SPSO decision report

Case: **201200273, Lothian NHS Board**
Sector: health
Subject: admission, discharge & transfer procedures
Outcome: upheld, recommendations

Summary

Following a stroke, Mr C's late aunt (Mrs A) was transferred to a hospital for rehabilitation and discharge planning. Mrs A's solicitor had welfare power of attorney for her. Mrs A had a degree of cognitive impairment (a condition that affects the ability to think, concentrate, formulate ideas, reason and remember), which got worse while she was in hospital. Several months later, Mrs A was discharged to a nursing home. Mr C complained about the way the board discharged his aunt, which he said was done too quickly and without input from her family or her advocate, and about the handling of his complaint, including that the board inappropriately contacted Mrs A's solicitor about it.

We took advice on this complaint from one of our medical advisers, who specialises in mental health. Our investigation found that the views of Mrs A and her family were not fed into the decision-making process, contrary to the board's discharge policy, and that Mrs A was denied the opportunity to visit the nursing home before being discharged there. Her family were not kept updated and there is no evidence that the board made Mrs A, her welfare power of attorney or her family aware of her right to independent advocacy. Finally, the principles underpinning the Adults with Incapacity Act were not adhered to - as Mrs A was unable to give informed consent to treatment or to make reasoned decisions, a certificate of incapacity should have been completed and the interventions being authorised should have been set out in a care plan.

We were satisfied that the board acted properly when they told Mr C that they could not release confidential information about Mrs A without her or her solicitor's consent, because the solicitor had welfare power of attorney. However, our investigation found that early in the complaints process the board were aware of information that brought Mrs A's capacity to consent into question. We were, therefore, critical that they did not make Mr C aware of this until some five months later, after he had obtained and sent Mrs A's consent to his complaining on her behalf. Although the board provided detailed responses to Mr C's concerns, we noted delays and inaccuracies in these (particularly around Mrs A's reaction following her visit to another nursing home).

In relation to the board's handling of Mr C's complaint, we were satisfied that their actions were reasonable in light of the legal advice they received. They carried out several investigations, including having an independent healthcare professional review Mrs A's care. Mr C was disappointed that a senior official was not available to meet him when he arrived at their office (having travelled from abroad), but the board had made no arrangements to meet him at that time. Instead, they met him the following month, and although they withdrew their offer of a teleconference (following legal advice), this was not in itself evidence of maladministration. Finally, the board properly referred Mr C to the council for a response about his concerns relating to the actions of the social workers involved in his aunt's discharge.

Mr C was unhappy that the board had potentially breached confidentiality by seeking comments from Mrs A's solicitor about his complaint. It is not for us to decide whether there has been a legal breach in relation to data protection, but we can consider whether the board's actions were reasonable in the circumstances. Normally, when a family member complains on an individual's behalf, health boards do not directly contact the individual

affected by a complaint, rather they would tell the family member they needed to get consent from the individual before the board would look at the complaint. In this case the board contacted the solicitor who was speaking for Mrs A, which was the equivalent of contacting Mrs A herself. Our view was that the existence of a welfare power of attorney did not mean there should be any change to the normal practice, as there are good reasons for that practice and we were aware of no reason why this situation required an unusual approach. We were critical that the board contacted the solicitor about Mr C's complaint, which would not have occurred under ordinary circumstances. We upheld both Mr C's complaints and made recommendations for improvement.

Recommendations

We recommended that the board:

- ensure patients who lack capacity are treated in line with the relevant legislation;
- inform patients with dementia and their families of the right to independent advocacy (and how to access the service) and ensure advocates are given the opportunity to express the views of their clients;
- review their complaints handling procedures in the light of this complaint to ensure that communication with families and/or individuals with welfare power of attorney are appropriate; and
- make a further apology to Mr C in light of the findings of our investigation.