Scottish Parliament Region: Mid Scotland and Fife

Cases 200603044 & 200700888: Forth Valley NHS Board and a Medical Practice, Forth Valley NHS Board

Summary of Investigation

Category

Health: Hospital, Psychiatry, discharge
Health: GP, Psychiatry.

Overview

The complainant (Mrs C) raised a number of concerns about the psychiatric care and treatment of her late husband (Mr C) who suffered from bi-polar affective disorder.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C's GP Practice failed to properly monitor his lithium levels (*not upheld*);
(b) Forth Valley NHS Board (the Board) inappropriately discharged Mr C from psychiatric care (*upheld*);
(c) the Board failed to provide Mr C with appropriate psychiatric care from October 2005 to October 2006 (*not upheld*); and
(d) the Board failed to take Mrs C's input on Mr C's psychiatric condition and requirements (*not upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) develop more effective and practical policies for dealing with a breakdown in doctor-patient relationships and for referring patients between services; and
(ii) apologise to Mrs C for discharging Mr C without ensuring that necessary support mechanisms were in place.

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

The Ombudsman has no recommendations in respect of Mr C's GP Practice.

Main Investigation Report

Introduction

1. On 8 November 2005 the complainant (Mrs C)'s MP (the MP) complained on her behalf to Forth Valley NHS Board (the Board) about the care and treatment received by her husband (Mr C). Mr C had been admitted to hospital with high lithium levels. Thereafter, Mrs C and the MP also raised concerns about Mr C's subsequent care and treatment including the fragmented nature of his care, the lack of psychiatric input and the failure to take Mrs C's input into account when planning Mr C's care. The Board conducted reviews of the issues raised and revised their policies as a result. Mrs C complained to the Ombudsman on 10 January 2007.

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

(a) Mr C's GP Practice (the Practice) failed to properly monitor his lithium levels;

(b) the Board inappropriately discharged Mr C from psychiatric care;

(c) the Board failed to provide Mr C with appropriate psychiatric care from October 2005 to October 2006; and

(d) the Board failed to take Mrs C's input on Mr C's psychiatric condition and requirements.

Investigation

3. During my investigation of this complaint, I reviewed the documentation supplied by Mrs C as well as the Board's and the Practice's complaint files on the matter. I obtained Mr C's medical records and his care home records and asked the Ombudsman's GP adviser (Adviser 1) and psychiatry adviser (Adviser 2) to review these and advise me on the clinical aspects of the complaint. I also met with Mrs C and the MP to discuss the complaint.

4. 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.

(a) The Practice failed to properly monitor Mr C's lithium levels

5. Mr C was discharged by the Board from their psychiatric care on 24 October 2004 and the Practice had sole responsibility for reviewing Mr C thereafter. I have addressed the complaints regarding his discharge under complaint heading (b).

6. On 8 November 2005 the MP wrote to the Board to raise concerns that Mr C had been admitted to hospital because of a build-up of lithium in his system. He questioned why no action had been taken when blood test results had given cause for concern.

7. The Practice responded to this complaint via the Board on 22 November 2005. They explained that lithium therapy had been used successfully in controlling many of Mr C's mental health symptoms over the past years but that he had consistently required a dose at the top end of the therapeutic range. They stated that patients on lithium should have regular checks on lithium blood levels to make sure they are within the therapeutic dose. They explained that Mr C was at times reluctant to undergo regular blood tests and frequently failed to attend appointments. They advised that Mr C would often have to be reminded by telephone call or letter to attend for a blood test.

8. The Practice explained that their system for monitoring lithium ensured that if a patient had not attended for a lithium check, they would be contacted to make an appointment for a blood test.

9. Mr C attended the Practice on 6 June 2005 and was prescribed a new medication for his diabetes. Because of the potential of this medication to interact with lithium, the Practice asked Mr C to return for a blood test in a week's time. Mr C made an appointment for 16 June 2005 but failed to attend the appointment. The Practice only realised that Mr C did not have an up-to-date lithium check on 19 August 2005 so they wrote to him asking him to make an appointment. Mr C made an appointment 18 days later and his lithium level was raised at 1.37 but was not at a level which would cause any dangerous toxic effects. Because Mr C's lithium level was outwith the therapeutic range, he was asked to make another appointment for a blood test. Mr C did not make another appointment but did attend the Practice on 28 September 2005 to discuss his psychiatric care. The Practice also asked Mr C to make an appointment to check his lithium levels. At that time, the GP did not feel that Mr C was exhibiting any signs of lithium toxicity.

