SPSO decision report

Case: **201204670, The City of Edinburgh Council**
Sector: local government
Subject: sheltered housing issues/residential homes
Outcome: upheld, recommendations

Summary

Mr C's late aunt (Ms A) had been in hospital following a stroke, and was discharged to a nursing home. Mr C complained that council social workers did not give Ms A the chance to visit the nursing home before sending her there (even though the manager had offered to let her visit), and did not offer her a choice of homes. He also said that the council failed to obtain the views of or inform Ms A's advocate and her family.

We do not normally investigate complaints about the actions of social workers, as these are normally considered by a complaints review committee (CRC), who have greater powers than we do to question the decisions of social workers. In this case, however, the council had decided that the complaint could not be considered by a CRC, so we investigated the actions of the social workers. In doing so, we took independent advice from a social work adviser with significant experience in older people's services.

Ms A was considered to lack the capacity to make her own decisions. However, the council's assessment of her said that she had a little insight and would be pleased to be helped to seek a good nursing home placement. Despite this, Ms A was then discharged to a nursing home that she had not seen. The council told us this was because hospital staff had said that a visit to another home had unsettled her. However, there was no evidence that, before Ms A was discharged, social workers had assessed her needs, taken into account her wishes, or gathered information from a range of sources, including her independent advocate. This amounted to a failure to obtain and consider material and important information. We took the view that, at the very least, social work staff should have recorded why they felt that the views and interests of hospital staff should take precedence over those of Ms A. We would have expected the records to show why the potential upset of a visit was felt to be more significant than that of having to move to a home that she had not seen or visited.

We also found that the council had failed to give Ms A a choice of nursing homes, as they should have done in line with both national policy and their own policy on patients being discharged from hospital to a home. In addition, Mr C was recorded as Ms A's next of kin, but the council had not contacted him about Ms A's discharge in line with principle 4 of the Adults with Incapacity (Scotland) Act 2000. We found that these failings amounted to maladministration and upheld Mr C's complaint about Ms A's discharge to the nursing home.

Mr C also complained about the way in which the council handled his complaint. They had suspended it, as they considered that he was not entitled to confidential information about Ms A, and in view of this decided that a CRC could not be held. Guidance from the Scottish Government on holding CRCs says that a complainant has no right of access to personal information held about a third party, unless the third party gives consent. As Ms A had died before Mr C made his complaint, consent could not be obtained. In view of this, we considered that it was reasonable for the council not to refer the complaint to a CRC, and noted that the decision to suspend it had in fact been approved by a CRC. However, we found that the council had delayed in dealing with Mr C's complaints. They had also incorrectly told him that no family members had been recorded as next of kin. In view of this, we also upheld this aspect of Mr C's complaint.

Recommendations

We recommended that the council:

- issue a written apology to Mr C for the failings we identified;
- take steps to ensure that all staff involved in the discharge of patients from hospital are aware of and are acting in line with the relevant national and council policies;
- consider issuing guidance to staff on how they should complete one of the relevant forms when patients are discharged to a care home; and
- confirm that lessons have been learned and steps have been taken to prevent similar delays occurring when they respond to complaints about social work issues.