The investigation of a complaint by Mrs C against
Aneurin Bevan Health Board, Cwm Taf Health Board and
Caerphilly County Borough Council

A report by the Public Services Ombudsman for Wales

Case: 201002841, 201100156 and 201100157

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Introduction

This report is issued under section 21 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs C and her husband, the aggrieved, as Mr C.

The complaint is against three organisations as follows:

- Cwm Taf Health Board, responsible for Prince Charles Hospital;

- Aneurin Bevan Health Board (formerly Gwent Healthcare NHS Trust; also encompassing the former Torfaen Local Health Board and Caerphilly Local Health Board), responsible for Ystrad Mynach Hospital; and

- Caerphilly County Borough Council, responsible for social services.

Summary

Mrs C complained about aspects of the care and treatment of her severely disabled husband following his admission to Prince Charles Hospital (PCH) in February 2009. PCH is managed by Cwm Taf Health Board. Mr C was transferred to Ystrad Mynach Hospital (YMH) from where he was discharged home in June 2009. YMH is managed by Aneurin Bevan Health Board. Caerphilly Council's social services were also involved in Mr C's care.

The Ombudsman's investigation found that as Mr C's ability to communicate was very limited, his capacity should have been assessed under the Mental Capacity Act 2005 (MCA). Despite Cwm Taf HB and Caerphilly social services being in agreement with the need for this, Cwm Taf HB failed to carry out an assessment. This meant that, at best, Mr C was given very little choice about his care and treatment, and about whether he remained in hospital, and, at worst, he was detained in hospital against his will. This was therefore a significant failing and the complaint was upheld. Cwm Taf and Aneurin Bevan Health Boards agreed with the Ombudsman's recommendation to provide training to staff about their responsibilities under the MCA.

The Ombudsman investigated a number of other complaints. He concluded that it had taken too long to discharge Mr C from hospital, and asked the authorities to consider how the process can be speeded up. He also upheld a complaint that Mr C was allowed to remain constipated for several days. But he did not uphold complaints relating to mouth care and provision of antibiotics, or that it was inappropriate to consider the possible need to instigate the Protection of Vulnerable Adults procedure.

Finally, the Ombudsman upheld Mrs C's complaint that the three bodies failed to provide a joint or cohesive response about her complaints.

The complaint

1. Mr C suffered with progressive multiple sclerosis (MS)[1] and had become fully dependent on his wife and carers. He was unable to move and increasingly unable to communicate. He was receiving care at home from Mrs C and from carers funded by Direct Payments from Caerphilly County Borough Council (the Council). In February 2009, Mr C was taken ill and was admitted to Prince Charles Hospital (PCH). He was transferred to Ystrad Mynach Hospital (YMH) on 24 April before being discharged home on 17 June. Mr C very sadly died in November 2011 while this investigation was on-going.

2. Mrs C complained to Cwm Taf Health Board (Cwm Taf HB), Aneurin Bevan Health Board (ABHB) and Caerphilly County Borough Council (the Council) about a number of issues relating to the care of her husband. Having failed to resolve the majority of her complaints through local resolution Mrs C submitted her complaints to the Ombudsman with the assistance of a complaints advocate.

3. The complaints investigated were:

Against all the bodies:

(1) Delays in arranging Mr C's discharge from PCH and subsequently from YMH in 2009. In particular:

(a) there was confusion over the need for a mental capacity assessment, and who requested this;

(b) Mrs C was unable to discharge her husband, as she believed this would result in POVA[2] action; and

[1] A progressive condition with a degeneration of nerves in the brain and spinal cord leading to a variety of symptoms including loss of mobility, vision problems, loss of bladder and bowel functions, and speech difficulties.

[2] Protection of Vulnerable Adults.

(c) Mr C had no advocate, and no independent mental capacity advocate (IMCA)[3] was appointed.

(2) Failures in discharge planning. In particular, there was confusion regarding organisational responsibilities and failures in communication between organisations.

(3) There was confusion around possible POVA proceedings; health staff proceeded as if a POVA plan was in place, and, as a result, Mrs C felt stigmatised, and her husband was not allowed home.

(4) There was no joint or cohesive response to Mrs C's complaint from the three organisations.

Against Cwm Taf HB:

(5) While at PCH:

(a) poor bowel management resulted in faecal impaction;

(b) Mr C acquired a urine infection because antibiotics were stopped;

(c) there was a lack of mouth care; and

(d) there were delays in the provision of a new PEG[4] tube.

Investigation

4. I obtained comments and copies of relevant documents, including clinical records, from the bodies complained against and I

[3] A statutory advocate under the Mental Capacity Act 2005. IMCAs represent people who lack capacity to make specific decisions.

[4] Percutaneous Endoscopic Gastrostomy feeding, where nutrition is provided through a tube inserted through the skin directly into the stomach

considered these in conjunction with the evidence provided by Mrs C and her advocate. I interviewed Mrs C in the presence of Mr C and her advocate.

5. I obtained medical, nursing and mental health nursing advice from three of the Ombudsman's professional advisers, Dr R McGonigle, a consultant physician, Ms R McKay, a senior nurse and Mr J Murphy, a registered mental health nurse. Their advice is included in full at **Appendices A, B, C and E**, and is summarised at paragraphs 114-132 and 141-146. I have not included in this report every detail investigated but I am satisfied that nothing of significance has been overlooked.

6. Cwm Taf HB provided comments on the initial mental health nursing advice and these comments (which have been slightly edited for readability) are attached at **Appendix D**.

