SPSO decision report

Case: **201607458, Highland NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C complained about the care and treatment her father (Mr A) received from the board at Caithness General Hospital. Mrs C complained that the board unreasonably failed to take into account her father's dementia, unreasonably failed to establish that Mrs C held a welfare power of attorney in respect of her father and unreasonably failed to obtain appropriate consent for a gastroscopy procedure (an examination of the inside of the gullet, stomach and the first part of the small intestine).

We took independent advice from a nurse and from a consultant in acute medicine. Based on the information in Mr A's records and the advice we received, we considered that the board did not unreasonably fail to take into account Mr A's dementia while he was in hospital and we did not uphold this part of the complaint. However, we were concerned that some documents relating to this were not completed by hospital staff and so we made a recommendation regarding this.

On the issue of welfare power of attorney, we found that attempts should have been made to establish if Mr A had a welfare power of attorney within 24 hours of admission. We found that this had taken the board three days and that this was an unreasonably long time for this to take. We upheld this aspect of the complaint.

Mr A had more than one gastroscopy and Mrs C's complaint was that the board had not obtained appropriate consent for the first gastroscopy. We found that it was reasonable for staff to conclude that Mr A had sufficient capacity to give his consent for his first gastroscopy procedure and that appropriate consent was obtained. We, therefore, did not uphold this part of Mrs C's complaint. However, we were concerned about the consent process for Mr A's second gastroscopy and we found that an adult with incapacity form (completed for patients deemed not to have capacity to consent) should have been completed and that the procedure should have been discussed with Mrs C. We also found that the board's response to Mrs C's complaint was inadequate. We, therefore, made recommendations on these matters.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C, Mr A and their family for the failings in establishing if Mr A had welfare power of attorney, the failings in record-keeping and the complaints handling failures. The apology should meet the standards set out in the SPSO guidelines on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- Patients' Admission/Care Records and Treatment Escalation Plans should be completed fully and accurately.
- In cases such as this, staff should establish if patients have a welfare power of attorney in a timely

manner.
- In cases such as this, staff should obtain appropriate consent for patients' surgical procedures.

In relation to complaints handling, we recommended:

- Information in internal investigations of complaints should be accurately reflected in complaint responses and full explanations of decisions should be provided.

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.