SPSO decision report

Case: **201604643, Fife NHS Board**
Sector: health
Subject: communication / staff attitude / dignity / confidentiality
Decision: not upheld, recommendations

Summary

Ms C, who works for an advocacy service, complained on behalf of her client (Ms A). Ms A had been referred to the community psychiatric nursing service. After a number of attendances, Ms A was referred to a psychiatrist as she felt she was not improving. An appointment was made for her which Ms A did not attend as she said she was not informed of it. As a consequence of non-attendance, Ms A was removed from the list and told she would have to approach her GP should she wish to see a psychiatrist. Later, Ms A attended a day hospital and saw a community psychiatric nurse (CPN) who Ms A felt was judgemental. She said that she was told there was nothing wrong with her.

Ms C complained to the board and was told that Ms A had been informed of her appointment with the psychiatrist, and that it had been reasonable to remove her from the list because of her failure to attend. They also said that the CPN concerned had treated her reasonably and there was no evidence that she had been told there was nothing wrong and that Ms A had misunderstood. Nevertheless, they sincerely apologised for any distress Ms A had been caused and said that this was unintentional.

We took independent advice from a mental health adviser and we found that there was no evidence in Ms A's clinical records to show that she had been told of her appointment or been sent an appointment letter. We concluded that it was unreasonable, therefore, to have removed her from the psychiatrist's appointment list. However, contrary to Ms A's belief, we also found that the CPN was not responsible for this breakdown in communication. We further found that the CPN had treated Ms A appropriately and reasonably, identifying her presenting symptoms and drawing up a plan to deal with them. However, it was not the CPN's usual role to diagnose psychiatric illness and they did not do so. We, therefore, did not uphold the complaint. However, we made a number of recommendations in relation to the board's communication failure.

Recommendations

What we asked the organisation to do in this case:

- Send a written apology to Ms A for failing to advise her about a psychiatric appointment.
- Review Ms A to consider whether or not a further appointment is appropriate, if Ms A so wishes.

What we said should change to put things right in future:

- The community psychiatric nurse involved should be reminded of the necessity to keep accurate records.
- The process required to issue appointment letters should be fit for purpose.
- Adequate follow-up should be in place for similar situations.

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.