7. Mrs C, Cwm Taf HB, ABHB and the Council were given the opportunity to see and comment on a draft version of this report. Their comments have been taken into account in producing this final version.

8. I am issuing this report under the authority delegated to me by the Ombudsman under paragraph 13(1) of schedule 1 of the Public Services Ombudsman (Wales) Act 2005.

Relevant legislation, policy, guidance etc

9. I attach at **Appendix F** a note which includes information about:

- The Mental Capacity Act 2005;
- The Healthcare Standards for Wales 2005;
- Application of the 'In Safe Hands' guidance which relates to POVA;
- Complaints handling procedures.

10. There are five statutory principles of the Mental Capacity Act 2005 (the Act) which include that a person must be assumed to have capacity unless it is established that they lack capacity, and that practical steps must be taken to help a person make a decision.

11. The Healthcare Standards for Wales[5] provide a common framework of standards for NHS care. They set out that patients and their carers must be treated with dignity and respect, that patients are not discriminated against on the grounds of disability, and that care is integrated across services.

12. The applicable POVA procedure[6] includes that people should be enabled and encouraged to take decisions for themselves wherever possible. It emphasises that the safety and welfare of vulnerable people is paramount at all times.

13. The complaint handling process for social services departments[7] encouraged local authorities and the NHS to work together in responding to complaints. On 29 July 2011 (so after these events) the Welsh Government issued a model concerns and complaints policy for adoption by public service providers in Wales. This aimed to make it easier to deal with multi-agency complaints and to provide the complainant with a single contact point and a single investigation process. Changes to social services complaints procedures are currently being considered, to more closely align them to the model policy.

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[5] Issued by the Welsh Assembly Government (now the Welsh Government) in 2005

[6] In September 2000, the Welsh Assembly Government launched a guidance document called 'In Safe Hands'. Based on this, in 2004, the South Wales Adult Protection Forum produced the 'Inter-Agency Policy & Procedures for responding to alleged abuse and inappropriate care of vulnerable adults in South Wales'. This was updated in November 2010 (after the events considered here).

[7] Listening and Learning - A guide to handling complaints and representations in local authority social services in Wales 2005.

The background events

14. On 2 January **2009**, Mr C provided his consent for the insertion of a PEG feeding tube. He was able to understand the nature of the procedure but was unable to provide a signed consent because of his physical disability.

February

15. On 16 February, Mr C underwent surgery to have the PEG tube inserted. He was discharged home on 20 February. Unfortunately, Mr C aspirated (inhaled food or fluid into his lungs) overnight following discharge and was admitted to the A&E department at PCH on 21 February. He was noted to be mentally aware and that he was responding by 'blinking for yes'.

16. Mr C was transferred to a ward. On 24 February a doctor recorded 'home whenever wife and dietician happy'.

17. On 26 February, the nursing staff spoke to Mrs C about Mr C's discharge plan. The nurse stated that it was unsafe to discharge Mr C 'tomorrow' and Mrs C agreed with this decision, due to Mr C's difficulties in swallowing.

18. On 27 February Mr C was examined by a consultant physician. The consultant physician noted that Mr C's chest was clear and that arrangements should be made for his discharge as soon as he was 'fit to go'. Mr C was also seen by a dietician who noted that Mrs C had reported concerns about pump feeding her husband overnight. A meeting on the ward was arranged for 2 March to discuss a safe discharge plan.

19. The nursing staff had a conversation with Mrs C about the risks associated with feeding her husband. The following was also discussed:

- that Mrs C left her husband in the car sometimes when she went out for a walk or to do shopping;
- that at times when the home carers were not there, her husband was at home alone;
- that the home carers were very good and capable of identifying problems with Mr C's swallowing;
- Mrs C said she would rather have her husband at home and at risk rather than being away from her in a nursing home.

March

2 March

20. On 2 March, nursing staff spoke to the senior nurse about concerns that Mr C may be a vulnerable adult, and that he was not swallowing safely. The senior nurse contacted social services and spoke to the duty member of the adult disability team. The senior nurse's notes record that the duty social worker stated that there had been ongoing issues with Mrs C and suggested that a vulnerable adult referral should be made. The duty social worker's note of the conversation included that the senior nurse did not want pursue the POVA procedure at that time. Also that she raised concerns about Mrs C leaving her husband alone in the car and at times at home. They agreed that the senior nurse would speak to Mr C's social worker.

21. Later that day, a ward meeting took place between nursing staff (including the senior nurse), a speech & language therapist (SALT), a dietician, the district nurses (who had been involved in Mr C's care at home), two of Mr C's home carers and Mrs C. It was agreed at this meeting that Mr C would need to be fed by day with constant supervision. Also on 2 March, Mr C's consultant physician carried out his weekly review. The note of this indicates that he discussed resuscitation with Mr & Mrs C and that '[Mr C] wishes to be resuscitated'. He planned to monitor the PEG feed as Mr C was at high risk of aspiration.

3 March

22. On 3 March, a doctor noted ‘met with wife who is extremely keen to get him home …’ and ‘we need a full capacity assessment regarding [Mr C’s] ability to make an informed decision regarding his future care’.

23. The manager from social services’ adult disability team attended the ward with Mr C’s allocated social worker. They identified the following:

- when Mr C was asked a straightforward question requiring a yes or no answer he appeared to have capacity;

- when more information was required from Mr C to support the decision-making process it was apparent that he became confused as he frowned (Note: on seeing this report in draft form, Mrs C explained that frowning did not indicate confusion, instead that it was her husband’s way ‘of telling you that he wanted to be asked different questions or that he was fed up of repeating himself. There were 2 new social workers that he had not met before, asking him a series of questions, and they may well have found it difficult to know how to communicate. …’);

- that it was questionable that Mr C had capacity if he was required to make decisions based upon large amounts of information.