10. Five days later Mr C was admitted to Stirling Royal Infirmary (the Hospital) with a chest infection. Upon admission his lithium levels were very high and he was exhibiting signs of lithium toxicity. The Practice explained that infection can

sometimes result in a change in lithium levels particularly if the patient is dehydrated.

11. The Practice accepted that Mr C had not been a suitable candidate for lithium therapy given his reluctance to attend for regular blood monitoring. They also stated that as Mr C had been without organised psychiatric care over the past year, he was not having planned assessment of his mental health and drug treatment.

12. The Practice also accepted that their procedures for monitoring lithium could be tightened up. They suggested that if patients were unreliable in attending for regular blood tests then their suitability for regular lithium therapy should be reviewed. Secondly, that if patients needed their lithium levels reviewed earlier either because of an unexpected high reading or a change in medication, any failure to attend for a repeat blood test should be pursued rather than left until the next routine review. Thirdly, they recognised that even patients who had been on long-term lithium therapy without any problems still needed regular advice as to the problems that they may encounter and be encouraged to report any possible side-effects at an early stage. The Practice confirmed that they had taken steps to address these points.

13. The Practice treated this as a critical incident and compiled a report on 26 November 2005 which identified changes which were to be made to the Practice's lithium monitoring processes.

14. I made enquiries of the Practice and they confirmed that all patients on lithium are now encouraged to carry a lithium treatment card which tells them how to take lithium preparations, what to do if a dose is missed and what side-effects to expect. It also emphasises the need for regular blood tests and to seek help if there are any symptoms of lithium toxicity. All patients on lithium now have a lithium monitoring sheet within their medical records and this is completed on every occasion a lithium level is checked. There is a dedicated member of staff who ensures that the results are complete and up-to-date and she will call any patients for review who have not attended for their routine check. The Practice also decided that if patients consistently failed to attend for lithium monitoring, they should have their need for continuation of lithium therapy urgently reviewed and alternative therapy issued if appropriate.

15. I asked Adviser 1 to review the Practice's response to this complaint as well as the actions which they took to improve their lithium monitoring practices. Adviser 1 stated that he considered that the Practice took reasonable steps to ensure that Mr C returned for his blood tests but that the additional actions which the Practice have taken since the episode should be praised.

(a) Conclusion

16. Although Mr C's lithium levels were high when he was admitted to the Hospital, Adviser 1 considers that the Practice took reasonable steps to ensure that Mr C's lithium levels were monitored. He also praised the actions taken by the Practice to improve their lithium monitoring processes. I commend the Practice for their thorough review of the circumstances surrounding this complaint and I do not uphold the complaint.

(b) The Board inappropriately discharged Mr C from psychiatric care

17. In May 2002, a psychiatric consultant at the Board (Consultant 1) took over Mr C's care. The pattern was that Consultant 1 saw Mr C at his clinic and a community psychiatric nurse (CPN) was involved. Medication was prescribed by the GP who was also responsible for the necessary blood tests.

18. In February 2003 the therapeutic relationship broke down because of a disagreement between Consultant 1 and Mrs C about changes in Mr C's drug regime. Because of Mr C's age, Consultant 1 decided to refer him to Old Age Psychiatry. On 27 October 2004 Consultant 1 wrote to an Older Adults Psychiatry Consultant in the Board (Consultant 2) and asked if he would take over Mr C's care. Consultant 2 was on sick leave and his locum responded to Consultant 1. He stated that he would discuss this with Consultant 2 upon his return. Mr C's medical records show that he was discharged by Consultant 1 on 25 October 2004.

19. On 31 November 2004 Consultant 2 wrote to Consultant 1 and declined the referral as a matter of policy. Mr C was, therefore, left without a psychiatrist.

20. Patients who have a long-term illness and who move from Adult Mental Health Services to Old Age Mental Health Services are referred to as 'graduate patients'. The Board explained to Mrs C that patients with an active mental disorder and under the care of the Adult Mental Health Services remain with Adult Mental Health Services after the age of 65 unless transfer to Old Age Mental Health Services is agreed by one of the old age psychiatric consultants.

