SPSO decision report

Case: **201304515, Lanarkshire NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Outcome: upheld, recommendations

Summary

Ms C had welfare power of attorney (a legal document appointing someone to act or make decisions for another person) for her late brother (Mr A) who had profound learning difficulties and significant communication difficulties. Mr A was admitted to Hairmyres Hospital but died three days later from sepsis (blood infection). Ms C had concerns about some of the clinical decisions that were made and said that staff failed to communicate with her as welfare power of attorney. If they had, Ms C said she could have provided additional and important information about her brother's normal condition and that she could have contributed to the treatment plans that were set up. The board apologised to Ms C that staff failed to act on changes in her brother's medical condition but maintained this was not due to his learning disabilities.

Our investigation found that the board have an 'Adults with Incapacity: Best Practice Guide', in line with the principles of the Adults with Incapacity Act (Scotland) Act 2000. The guide says that, along with the patient's wishes, staff should take account of the views of relevant others as far as it is reasonable and practicable to do so. We took independent advice on the board's actions from our nursing adviser. She said that the best practice guide was very good, but that staff failed to implement it in relation to Mr A's care, and the level of communication fell below the level she would have expected. Ms C was not consulted or involved in the decision-making process and, more importantly, her information about her brother's deterioration was not taken seriously. We upheld Ms C's complaint, as we found staff did not communicate adequately with her, when she was best placed to advise on her brother's medical history and usual state of health, and so failed to act in accordance with the principles of the Adults With Incapacity (Scotland) Act 2000.

Recommendations

We recommended that the board:

- apologise to Ms C for the failings in communication; and
- remind staff of the best practice guidance and ensure it is implemented in appropriate circumstances.