24. Social services’ assessment of Mr C at this time noted that:

- Mr C’s communication needs meant that he was unable to advocate on his own behalf and that his wife had traditionally filled this role;

- Mr C's capacity to make decisions regarding his own care was unknown at this time and that staff at PCH were seeking an assessment;
- an MDT meeting was needed to consider Mr C's eligibility for CHC;
- that Mr C appeared able to communicate his wish to return home. However, it was not certain that he had the capacity to make this decision taking into account his needs and the risks. Therefore, the hospital had requested a capacity assessment.

25. A ward nurse, the senior nurse, the social services team manager and the social worker met and agreed that Mr C needed a 24-hour nursing assessment and a matrix[8] meeting prior to his discharge. Also that doctors would be asked to assess his mental health capacity.

26. A discussion also took place between the nursing staff at PCH and the discharge liaison nurse[9]. The discharge liaison nurse advised that a matrix meeting would be required but that this could only go ahead when Mr C was medically stable. She noted: '… we need a full capacity assessment regarding [Mr C's] ability to make an informed decision regarding his future care. [He] is unable to express his needs.' The discharge liaison nurse spoke to Mrs C who was noted to be extremely keen for her husband to be discharged home. It was reported that Mr C had met criteria for Continuing Healthcare (CHC)[10] in the past but this had been declined by Mr & Mrs C.

[8] The matrix meeting considers the patient's needs in established categories which are set out in a matrix.

[9] The discharge liaison nurse was employed by ABHB to coordinate discharge of patients within the Caerphilly area.

[10] Continuing healthcare, where care is fully funded by the NHS because a person has a significant level of need. Need is assessed against established criteria.

27. Nursing staff noted that Mr C needed a 'full capability assessment' to establish whether he was capable of making a decision about his care needs.

4 March onwards

28. On 4 March, Mr C was noted to be responding to short simple questions by eye movement. Nursing staff spoke to a mental health team in another Health Board about a mental capacity assessment but they indicated that this type of assessment was outside of their remit.

29. Mrs C informed staff that she would like her husband out of bed for short periods. She expressed concern that he had not opened his bowels for 12 days. Mrs C also approached nursing staff with concerns about her husband's chest. When a member of staff went to examine Mr C, she noted that Mrs C was using paper towel to clear sputum from his throat. The nurse asked her to refrain from doing this and provided Mr C with a saline nebuliser to help loosen the phlegm.

30. On 5 March, a doctor faxed a request to St Tydfil's Hospital[11] for an assessment of Mr C's 'capacity to make decisions himself' and 'Mental State Capacity'.

31. On 6 March, Mr C's consultant physician reviewed him. The clinical plan was to obtain a chest x-ray to assess Mr C's condition, an MRI brain scan, and a mental capacity assessment. The consultant physician and nursing staff met with Mrs C to discuss:

- concerns about Mr C's difficulty in swallowing and that he was at increasing risk of aspiration;

[11] Cwm Taf HB's community and mental health hospital

- that Mr C was showing typical signs of progressive MS and that his continued swallowing difficulties may indicate an overlapping element of CVA[12] (with a possible loss of brain function);
- that an independent assessment of Mr C's mental capacity was required;
- Mrs C indicated that her husband wished to be resuscitated.

32. They agreed to actively treat Mr C until his mental capacity was assessed and an MRI scan had been completed; and that if Mr C was clinically stable after investigations he would be discharged home.

33. On 9 March, the consultant physician noted that Mr C was awaiting the MRI scan and mental capacity test. The consultant physician faxed a letter to colleagues in adult psychiatry which included:

- since admission, the team treating Mr C had discussed his resuscitation status and they had agreed that it would not be in his best interest to attempt cardiac resuscitation in the event of an arrest. However, Mrs C was adamant that her husband wished to be resuscitated and that it was in his best interest;
- the team felt that it was difficult to make an accurate assessment of Mr C's mental capacity status and ability to make an informed decision as his communication skills were limited and it was difficult to judge if his head movements reflected his true feelings;
- when Mrs C was present she often interjected and answered questions on Mr C's behalf when discussing the issue of capacity and resuscitation;
- the team realised that although MS does not normally cause a loss of higher brain functioning, it may be possible that an

[12] Cerebrovascular Accident: a stroke

additional underlying process may be occurring. An MRI scan had been requested to assess this further;
- the team were anxious for a decision to be made soon and asked if an assessment could be carried out within the next few days.

34. Mr C's social worker contacted the ward and was informed that the staff were awaiting a mental capacity assessment from a consultant psychiatrist.

35. On 10 March, Mr C suffered 'massive PR bleeding' (rectal bleeding). At 10.36am, Mr C was seen by the surgical registrar who planned to carry out a sigmoidoscopy (a procedure to look inside the large intestine). On 11 March, Mr C was sent for a sigmoidoscopy, but this could not be carried out as his bowel had not been prepared properly. On 13 March, the consultant physician noted that Mr C was awaiting a sigmoidoscopy and MRI scan. On 16 March, the junior doctor sent a reminder to the relevant department about the sigmoidoscopy.

36. Mr C's social worker telephoned the ward for an update. She was informed that Mr C was awaiting an MRI scan and sigmoidoscopy. The social worker noted that a mental capacity assessment was still necessary.