They stated that such a transfer would usually only occur when new factors pertinent to Old Age Mental Health Services become known.

21. I asked Adviser 1 to comment on whether it was reasonable to expect a GP to solely manage Mr C's care following his discharge. He stated that Mr C's lithium treatment had been monitored by the Practice for some time but that people with chronic mental disease often have chaotic lifestyles. Generally patients have a duty of self care such that if a request for review from their GP is not accepted then it is usually deemed to be their fault if something goes wrong. He advised, however, that this does not apply to all psychiatric patients who might need encouragement to attend. Adviser 1 stated that along with family members, CPNs also have an important role in ensuring that regular tests are carried out. Since Mr C was not under the care of a specific team, this could have been another reason for his failed attendance for a blood test.

22. Adviser 1 stated that lithium could be monitored successfully in primary care. However, that this has to be done by a team and not by the GP alone. He clarified that the team might include family members, friends, neighbours, paid carers as well as CPNs, secondary care and GPs. He advised that the team needs to identify the potential problems each patient may have in complying with the lithium regime and try to overcome them.

23. I asked Adviser 2 to review Mr C's clinical records and the complaint file. He advised that because of the breakdown in the relationship between Mrs C and Consultant 1, it was reasonable for Consultant 1 to withdraw from Mr C's care. Although Mr C was the patient, he would probably not have been able to get to the appointments without his wife's efforts. Adviser 2 considered that Adviser 1's advice confirmed that it was not unreasonable for the Practice to have resumed the care of Mr C and that it was not unreasonable for Consultant 1 to have asked the Practice to do so by discharging him. Adviser 2 also stated that the Practice could have referred Mr C back, or to another consultant, if they found that he needed help.

24. Adviser 2 stated that he would have tried very hard to ensure that Mr C received some input from psychiatric services as it was predictable that he would be too difficult to manage in unaided primary care. However, in light of Adviser 1's comments and the fact that Mrs C no longer wished Consultant 1 to be involved in Mr C's care, Consultant 1 could not be criticised for discharging Mr C. Adviser 1 commented that Consultant 1 had tried hard to arrange for

somebody else to take over Mr C's care but was unsuccessful. Adviser 1 considered that it would have been unreasonable to ask another general adult psychiatrist to take him over. He advised that Old Age Mental Health, had they not refused him, might have been a suitable service.

25. Adviser 2 explained that the problems which can arise during a patient's transition from one service to another are common and it is incumbent on the group of consultants and/or the management to organise a system for dealing with them so that patients do not suffer. An indication of widespread awareness of this specific difficulty is that the Royal College of Psychiatrists have now produced two reports: CR 110 (2002) Caring for People who enter Old Age with Enduring or Relapsing Mental Illness, and CR 153 (2009) Links not Boundaries: Service Transitions for People Growing Older with Enduring and Relapsing Mental Illness. Adviser 2 considered that the Board could be criticised for not making reasonable arrangements for Mr C.

26. Following the Board's Critical Incident Review which identified several failings, they developed a formal policy for referring patients between services. They also developed best practice guidance which details what clinicians should do when there is a breakdown in the therapeutic relationship. Adviser 2 reviewed these documents but considered that they were not adequate because they do not offer any practical route for resolving just this sort of difficult case and disagreement.

(b) Conclusion

27. Mr C was discharged by Consultant 1 on 25 October 2004. Consultant 1 tried but failed to arrange for Consultant 2 to take over Mr C's care and, therefore, responsibility for Mr C's care fell to his GP.

28. Based on the clinical advice which I have received and although Consultant 1 cannot be criticised, I consider that Mr C's case was too complex for the GP to manage without support from secondary services and CPNs. A CPN would not have been able to work without a consultant. Under complaint heading (a) I have already established that the Practice took reasonable steps to ensure that Mr C was reviewed. Because of Mr C's failure to comply with requests from the Practice and because of lack of other support, Mr C's lithium levels were not appropriately monitored.

29. Although the Board have developed new policies in an attempt to address the issues which arose in this case, I have been advised that these are inadequate. I consider that the Board should not have discharged a patient such as Mr C and should have more robust policies and procedures in place to deal with such difficulties. For these reasons I uphold this complaint.

