SPSO decision report

Case: **201402116, Lothian NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: some upheld, recommendations

Summary

Mr C's daughter (Ms A) was an in-patient at the Royal Edinburgh Hospital's Child and Adolescent Mental Health Services In-Patient Unit. He raised a number of concerns about the care she received as an in-patient and also the steps taken around her trial return home.

Mr C was unhappy that Ms A had been left unobserved for a period of time that allowed her to self-harm whilst an in-patient, with the level of nursing care that was to be provided for the home trial, and also with the nursing care that his daughter then received at home. As part of our investigation we took independent medical advice from an experienced mental health nurse. Looking at Mr C's complaint about Ms A's care whilst an in-patient, our adviser outlined the importance of taking an effective approach to risk, but said he could not confirm that had happened in this case. The adviser explained that staff had a difficult balancing act in using the least restrictive means necessary when providing care and he said there may have been a phased plan to have reduced observation of Ms A. Although, for that reason, we could not say it had been unreasonable to have reduced Ms A's observation in the unit, we shared the adviser's concerns about the record-keeping and the fact that we could not identify the board's rationale for their actions. Although we did not uphold that specific complaint, we took this into account with our subsequent recommendations.

Mr C also complained that the transition plan for Ms A's trial return home lacked detail and was prepared hurriedly. Our advice largely reflected Mr C's concerns about the plan's lack of detail and we upheld Mr C's complaint. We also upheld his complaints about the lack of clarity regarding the planned level of nursing for Ms A's first day home, and about the nursing care that was ultimately received (the nurse had arrived at Mr C's house considerably later than had been arranged, in which time Ms A had taken action that may otherwise have been avoided). We made five recommendations in total.

Recommendations

We recommended that the board:

- apologise to Mr C for the failings identified in our report;
- remind staff of the importance of logging incidents - including near misses - on the relevant system in line with their policy;
- take steps to ensure that future transition care planning is done effectively to minimise the risks and maximise recovery for the individual;
- take steps to ensure that future transition care planning is communicated adequately to all relevant stakeholders; and
- remind staff of the importance of accurate record-keeping, in line with the relevant Nursing and Midwifery Council guidance.