37. On 17 March, Mr C's temperature 'spiked'. He was provided with antibiotics. It was noted that he was not communicating at this time. However, on 20 March, Mr C was seen by a physiotherapist when he consented by blinking to sitting out in a chair.

38. By 23 March, the MRI scan had been done and this was reviewed by the consultant physician. He also noted that the sigmoidoscopy was to be carried out 'tomorrow' and that once Mrs C was happy for her husband to be discharged he was medically well

enough to go home. It was planned that Mr C would continue with the PEG once a package of home care was in place. The consultant physician noted that concerns regarding Mr C's vulnerability would need to be addressed before he could leave the ward and that he was 'not to leave ward this week'.

39. On 27 March, Mr C was reviewed by the consultant physician who noted that there were issues and concerns surrounding Mr C's home care package and vulnerability. A junior doctor subsequently spoke to Mrs C. He explained that the sigmoidoscopy had not gone ahead due to poor preparations but that Mr C's consultant physician felt that no further investigations were required at this time. He also discussed the MRI scan results and informed Mrs C that they planned to discharge her husband next week.

40. On 29 March, Mrs C indicated to nursing staff that she was not happy because her husband's head was slumped, his urine was concentrated and she believed that his bladder needed 'flushing' and that he needed IV fluids.

41. On 30 March, issues regarding Mr C's home care were discussed. The consultant physician said that he was unable to comment on Mr C's capacity as he 'doesn't communicate with us'.

42. Mr C's social worker queried with the ward whether Mr C's mental capacity assessment had been carried out; she was told it had not.

April

43. On 3 April, the consultant physician noted that Mr C was awaiting a 'social package'. He said that Mr C required a mental capacity assessment but that he was unable to perform this. The clinicians discussed Mr C's discharge plan to return home. Mr C was described as 'medically fit for home'. The nursing notes included:

'…spoke to wife aware that we are still awaiting capacity assessment. Spoken to … social worker. Aware of the above. … wife panicking that social services will not allow him home. Informed that I was unaware of any plans other than discharge at present.'

44. On 6 April, a doctor noted that the plan was to discharge Mr C but this depended on social services. Mr C was awaiting a capacity assessment and a 'piece' for the PEG from Caerphilly District Miners Hospital. The dietician reviewed Mr C because of 'PEG leakage'. It then appeared that the PEG compartment could be replaced at PCH and the replacement part was ordered.

45. On 7 April, a medical review of Mr C confirmed that there were no medical issues to address but that the 'social issue' was being dealt with at a 'managerial' level.

46. On 8 April, the dietician reviewed Mr C's PEG feeding. In view of the leakage, arrangements were made for a replacement 'Y adapter' to be sent from Caerphilly District Miners Hospital. Initial arrangements were made for an MDT meeting on 15 April. This was postponed to 24 April.

47. On 9 April, Mrs C raised concerns regarding her husband's discharge; she said she wanted him home. The hospital staff explained that although Mr C was medically fit for discharge, an MDT meeting was required and this would take time to arrange. Mrs C was advised to speak to the discharge liaison nurse. Mrs C met with the social worker for a carer's assessment. She expressed her wish for her husband to be discharged but asked if, as an alternative, he could be transferred to YMH. On 10 April, the social worker informed Mrs C that her husband could potentially be in hospital for a further five weeks. Mrs C raised her concerns with hospital staff about her husband's low mood as he wanted to go home, and his risk of acquiring an infection while in hospital.

48. On 13 April, Mrs C approached the nursing staff once again to ask about the date of discharge. Staff explained that as Mr C might be eligible for CHC, assessments needed to be carried out.

49. On 14 April, Mrs C was informed by nursing staff that her husband could not return home until everything was in place for a safe discharge. The staff said they were waiting for the discharge liaison nurse to arrange the MDT meeting. Mrs C said she wanted the staff to be aware that she was now formally requesting a MDT meeting and that she expected a response within one week. She spoke to the social worker, whose note indicates she advised Mrs C that it was the hospital's responsibility to organise discharge and arrange a CHC assessment.

50. On 15 April, a 'professionals meeting' was held and it was decided to transfer Mr C to a hospital nearer to his home as he no longer needed acute care.

51. On 16 April, a nurse noted that she had spoken to a senior doctor about a capacity assessment who had advised that any junior doctor could do an assessment. On the same day, a junior doctor noted that the Clinical Director was to do the Mental Capacity Assessment. However, later that day the same doctor noted that she had been:

> 'Asked to do mental capacity assessment. I haven't done such an assessment before. Obviously [Mr C's] case is not straightforward. Will ask for assistance/supervision by mental health team and do assessment on Monday [19 April].'

52. The ward was informed that the matrix meeting would take place at PCH on 23 April and that Mr C would be transferred to YMH following this meeting. On 20 April, the matrix meeting was re-scheduled to 24 April.

53. On 21 and 23 April, it was noted that Mr C was awaiting transfer to YMH and that there was no need for a mental capacity assessment at the time.

54. Mr C was transferred to YMH on 24 April. The transfer documentation did not refer to his capacity. The matrix meeting was held that day to consider Mr C's eligibility for CHC. It was attended by Mrs C, a doctor, nursing staff, the social worker, the discharge liaison nurse, an occupational therapist (OT) and a dietician. The meeting concluded that Mr C would be eligible for CHC as he had complex and unpredictable needs. A home care package was discussed for submission to Torfaen LHB (as the responsible commissioning authority).