(b) Recommendations

30. The Board have already taken steps to develop their referral policy and best practice for dealing with a breakdown in the relationship between patients and clinicians but Adviser 2 considers these inadequate and lacking in practical advice. The Ombudsman recommends that the Board develop more effective policies for addressing these problems and that they apologise to Mrs C for discharging Mr C without ensuring that necessary support mechanisms were in place.

(c) The Board failed to provide Mr C with appropriate psychiatric care from October 2005 to October 2006

31. Mrs C raised concerns that Mr C was placed in care homes which were not psychiatric units and did not have any trained nursing staff. She told me that staff in the homes did not know what bi-polar was. Mrs C explained to me that Mr C had a very poor quality of life prior to his death and that there was a lack of continuity in his care. Mrs C considered that Mr C had not been appropriately assessed by a psychiatrist during this period and explained that staff had repeatedly told her that Mr C was not mentally ill.

32. On 2 October 2005 Mr C was admitted as an emergency to the Hospital. He was comatose and seriously ill with infection, renal failure, diabetes and a toxic level of lithium. Mr C was regularly reviewed by psychiatrists. He could no longer take lithium because of his renal failure, so he was put on valproate, another long-term mood stabiliser, and his dose of haloperidol was adjusted. Mr C was discharged home on 16 November 2005. Adviser 2 stated that Mr C received a good service from psychiatry during his stay in hospital.

33. Mr C was admitted to Falkirk District Royal Infirmary on 18 November 2005 with falls and increasing confusion. He collapsed on 22 November 2005 and was transferred to the Hospital. He was under the care of a liaison psychiatry specialist registrar and a consultant psychiatrist (Consultant 3). Mr C was transferred to the Rehabilitation Unit at the Hospital on 21 March 2006. Adviser 2 commented that Mr C continued to receive good

psychiatric service and that the two psychiatrists continued to see him from time to time in the Hospital. There was a discharge meeting on 16 May 2006 and Mr C went home. Adviser 2 stated that this was reasonable.

34. On 29 May 2006 Mr C was seen at home by the psychiatric Intensive Home Treatment Team (IHTT) and taken on by them. However, on 3 June 2006 he was admitted to Accident and Emergency after a fall. At this stage there was a disagreement between Mrs C and psychiatric services about the feasibility of looking after Mr C at home.

35. Between 6 June 2006 and 25 July 2006 Mr C was staying in a nursing home on a temporary basis. He was seen by a doctor from IHTT on 7 June 2006 and by a psychiatric consultant (Consultant 4) on 10 July 2006. Adviser 2 stated that Consultant 4 wrote a good and full assessment letter. It was decided that Mr C could be transferred to a respite bed with a view to a permanent place at another care home. It is recorded that this was desired by both Mr C and Mrs C. Mr C moved to a second home on 25 July 2006. Two days later there was a case conference attended by Consultant 4 who wrote a full letter discussing the problems of illness, behaviour and placement. Once again it was hoped that he might be eligible for the psychiatric service for the elderly and Consultant 2 was approached again and put him on the waiting list. However, Mr C proved impossible to manage in the home and was admitted to a psychiatric ward in the Hospital by Consultant 4 on 31 July 2006. Although Mr C's mental state improved initially, it deteriorated again and he required to be moved to the psychiatric intensive care unit on 15 August 2006 where he died suddenly and unexpectedly on 29 August 2006.

36. Adviser 2 stated that Mr C's psychiatric disorder was not simple and that the severity of his symptoms was not constant. He advised that Mr C did not have classic bi-polar disorder in which periods of illness occur and then resolve, leaving the normal personality intact. We are informed that Mr C's personality showed adverse traits such as apathy, inertia, irritability and awkwardness which may not have been entirely explicable and excusable in terms of illness. There is also the interaction with Mr C's physical illnesses and the limitations these put on the use of drugs for his psychiatric disorder. Adviser 2 stated that it is not easy to find a suitable place for long-term care of someone with this combination of problems. He advised that there will always be an element of trial and error because personal factors in patient and staff in any home may be crucial to determining whether someone settles down. Adviser 2 agreed that

Mr C's care did not go smoothly and that this might have given the impression of being muddled but that he could find no evidence that the move from a care home to another care home on 25 July 2006 was unreasonable. Adviser 2 explained that Mr C had to return to the Hospital the last time because his psychiatric illness worsened, and once there his management was reasonable. Adviser 2 considered that if Mr C had not died suddenly, there was a good prospect of his improving and leaving hospital once more.

