SPSO decision report

Case: **201800744, Lothian NHS Board - Acute Division**
Sector: health
Subject: clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

Ms C complained about the care and treatment her husband (Mr A) had received at St John's Hospital following a suicide attempt. Ms C complained that Mr A was inappropriately given diazepam (a medicine used to treat anxiety), as it can be addictive.

We independent advice from a consultant psychiatrist. We found that it might have been appropriate to have given Mr A diazepam on a short term basis but the reason for prescribing it to him was not recorded. We found that when Mr A self-discharged from the hospital, there was a failure to carry out and/or document an appropriate suicide risk assessment. There was no evidence that medical staff considered detaining Mr A. There was also no evidence that they signposted him to any other sources of support or carried out any contingency planning in case his condition or level of risk to himself changed. In addition, we found that a junior medical staff member was not able to reach a senior colleague by phone for advice. Therefore, we upheld this aspect of Ms C's complaint. We also found that the board had not handled Ms C's complaint regarding the diazepam appropriately and we made a recommendation in relation to this.

Ms C also complained that there was a failure to provide Mr A with appropriate follow-up care after he self-discharged from the hospital. Mr A had been offered a follow-up appointment in two months' time. When he was unable to attend that appointment due to his poor mental health, he was offered an appointment for six months later. We found that Mr A was not given follow-up care that was appropriate to his needs, and that, in the circumstances, Mr A should have been offered an appointment within a week of him leaving the hospital. When Mr A could not attend that appointment due to poor mental health, he should have been offered a review at home. We upheld this aspect of Ms C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for failing to provide Mr A with reasonable care and treatment, for failing to provide him with appropriate follow-up care and for the inaccuracy in responding to her complaint. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- The reason for prescribing any medication, including one-off doses, should be clearly recorded.
- If a patient wishes to self-discharge and it is unplanned, there should be adequate processes in place, and adhered to, to manage this. This should involve carrying out appropriate risk assessments, appropriately signposting patients and/or carers to crisis services and carrying out contingency planning.
- Junior medical staff should have adequate supervision from senior medical staff, especially out of hours, and reliable mechanisms should be in place so they can contact senior colleagues for advice.

- Patients should receive follow-up care that is sufficiently timely and robust, which is appropriate to their individual needs. If patients are unable to attend their out-patient appointment, the board should consider alternative arrangements such as home visits.

In relation to complaints handling, we recommended:

- The board's complaints handling system should ensure that accurate responses are issued, which are based on the evidence gathered during their investigation.