55. On 27 April, Mrs C asked for the matter of CHC and Mr C's discharge to be considered urgently. On 28 April, Mrs C was visited at home by an OT.

56. On 30 April, Mrs C's complaints advocate contacted the staff at YMH regarding Mr C's package of care. The staff explained that the care co-ordinator would send all the information to the complex care team at Torfaen LHB. The staff indicated that the matter would go to the CHC funding panel on Friday 1 May.

May and June

57. On 1 May, the social worker noted two calls from Mrs C and that she was very distressed at the delays in considering her husband's care package. She had been advised that the CHC panel would not be able to consider the application until 20 May.

58. The sequence of events regarding the CHC application was then as follows:

- 14 May - a summary report was completed by ABHB staff for the CHC funding panel;
- 18 May - further clarification on Mr C's case was requested;
- 22 May - the CHC funding panel met to consider Mr C's care package. The panel wanted additional information, which was requested in a letter dated 26 May;
- 1 June - Mrs C confirmed that she would accept the package of care being offered by the CHC funding panel as otherwise her husband would not be discharged. She was disappointed by the lack of flexibility in the package;
- 3 June - the 'associate specialist in adult medicine' at YMH wrote to the Manager of the Complex Care Team (ABHB) for the purposes of the CHC application as follows:

  'This is to confirm that [Mr C] has progressive multiple sclerosis. … He is at an advanced stage of the disease. His communication is limited to eye blinking for yes and no, and sometimes nodding or shaking his head for yes and no respectively. There is no prospect of further improvement. With limited interaction available at present, it seems likely that [Mr C] has no receptive problems and so does not have any problems with comprehension. As his responses are consistent the risks of home discharge had been explained to him and he seems to understand and give appropriate responses. So I would be happy to certify that [Mr C] has a good understanding of the problems he faces and has indicated his consent for home discharge'.

- 4 June - the discharge liaison nurse faxed the CHC funding panel with the further information requested on 22 May;
- 5 June - Mrs C contacted hospital staff for an update.

[Note: the final decision of the Panel was not provided to me.]

59. On 17 June, Mr C was discharged home from hospital.

60. On 6 June 2009, Mrs C sent a complaint (via email) to all the parties.

The complaints process: Welsh Government

61. On 24 June 2009, the Minister for Health and Social Services wrote to Mrs C about her complaint. The Minister's letter included:

> 'To try to gain an overall picture for you, I have … written directly to [the] Chief Executive of Gwent Healthcare NHS Trust asking him to liaise with [the] Chief Executive at Cwm Taf NHS Trust, and with the LHB, to look into exactly what happened with your husband's care and ongoing assessment and to contact you directly with a joint response. …'.

62. The Minister wrote to the Chief Executive of ABHB:

> '… I should … like you to liaise with [the Chief Executive of Cwm Taf NHS Trust], and the Local Health Board, to ensure that all these concerns are thoroughly investigated and that [Mrs C] is provided with a full and proper response as soon as possible on behalf of all the bodies involved
> …'

The complaints process: Cwm Taf HB

63. On 30 July, Cwm Taf HB received an e-mail from ABHB that Mrs C was in agreement with the provision of individual responses from each of the bodies, with a joint meeting to follow.

64. On 7 August, Cwm Taf HB provided its complaint response to Mrs C. On 12 August, Mrs C sent an email to Cwm Taf HB setting out her outstanding complaints; she requested a meeting.

65. On 28 September, the Council wrote to the Chief Executive of Cwm Taf HB disagreeing with some of the content of Cwm Taf's letter of 7 August.

66. On 29 October a resolution meeting was held with Cwm Taf HB which was attended by Mr C's consultant physician and other PCH staff members.

The complaints process: ABHB

67. On 22 July 2009 ABHB wrote to Mrs C to advise her that it would consider her complaint.

68. On 31 July, the Complaints Manager at ABHB e-mailed her counterparts in the other organisations. She said that she had spoken to Mrs C who was happy to receive individual responses from the different organisations. The plan was to then meet together to decide how improvements could be made.

69. On 3 August, ABHB provided its response to Mrs C's complaint. On 22 September, a further response was sent by ABHB to Mrs C. On 25 Feb 2010, a resolution meeting was held between Mrs C and ABHB staff.

The complaints process: the Council

70. On 28 September 2009, the Council sent a letter to Cwm Taf HB indicating that its account of events differed from theirs.

71. On 30 March 2010, a meeting was held between Mrs C and the Council. On 12 May, the Council wrote to Mrs C in response to her concerns.

Mrs C's evidence

72. Mrs C said that her husband was diagnosed with MS in 2000 and his condition had steadily deteriorated. By 2009, he could not

mobilise or speak and mostly communicated ‘yes or no’ through blinking.

73. Mr C had a PEG tube fitted to assist with feeding. He was discharged home on 20 February but aspirated overnight on the PEG feed and was admitted by ambulance to PCH on 21 February.

74. Mrs C said that her husband remained at PCH until 28 April when he was transferred to YMH, a community hospital. This was despite him being deemed medically fit for discharge on 3 April. Mrs C said that she and her husband wished for him to be safely discharged from hospital as soon as possible so that he could be cared for at home.

