SPSO decision report

Case: **201602926, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment provided to her late father (Mr A). Mr A suffered from advanced dementia, and was cared for at home by his daughters, with support provided by community mental health services and district nurses. Mrs C was concerned that Mr A was over-sedated and did not receive enough stimulation. Mrs C raised concerns that a decision was made to continue a three week trial of diazepam without a review by the psychiatrist. Mrs C complained that the decision to prescribe diazepam was inappropriate. Mrs C was also concerned that staff recommended continuous bed rest for Mr A, which meant that he was no longer able to get up or sit in his chair. Mrs C did not agree that Mr A could no longer mobilise and did not feel that he was at risk of falling, aside from being over-sedated from the diazepam. She complained that the decision to recommend Mr A remain on bed rest was inappropriate. Mrs C also complained that mental health services failed to appropriately assess Mr A's mental health problems. She felt that staff failed to address environmental factors that were contributing to his distress, such as poor personal care and lack of stimulation.

The board provided two written responses to Mrs C's complaints, responding separately to her concerns about the district nurses and about the mental health services. The board considered that the care and treatment provided was appropriate. Staff from the board also met with Mrs C to talk through the issues. Mrs C was not satisfied with the board's response and she brought her complaints to us.

After taking independent psychiatric, mental health and nursing advice, we upheld Mrs C's complaint about the assessment of Mr A's mental heath problems. We found that there was an individual mental health care plan in place for Mr A. However, we found that this should have been a multi-disciplinary care plan, in view of Mr A's challenging symptoms and the involvement of a number of health professionals. We also found the mental health care plan was not reviewed timeously. We did not uphold Mrs C's other complaints as we found the decisions made regarding bed rest and diazepam to be reasonable. However, we found that Mr A's mobility and falls risk was not appropriately assessed and we made recommendations to address this.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failings in mobility and falls assessment, and in multi-disciplinary care planning. 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:

- Where a patient's mobility is deteriorating, a Moving and Handling Assessment should be carried out to benchmark, and keep under review, how the patient might best be supported.
- Where there are concerns about a patient's falls risk, a falls assessment should be arranged.
- For patients with distressing symptoms or challenging behaviour, where a number of health services are

involved, a single multi-disciplinary care plan should be put in place and reviewed every six months.

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.