SPSO decision report

Case: **201609699, Renfrewshire Health and Social Care Partnership**
Sector: health and social care
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment provided to her son (Mr A) by the partnership after he was diagnosed with psychosis. She considered that there were issues with his treatment plan which led to him having relapses. She complained that, when Mr A was admitted to hospital, he was not able to consent for information to be shared with her. She said that this was not addressed for several weeks. Ms C also complained that, after an occasion when Mr A came close to attempting suicide, there was a delay in meeting with her to discuss this. Ms C also raised concerns about how closely Mr A was monitored in the lead up to this occasion. In particular, she had concerns that Mr A was allowed to leave the hospital unchallenged, after she had raised concerns about his mood.

We took independent advice from a consultant psychiatrist. We found that Mr A's treatment plan was reasonable, as it took into account Mr A's own wishes about his treatment. However, we found that Mr A's ability to consent to share information with Ms C was not reviewed regularly after his admission to the hospital. The partnership had acknowledged this and had apologised to Ms C. We upheld this aspect of the complaint and we made a recommendation to improve this in the future.

We noted that the partnership had acknowledged an unreasonable delay in meeting with Ms C after the occasion when Mr A came close to attempting suicide. Although we upheld that aspect of the complaint, we found that the steps they had since taken to improve communication with Ms C were reasonable, and so we did not make any further recommendations in this regard.

We found that Mr A was appropriately monitored in the days leading up to the occasion when he came close to attempting suicide. However, the day before, Ms C raised concerns about Mr A's condition with hospital staff, which we found were not recorded. We also found that Mr A had briefly gone missing from the hospital on the night before he came close to attempting suicide and that he had been noted as being agitated. Given the concerns that Ms C had raised about Mr A earlier that day, and his agitation, we considered that a suicide risk assessment should have been carried out at that time. However, we found no record that this had been done. Therefore, we upheld this aspect of the complaint and we made recommendations in light of our findings. However, we did find that it was reasonable that Mr A was allowed to leave the hospital unchallenged that day, as he was allowed unaccompanied time out of the ward as part of his rehabilitation.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Ms C for failing to record the concerns that Ms C raised about Mr A's condition. Also apologise that a suicide risk assessment was not carried out. The apology should comply with the SPSO guidelines on making an apology, available at: www.spso.org.uk/leaflets-and-guidance.

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

- When a patient has been deemed incapable, the partnership should regularly review the patient's capacity to give consent about sharing information. Relatives or carers should be kept up to date on those reviews.
- All significant events should be documented in the medical records, including feedback from relatives and carers about a patient's condition.
- In circumstances similar to Mr A's in the future, staff should carry out a suicide risk assessment.

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.