75. Mrs C said that prior to her husband’s hospitalisation his care was provided through a system of direct payments from social services. This was withdrawn at the time he was admitted to PCH. Mrs C said that because the care package was withdrawn with nothing to replace it this led to months of unnecessary time in hospital. Mrs C said that her husband had qualified for CHC in June 2008 but they had declined that due to the rigidity of the CHC system and previous bad experiences in using CHC for respite services. However, at a meeting on 2 March at PCH – which Mrs C understood to be an MDT meeting - Mrs C agreed that because the PEG needed to be used during the day to reduce the risk of aspiration, CHC would now be necessary. As her husband had previously been assessed for CHC, Mrs C believed that this should have speeded up the process.

76. Mrs C said there was no discharge planning between the meeting on 2 March and 16 April, when she was informed that an MDT meeting would take place on 28 April. Mrs C’s GP had written to the hospital on 14 April regarding Mr C’s discharge, and this, in Mrs C’s view, along with her own persistence led to the meeting on 28 April. Mrs C also said that the joint hospital discharge liaison

nurse was not actively involved in her husband's case until 16 April. Nor was the GP involved in any of the discharge planning although he knew Mr C and his needs very well. Mrs C said that the various organisations involved in her husband's case failed to work together in relation to his discharge. Even when a decision was made to provide a care package at home this took weeks to organise.

77. Mrs C said that she constantly asked for updates on discharge planning but was told very little. She said that she spent much of her time e-mailing, telephoning and asking questions to try to move the process forward. She said that she was constantly misinformed by staff that her husband might be discharged imminently.

78. Mrs C said that during her husband's admission it was suggested that POVA action should be taken. Mrs C said this put her and her husband in an impossible position. If she discharged him she believed that POVA action would be initiated, but her husband could not discharge himself because he was awaiting a mental capacity review. Mrs C said that because her husband was not allowed home to her care she felt stigmatised. Mrs C felt she was inappropriately regarded by health care staff as being subject to POVA considerations. Mrs C said that the suggestion of POVA proceedings may have come about as a result of their refusal of CHC in 2008.

79. Mrs C said there was confusion as to who initially requested the mental capacity assessment. Mrs C said Cwm Taf HB had informed her that the mental capacity assessment had not been carried out because her husband was too unwell. However, Mrs C said that this was first requested on 6 March and that her husband was deemed medically fit for discharge on 3 April. She commented that the GP's opinion could have been sought regarding Mr C's capacity; similarly the MS consultant and the district nurses knew Mr C well enough to have a view about his capacity. Mrs C said after Mr C moved to YMH, the idea of a mental capacity assessment was 'quietly

abandoned'. She said that not knowing where they stood and what would happen put her and her husband under unbearable stress.

80. Mrs C said that if there were POVA concerns with regard to her caring for her husband at home and he required a mental capacity assessment, then an IMCA should have been appointed. Mrs C said that the hospital did not accept her as her husband's advocate but no one acted instead.

81. Mrs C said that when her husband was at PCH he suffered indignity and there were times when he received a poor standard of care. He was not provided with medication for his bowels and did not have a bowel movement for 10 days. She said that as a result, he suffered faecal impaction and profuse rectal bleeding. Mrs C said that she was advised to contact her husband's family as he was so unwell. Subsequently, Mrs C said that her husband experienced diarrhoea as he was given excessive laxatives. Mrs C said that this continued while he was at PCH and was not resolved until he was transferred to YMH.

82. As a result of the bleeding, Mr C's consultant physician requested a sigmoidoscopy. However, following two attempts this could not be done as he was covered in faeces. Mrs C said that her husband did not have any incidences of faecal incontinence following his discharge from hospital.

83. Mr C was referred by his GP for a sigmoidoscopy on 12 January 2010 which revealed a polyp in his rectum. She said that this led to a carcinoma tip being removed at Caerphilly District Miners Hospital. Mrs C questioned whether this could have been found earlier if the sigmoidoscopy had gone ahead at PCH.

84. Mrs C said that her husband's long term antibiotics were stopped at PCH. She understood that the consultant physician did not agree with the prescription of antibiotics as a preventative

measure. Mrs C said that her husband contracted two urine infections during his time at PCH. She said she noticed debris in his catheter bag and had requested bladder washouts which he regularly had at home. She said that by the time the doctor had prescribed these her husband had an infection which was then followed by a further infection.

85. Mrs C said that her husband required suction for dealing with saliva discharges. She said that patches were applied to reduce saliva but oral care was frequently not undertaken and she found solidified mucus in her husband's mouth.

86. Mrs C said that there was a delay at PCH in obtaining the replacement part for her husband's PEG feeding tube despite her providing details of the required part. She said that the tube had become 'glued' at the port (which can happen when the feed stops flowing through and solidifies). She said that by the time the replacement part was purchased the PEG was unusable and was taped with dressing tape. She said that this could have led to a further infection. At the time her husband was 'nil by mouth' and without the PEG tube he was not receiving sufficient fluids. Mrs C said that as her husband had been identified as at high risk of malnutrition, the delay was not acceptable.

87. Mrs C said she was not provided with a joint and co-ordinated response to her complaint although she had been promised that by the Minister. She said had found ABHB's responses to her complaints more apologetic and empathetic than Cwm Taf HB's.

Cwm Taf HB's evidence

88. The Health Board said that ward staff had contacted social services' adult disability team to discuss concerns regarding Mr C's changed needs and his vulnerability at home. Ward staff were told that there were ongoing issues between social services and Mrs C,

and the duty social worker suggested that a vulnerable adult referral should be made. The Health Board said that the staff trusted Mrs C to care for her husband but were concerned about his potential vulnerability at home.

