SPSO decision report

Case: **201700529, A Health and Social Care Partnership**
Sector: health and social care
Subject: other
Decision: upheld, recommendations

Summary

Mrs C complained about an adult support and protection (ASP) investigation that was carried out following an incident involving her father (Mr A). Mr A was a hospital in-patient at the time of the incident and Mrs C held welfare power of attorney for him. There was a delay between the incident being identified by a student nurse and the matter being reported as an ASP issue. An ASP investigation took place over an extended period and Mrs C was interviewed as part of this process. During her interview, Mrs C raised highlighted concerns about Mr A having appeared over-sedated. In addition to the individual ASP investigation for Mr A, a large scale investigation also took place, alongside other investigations and enquiries.

Mrs C was not informed about the outcome of the ASP investigation until several months after the incident. In the interim period, Mrs C had complained directly to the local health board about the lack of information provided and the poor standard of communication in relation to the ASP investigation. In responding to the complaint, the local health board acknowledged that the ASP timescales had been extended due to the exceptional circumstances of the case and that issues with the multiple investigations had resulted in an unsatisfactory timescale. Mrs C was advised that there was no allegation investigated regarding Mr A's medication. The conclusion of the ASP investigation was that Mr A had been an adult at risk of harm, however, there was no evidence of actual physical or psychological harm to him as a result of either the incident or staffing levels on the ward (it was acknowledged that there was, at that time, evidence of staff shortages on the ward). Mrs C was unhappy with the way that her concerns were handled and asked us to consider her case. After making enquiries it was determined that the complaint response issued by the local health board did not represent the final position from the social work point of view. Mrs C met with members of staff at the partnership and they agreed to investigate her concerns fully. As a result, we closed our own investigation at that time as it was considered that the outcome Mrs C wanted was most likely to be achieved from the partnership's consideration of her concerns. However, Mrs C did not receive a response and we opened a new investigation with an expanded remit.

Mrs C complained to us that the partnership:

unreasonably failed to follow ASP investigation procedures;

unreasonably failed to use relevant planning tools to ensure safe staff numbers on the ward;

unreasonably failed to evidence that no harm resulted from the incident involving Mr A or from staffing levels on the ward; and

failed to communicate reasonably with the family.

We took independent advice from a social work adviser. We found that there had been delays in reporting the initial incident and that the ASP process could have been concluded earlier, without awaiting the outcome of other investigations that were ongoing. We also found that there was a lack of clarity regarding who would action the

recommendation of the large scale investigation. We upheld Mrs C's complaint about the failure to follow ASP investigation procedures.

Mrs C highlighted particular concerns about a failure to use planning tools to ensure safe staff numbers on Mr A's ward. We took independent advice from a mental health nursing adviser on this issue. We found that there were acknowledged delays in the implementation of planning tools on the ward (although there were reasons for this) and the advice we received highlighted issues with staffing numbers on the day of the incident and some more general issues, including the use of student nurses to bolster staff numbers on wards. We upheld this aspect of Mrs C's complaint.

We took independent advice from a consultant old age psychiatrist in relation to Mrs C's concerns about over-sedation and that there had been an unreasonable failure to evidence that Mr A had not been harmed. The advice we received was that the management of Mr A's medication was reasonable and that there was no indication that he had been harmed by the incident. However, we upheld Mrs C's complaint as we found that there had been an unreasonable failure to provide Mrs C with evidence to support this position.

Finally, we upheld Mrs C's complaint about communication. We found that there had been failings in this area in relation to aspects of Mr A's treatment and that overall communication on ASP matters was inadequate. In addition, we found that the handling of Mrs C's complaint was unreasonable. We made a number of recommendations to address the failings identified.

Recommendations

What we asked the organisation to do in this case:

- Apologise for the failures in reporting the incident in terms of the ASP procedures. Also apologise for the failures in communication and failure to evidence that no harm came to Mr A from the incident. The apology should meet the SPSO guidance on apology available at https://www.spso.org.uk/leaflets-and-guidance.

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

- In similar cases individual ASP investigations should be carried out without awaiting the outcome of any other investigations unless, for a specific reason, these are inextricably linked. There should be clarity on who will action recommendations arising from a large scale investigation. Organisational issues uncovered when making ASP enquiries should be placed back in the hands of that organisation (or other organisations concerned) to investigate and report back.
- Communication with adults or their representatives should be clearly defined and agreed early in the ASP process. Representatives with welfare power of attorney should be proactively involved in care and treatment.
- There should be clear reasoning documented in the notes when as-needed medications are administered.
- The supernumerary status of student nurses in training should be respected except for the planned rostered service contribution which is part of their course syllabus.

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.