(c) Conclusion

37. It is clear that Mr C's care in this period was difficult and did not go smoothly. It is unclear why Mrs C may have been told that Mr C was not mentally ill as he was frequently reviewed by psychiatrists and was prescribed medication to address his bi-polar disorder. It is possible that staff may have suggested to Mrs C that not all of Mr C's behaviour was attributable to his psychiatric condition and that this was not sufficiently well communicated to Mrs C. I recognise that this period of Mr C's life was distressing for him and for Mrs C. There were challenges in providing Mr C's care and this resulted in his being moved between several locations. Furthermore, there appears to have been some breakdown in communication between Mrs C and clinicians. However, I found no evidence that Mr C's psychiatric care during this period was inappropriate and I do not uphold this complaint.

(d) The Board failed to take Mrs C's input on Mr C's psychiatric condition and requirements

38. Mrs C considered that as she had real and everyday experience of his condition, her input into Mr C's care should have been more valued than it was and her awareness of his development in certain situations should have been similarly valued. Furthermore, Mrs C considered that Mr C should not have been given diazepam as it is not a psychiatric drug and did not address the cause of his illness. Mrs C told me that medical staff repeatedly told her that Mr C was not mentally ill. She considers that the views and concerns of relatives should be taken into consideration when planning and implementing care and that the Board should acknowledge that family members have a vast knowledge of the individual.

39. My investigation of the complaint under heading (d) found that Mr C's psychiatric care and treatment were reasonable.

40. Adviser 2 explained that Mrs C's perception of Mr C's illness may have differed from that of staff treating him in hospital who might at times have felt that his illness was not severe enough to need inpatient treatment. He commented that communication with families could almost always be improved and suggested that because of previous failures in Mr C's care (breakdown in psychiatric follow-up and monitoring of lithium treatment) it may have been hard to regain Mrs C's trust and ensure that she could redevelop confidence in the doctors.

41. Adviser 2 stated that he did not consider that Mr C's treatment would have been significantly different if Mrs C's views had been heard as she wished. He stated that, although Mrs C believed that it was problematical to give Mr C diazepam, he considered that its use here was reasonable, especially in a hospital where he was reasonably observed.

42. Following the Board's Critical Incident Review, they took steps to reinforce best practice regarding the communication with and involvement of patients and carers in the planning and delivery of care.

(d) Conclusion

43. It is unfortunate that Mrs C did not feel sufficiently involved in the planning of Mr C's care. Health boards should ensure that this type of communication occurs and that patients' relatives are kept appropriately informed about the care being received and the reasons for it. In this case, Adviser 1 concluded that Mr C's care and treatment were reasonable and that any input from Mrs C would not have significantly changed the care which he received. For this reason, I do not uphold this complaint.

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

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The MP	Mrs C's MP
The Board	Forth Valley NHS Board
Mr C	The aggrieved, Mrs C's husband
The Practice	Mr C's GP Practice
Adviser 1	The Ombudsman's GP adviser
Adviser 2	The Ombudsman's psychiatry adviser
The Hospital	Stirling Royal Infirmary
Consultant 1	An adult psychiatric consultant at the Board
CPN	Community psychiatric nurse
Consultant 2	An old age psychiatric consultant
Consultant 3	An adult psychiatric consultant
IHTT	Psychiatric Intensive Home Treatment Team
Consultant 4	A psychiatric consultant

Annex 2

Glossary of terms

Bi-Polar Disorder	A psychological disorder in which a person suffers from severe mood swings that range from depression to ecstatic mania
Diazepam	A tranquiliser with sedative effects
Haloperidol	An anti-psychotic drug commonly used to control acute psychotic symptoms but sometimes as a preventative measure
Lithium	Medication taken continuously in the long-term to reduce the frequency and severity of episodes of mania and depression which characterise bi-polar disorder. It is potentially very toxic and the difference between a safe therapeutic level and a toxic level is small
Valproate	A long-term mood stabiliser