89. The Health Board agreed that Mr C was medically fit for discharge on 3 April. However, due to his complex needs he required an assessment for CHC. Several agencies were involved and in that situation, meetings often took some time to organise. The Health Board said that as Mr C's care needs had changed with the use of the PEG feeding system staff needed to be certain that the appropriate care was in place when he was discharged home.

90. The Health Board said that during a meeting with Mr C's social worker on 3 March it was agreed that Mr C would not be discharged prior to a matrix meeting and that an assessment of his mental capacity would be carried out to determine if he was able to make an informed decision regarding his future care. The Health Board said that Mrs C was informed on 3 April of the reasons why her husband's discharge might be delayed.

91. The matrix meeting was not held until 24 April, as it is the Health Board's policy that such a meeting cannot be held until a patient is deemed medically fit for discharge.

92. About the mental capacity assessment, the Health Board said that social services had requested this before he was discharged home, and this was a view that was supported by nursing staff. The consultant physician felt it was more appropriate for a psychologist to carry out the mental capacity assessment. The Health Board said that a psychologist attended to see Mr C but was unable to carry out an assessment as a level of communication from the patient is required in order for a full mental capacity to be carried out. However, the

medical registrar later felt that as Mr C was being transferred to YMH the assessment was not necessary.

93. The Health Board agreed that the mental capacity assessment had partly caused some delay in the discharge planning. It said that it would not have been appropriate in Mr C's case to appoint an IMCA.

94. About Mr C's treatment, the Health Board said the following:

- with regard to the laxatives, due to Mr C's condition he was unable to use the commode which would have been necessary to undertake the usual method of giving enemas. As a result, in order to avoid constipation, laxatives were prescribed on the understanding that the nursing staff would have to regularly clean Mr C;
- it acknowledged that Mr C had severe diarrhoea and that it was difficult for the nursing staff to clean him quickly. However, it said that the staff made every effort to maintain Mr C's dignity and to keep him clean;
- Mr C's regular antibiotics were stopped because they were no longer effective. The antibiotics prescribed for Mr C's chest infection would have prevented a UTI from developing;
- when it was recognised that the PEG tube was split, every effort was made to obtain a replacement. A nearby Health Board advised that it could provide the part required but it was not forthcoming which resulted in staff having to find an alternative source. Unfortunately, the Health Board said that this did not happen as quickly as the staff would have liked and it was therefore necessary to temporarily tape the PEG to ensure that it was still effective.

95. The Health Board said that whilst appropriate action was taken throughout Mr C's stay this was not always communicated in a way that was constructive. It said that training would be provided to

enhance staff communication and people skills. However, it said that PCH staff had kept the discharge liaison nurse and the social worker fully involved.

96. Regarding complaints handling, an internal e-mail on 30 July 2009 included 'I've spoken to someone at Caerphilly and Torfaen LHB and they agree that providing one response will be a nightmare and it will be much easier if we all do our own responses… then meet to discuss any shortfalls'. The Chief Executive in her letter to Mrs C of 7 August said that the bodies were responding separately, but that senior staff would be happy to attend a meeting jointly with representatives from the other bodies.

97. Additional comments from Cwm Taf Health Board are at paragraphs 133 to 140, and paragraphs 147 to 149.

ABHB's evidence

98. ABHB said that Caerphilly borough had a dedicated Joint Hospital Discharge (JHD) team to which local residents with complex discharge needs are referred. This team is made up of health care and social work case managers who are collectively responsible for planning the complex discharges of Caerphilly residents from whichever hospital they have been admitted to.

99. In Mr C's case the discharge liaison nurse became actively involved in planning his discharge following the preliminary meeting on 15 April. The Health Board said that although the discharge liaison nurse was already aware of Mr C's case (within her remit as discharge liaison nurse predominantly covering PCH), a formal referral to the JHD team had not been made by PCH and therefore she was not involved in any formal discussions up until this date.

100. Mr C was transferred to YMH on 24 April. By 28 April the discharge liaison nurse had completed all the relevant CHC

documentation and had submitted it to the relevant complex care team. Upon receipt of this documentation, the complex care team required further information to support the decision making process and the discharge liaison nurse dealt promptly with this request.

101. The Heath Board said that the discharge liaison nurse did her best to keep Mrs C fully informed of developments with her husband's case. However, it required her intervention and that of Mrs C and her advocate before Mr C's application was considered at the CHC Panel meeting on 22 May. The Health Board said that unfortunately the systems and processes surrounding an application for CHC are complex, and that a six week period from the MDT meeting to discharge was normal.

102. The Health Board appreciated the anxiety and frustration caused to both Mrs C and her husband during the discharge process. However, it said that the actions of the discharge liaison nurse were appropriate and that she tried to expedite matters as much as possible.

103. The Health Board said that progress has been made in the CHC funding process since Mrs C's experiences particularly around communication with the families. Co-ordinators are better informed by the complex care team and therefore can communicate directly with families in a timely manner. Further, panel meetings are now scheduled on a weekly basis, and there is an out-of-panel decision making process to enable swift discharge.

104. The Health Board said that the Health Minister had requested that one organisation should lead the investigation. It said that it had liaised with Cwm Taf HB over the case but liaison with the Council was more difficult due to the different statutory processes.

105. An internal e-mail on 9 September 2009 by ABHB's investigator, the Community Senior Nurse, stated :

> 'I am concerned by some of the responses sent from PCH as it [stet] does not appear entirely accurate and I am sure differing responses will only fuel Mrs [C's] frustration.
> …'

106. The Health Board said that under the new 'Putting Things Right'[13] regulations there is a requirement for health organisations to work together to streamline the process and it hoped that this would improve partnership working when dealing with patient concerns in the future.

