SPSO decision report

Case: **202401439, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment given to their late sibling (A) who had a history of schizoaffective disorder. After a change in the consultant responsible for A's care, A's diagnosis was changed and their medication withdrawn over an extended period which led to A becoming unwell. They required admittance to hospital on a number of occasions before their death by suicide.

The board carried out a significant adverse event review (SAER) into what happened which identified a number of failures and made a number of recommendations as a result. Later the board issued their complaint response to C's complaint which detailed the consultant's position that A's symptoms were not in keeping with a continuing psychotic illness, and that, this view was shared by the wider clinical team.

We took independent advice from a consultant psychiatrist and a mental health nurse. We found that the decision to change A's diagnosis was not supported by their presentation, that the various diagnoses were referred to with no explanation and that the consultant involved in A's care held an incorrect belief that schizoaffective disorder and schizophrenia were, in essence, the same condition and were interchangeable. We also found that NICE guidelines were not always followed appropriately, that there was an over-reliance on remote methods of assessment, that changes were made to medication without having seen or assessed A and that clinicians unreasonably maintained that A did not present with psychotic symptoms when the evidence demonstrates otherwise. Finally, we found that the nursing care was reactive and treatment was crisis led and failed to provide support and strategies for early interventions, that there was a failure to create a community care plan and that there was a lack of multi-disciplinary working, and therefore, a lack of challenging decisions on patient care. As such, we found the care and treatment both in hospital and from the community nursing team to have been unreasonable and we upheld this aspect of the complaint.

We also considered the way in which the board handled C's complaint. We noted that the board provided a brief complaint response as they considered the SAER had addressed the main issues. We also found that the board's complaint response directly contradicted the findings of the SAER, as it included the consultant's view that A did not present with psychotic symptoms. We considered this to be unreasonable. Therefore, we upheld this aspect of the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failures identified. The apology should meet the standards set out in the SPSO guidelines on apology available at HYPERLINK "http://www.spso.org.uk/meaningful-apologies" www.spso.org.uk/meaningful-apologies .
- Appropriate clinical guidelines should be followed when providing treatment to patients.

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

- i) Appropriate clinical guidelines should be followed when providing treatment to patients.
- ii) Clinician's should have up-to-date accurate knowledge of the descriptions and classifications of conditions within their sphere of expertise.
- iii) Diagnosis reviews should be carried out when appropriate and in line with current disease classifications and treatment guidelines.
- iv) Clear rationale for decisions made to maintain or change a diagnosis should be recorded timeously in clinical records.
- v) Diagnoses should be clear, consistent, and evidenced.
- vi) When decisions are made to change, reduce, and/or withdraw medication there should be clear rationale recorded for this and close assessment of the patient should be carried out.
- vii) The emergence of symptoms or change in presentation should be assessed and considered thoroughly and the preferred diagnosis or treatment plan reviewed and adjusted in light of a patient's presentation and changing needs.
- Mental health nursing staff should have in place pro-active, person-centred support planning for their patients. Person-centred support plans should be reviewed and updated regularly. Concerns about patient care and safety should be escalated by nursing staff appropriately, either to medical staff or nursing supervisors.
- Appropriate clinical guidelines should be followed when providing treatment to patients.

In relation to complaints handling, we recommended:

- Complaints should be investigated in line with the NHS Model CHP. Complaint responses should be full, factual, clear, and easy to understand. Decisions reached should be evidenced, proportionate, and objective. We offer SPSO accredited Complaints Handling training. Details and registration forms for our online self-guided Good Complaints Handling course (Stage 1) and our online trainer-led Complaints Investigation Skills course (Stage 2) are available at https://www.spso.org.uk/training-courses.

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.