complaints as well as lethargy and poor motivation. Mrs C said that on 13 November 2006 Ms A asked CPN 2 about being referred back to a clinical psychologist but CPN 2 told her that she may have to wait for two years for an appointment. Mrs C wrote to the Board on 15 November 2006. She said that she was concerned that her daughter would become suicidal as she had no self esteem and considered this to be confirmation that she was not worthy of treatment. Mrs C also said that there was no formal discharge letter discharging her daughter from the care of the psychologists.

7. The Director wrote to Mrs C on 18 December 2006. She said that Ms A had accepted input from CPN 2 with whom Ms A had remained until her recent discharge. CPN 2 said that that Ms A was not prepared to work with her and wished only to be seen by a clinical psychologist. Ms A's GP had referred her to a clinical psychologist at Stirling University. The Director said that waiting time was based on clinical need and was regularly reviewed. Ms A had been placed on the waiting list but might indeed have to wait two years to be seen.[1]

[1] Subsequently waiting times were reduced and Ms A started to see a clinical psychologist in September 2007.

8. In a letter dictated on 22 December 2006 and typed on 3 January 2007 CPN 2 wrote to Ms A. She said that she understood that Ms A had been referred to the Psychology Department at Falkirk Royal Infirmary. (This was in response to a referral made by Ms A's GP.) In view of this the decision had been made to discharge her from the Community Mental Health Team.

9. In response to my enquiries the Board's Chief Executive (the Chief Executive) said that the consultant clinical psychologist responsible for the Community Mental Health Team (the Consultant Psychologist) had responded that as far as she was aware Ms A knew that the Assistant Psychologist's post was time limited as this had been discussed with her at the changeover from the Psychologist. The decision about who would see Ms A next would be based on progress made and what would be the most appropriate treatment.

10. The Chief Executive told me that it had been decided that the work done by the Assistant Psychologist could be done by many of the team members, and did not require the skills of a consultant clinical psychologist. The Assistant Psychologist had a degree in psychology and whilst being very competent was not trained and qualified as a clinical psychologist. Most, if not all, of the team members were as qualified and more experienced. The Chief Executive said that the decision for Ms A not to be seen by a clinical psychologist was a clinical one and made at a multi-disciplinary team meeting.

11. The Adviser who reviewed Ms A's clinical notes and the complaint correspondence said it appeared from the Chief Executive's response that the team felt that Ms A did not need the particular skills of a psychologist, and that she could be managed and helped by another experienced team member, such as a CPN, to whom they allocated her. The Adviser commented that there was no note of the meeting when the decision was made or the reasons for the decision in the clinical notes and he was critical of this. However, CPN 2 had subsequently recorded that she had been asked to take on the case by the Consultant Psychologist. While it appeared from this that the Consultant Psychologist had been aware of the decision and had requested CPN involvement, the Adviser said that this was not a record of the decision itself. He went on to say that the decision was the Consultant Psychologist's responsibility in consultation with the other members of the community mental health team and it should be properly recorded.

12. The Adviser said that hierarchical desensitization which the psychologists were following with Ms A is behavioural therapy which any modern CPN would be able to do with advice from a psychologist if necessary. CPN 2 notes that she was asked to see Ms A by the Consultant Psychologist 'for graded exposure programme and to monitor her mental state … she is using a hierarchical chart which she finds helpful … Ms A agreed to participate in the graded exposure programme'. The Adviser said it appears, therefore, that similar treatment was intended but Ms A would simply not accept a CPN rather than a psychologist and the proposed treatment was barely started as Ms A cancelled subsequent appointments. The Adviser also said that as Ms A was passed from one member of the team to another, albeit from a psychologist to a CPN, a discharge letter would not be necessary in those circumstances. Overall, he considered Ms A's management was reasonable.

(a) Conclusion

13. I can understand that Mrs C was concerned when her daughter appeared to be getting worse following her transfer to CPN 2. I can also understand that given Ms A's care had already been transferred to an Assistant Clinical Psychologist she would be concerned about any further transfers. However, it is clear from the advice I have received that similar treatment to the treatment which Ms A was receiving was intended to be followed by CPN 2. The Adviser said he did not consider Ms A's transfer to CPN 2 to be inappropriate. He also said that a discharge letter was not necessary in those circumstances. While I can appreciate Mrs C's concern that Ms A might have to wait two years to be referred back to a clinical psychologist the Board have confirmed during the course of the investigation that the waiting time has been reduced and Ms A started to see a clinical psychologist in September 2007. Overall, the Adviser considered Ms A's management was reasonable and having considered the matter carefully I have decided not to uphold this complaint. However, I am concerned that the decision to transfer Ms A's care to CPN 2 and the reasons for it were not recorded and the Ombudsman has the following recommendation to make.

(a) Recommendation

14. The Ombudsman recommends that the Board remind staff that clinical decisions should be documented and the importance of doing this.

(b) Explanations provided to Mrs C and Ms A were inadequate

15. Mrs C said that when the Assistant Psychologist left the Assistant Psychologist told Ms A that her care would be transferred back to the Psychologist when the Psychologist returned from maternity leave or to another clinical psychologist until then. Mrs C and Ms A had been unaware of the decision to transfer her care to CPN 2 until her visit on 21 August 2006. Mrs C said that it was not clear who had made the decision and no satisfactory explanation for the decision had been given. Mrs C said that CPN 2 had stated that the transfer was because Ms A had made sufficient progress and there was a lack of staff and resources to accommodate continued treatment from a psychologist. When Mrs C had contacted the Patient Relations Department, however, she was informed that there was no issue with human resources.

16. In her written response to Mrs C's complaint on 18 December 2006 (see paragraph 6) the Director said that it was Mrs C's opinion that Ms A's care was to be transferred to another psychologist when the Assistant Psychologist left her post in June 2006 and that Ms A was offered and accepted input from CPN 2 in August 2006. Her care was transferred to CPN 2 where Ms A remained until she was discharged. She went on to say that CPN 2 had advised that Ms A was not prepared to work with her and it was Ms A's expressed wish only to be seen by a clinical psychologist.

17. The Chief Executive stated that the Psychologist had commented that it had not been her intention to indicate to Ms A that she would require long term therapy from a clinical psychologist. To achieve the long term goals identified by Ms A may take several years and therapy can be one step in achieving them. The Chief Executive advised that the Consultant Psychologist was the only one working in the area and only worked three days a week. If she were to see Ms A she would require to wait on a waiting list. However, Ms A had previously indicated that she did not wish to see the Consultant Psychologist and she would, therefore, require to be seen outwith the area.

18. From the clinical notes, when the Assistant Psychologist saw Ms A on 20 June 2006 she explained that was their last meeting. She noted that Ms A did not yet feel able to work on her own and would still require to see someone on a fortnightly basis. She wrote that she had spoken to the Consultant Psychologist about the possibility of another assistant psychologist working with Ms A and she intended to explore this option and get back to the Consultant Psychologist. Ms A was happy for her to do this. The Assistant Psychologist

also prepared a note of progress made on the file and addressed it to the Psychologist.

19. Also from the clinical notes on 27 November 2006 Ms A asked CPN 2 for an appointment with the Consultant Psychologist to discuss her treatment. CPN 2 wrote that she offered Ms A an appointment with the Consultant Psychiatrist which Ms A refused. Ms A said that she was not trying to be difficult but wanted to continue with what worked for her.

20. The Adviser said that in the Assistant Psychologist's last session with Ms A on 20 June 2006 she discussed who would take over and might unwisely have raised Ms A's hopes by a definite plan. The Adviser also noted that Ms A was not informed of the decision to transfer her care to CPN 2 at the time it was made. Although a letter was sent to Ms A on 17 July 2006 telling her to expect CPN 2's visit, the Adviser said that Mrs C and Ms A may well have not been aware of the decision to transfer Ms A to a CPN until CPN 2 actually arrived at the house on 21 August 2006. The Adviser said that there was no evidence that a lack of psychologists influenced the allocation of the case to CPN 2. The Adviser also noted that it is clearly documented that on 27 November 2006 Ms A requested an appointment with the Consultant Psychologist. This contradicts the statement from the Chief Executive in her letter of 29 June 2007 that Ms A had indicated that she did not wish to be seen by the Consultant Psychologist.

(b) Conclusion

21. It is clear that Mrs C expected Ms A's care to be continued by another psychologist. Notwithstanding this, when the Assistant Psychologist left, Ms A's care was transferred to CPN 2. Ms A was not informed of the decision at the time and when she was told by CPN 2 there is no evidence that the explanation which she provided for the decision was correct. Additionally I cannot see that an adequate explanation was provided in response to Mrs C's complaint. There is no evidence to suggest that Ms A did not wish to be seen by the Consultant Psychologist. In the circumstances I have concluded that the explanations provided were inadequate and contradictory and I uphold this complaint.

(b) Recommendations

22. The Ombudsman recommends that the Board:

(i) apologise to Mrs C and Ms A for the failures identified in this report ; and

(ii) remind staff that adequate explanations of clinical decisions need to be provided to patients.

23. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Ms A	The complainant's daughter
The Hospital	Clackmannan County Hospital
Mrs C	The complainant
The Board	Forth Valley NHS Board
The Director	The Board's Director of Nursing
The Adviser	The Ombudsman's Professional Medical Adviser
CPN 1	The Community Psychiatric Nurse who treated Ms A initially
The Consultant	The Consultant Psychiatrist who subsequently referred Ms A to the Psychologist
The Psychologist	The Clinical Psychologist who treated Ms A until February 2006
The Assistant Psychologist	The Assistant Psychologist who treated Ms A from February 2006 until she left following their meeting on 20 June 2006
CPN 2	The Community Psychiatric Nurse to whom Ms A's care was allocated
The Chief Executive	The Board's Chief Executive
The Consultant Psychologist	The Consultant Clinical Psychologist with responsibility for deciding Ms A's future care in conjunction with the mental health team

Annex 2

Glossary of terms

Hierarchical desensitization	Behavioural therapy