The Council's evidence

107. The Council said that PCH staff contacted the social services department on 2 March advising of their concerns. It said that although no known abuse had taken place, there were increased risks to Mr C being left alone due to the risk of choking and it was agreed that this would need to be considered when planning Mr C's discharge.

108. The team manager for the adult disability team and Mr C's social worker visited Mr C at PCH. They spoke with Mr C and felt that he could respond with accurate yes or no responses to direct questions. However, there was uncertainty about his ability to make decisions based on larger pieces of information. The Council said that ward staff advised the officers that they would like a capacity assessment to be undertaken and all parties agreed that this should be carried out by an appropriate individual at the hospital. It said that Mr C's social worker agreed that a new care plan would be undertaken before discharge.

[13] 'Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011' (so after these events)

109. The Council said that at no point was Mrs C advised that discharging her husband would result in POVA action but that advice was provided to her in relation to her expressed wish to discharge her husband on two separate occasions. The issues were of care management, not POVA.

110. The Council said that prior to Mr C's admission, all communication and decision-making had been undertaken jointly with Mrs C acting as Mr C's advocate.

111. The Council said that an IMCA can only be appointed where a patient has had a formal capacity assessment and is deemed not have the capacity in specific decision making. It said that as this was not established it was not appropriate in Mr C's case.

112. The Council said that communication from the ward staff could have been improved with regard to keeping Mr C's social worker informed of his progress. However, the Council said there was regular communication between all agencies during discharge planning. Delays occurred in the discharge process due to Mr C's fluctuating health needs and the CHC application process.

113. The Council said that social services were in contact with both Cwm Taf HB and ABHB regarding a joint response in line with Welsh Government Listening and Learning Guidance[14]. However, despite efforts being made this did not prove possible. It said that once Cwm Taf HB had responded directly to Mr and Mrs C about the complaint a decision was made that each body would respond separately. The Council subsequently wrote to the Chief Executive at Cwm Taf HB disagreeing with aspects of her response to Mrs C.

[14] See Appendix F

Professional advice

The medical adviser

114. I have taken advice from a consultant physician with over 20 years experience. His advice is attached at Appendix A and is summarised below.

115. The medical adviser said that Mr C should not have been allowed to remain constipated for such a long period. He said it is rare that faecal impaction would cause rectal bleeding and it appeared that the eventual cause of Mr C's bleeding was a polyp.

116. The medical adviser said it is controversial whether preventive use of antibiotics is effective in patients with urinary catheters in place. The medical adviser said it can be effective in conjunction with bladder washouts. The adviser commented that as antibiotics for a chest infection to which the urinary bacteria was sensitive were prescribed at the same time, it was appropriate for Mr C to stop taking the preventive antibiotics and not to restart them immediately to avoid antibiotic resistance.

The nursing adviser

117. I have taken advice from a senior and experienced nurse. Her advice is at Appendix B and is summarised below.

118. The nursing adviser said that while Mr C was noted to be medically fit for discharge on 27 February the dietician noted that his swallowing reflex was so poor that he could not swallow his saliva. This meant that he would be unsafe for discharge until support was in place.

119. The nursing adviser noted evidence that a full review of Mr C's mental capacity was requested on or around 4 March and that nursing staff reminded medical staff about this. However, the failure by medical staff to pursue this did not cause the delay in Mr C's

discharge. The arrangements for extra home support were complex and involved multiple care teams. The nursing adviser said that it was inevitable therefore that there would be delays.

120. In relation to POVA action, the nursing adviser said there was evidence in the clinical records of nursing staff having concerns in relation to ensuring a safe discharge for Mr C. The nursing adviser said the records confirmed that these concerns were discussed with the Council's adult disability team who suggested that nursing staff should make a POVA referral. The nursing adviser said that the Council's notes indicated that social services were already aware that there might be potential for POVA proceedings but that as Mr C was safe in hospital and no abuse had occurred, there was no risk, and there is no evidence that any POVA action was taken. Had Mrs C insisted that her husband be discharged before a safe package of care was in place, the nursing adviser said further involvement of social services was likely with an escalation of the POVA process.

121. The nursing adviser said that Mr C's personal care assessment on admission, which would include mouth care, indicated that he was totally dependent. It recorded 'lips, mouth dry, sore'. There was evidence that the nursing staff assessed Mr C's need for oral care and that it was routinely given.

122. In relation to the new PEG tube, the nursing adviser noted that the nursing records confirm damage to the PEG tube on 31 March. On 6 April staff contacted Caerphilly District Miners Hospital (where the PEG had originally been inserted), but a dietician subsequently said that the part could be replaced at PCH and the item would be ordered. However, on 8 April the dietician recorded that 'Gwent dieticians will send us the Y replacement adaptor'. The nursing adviser said that the new part was fitted to the PEG system on 9 April. Having reviewed the fluid intake charts for the relevant period, there was no evidence to suggest that Mr C did not receive his PEG

feeds. Although there was evidence of a delay in replacing the necessary connector, this had not interrupted Mr C's feeding regime.

The mental health nursing adviser

123. I have taken advice from a registered mental health nurse with extensive experience in acute adult psychiatric nursing and who is able to provide advice regarding the Mental Capacity Act 2005 and the POVA issues involved in this case. His advice is at Appendices C and E. It is in two parts as it was necessary to obtain further advice from the mental health nursing adviser after Cwm Taf HB submitted additional information. I have summarised his advice below.

124. The mental health nursing adviser confirmed that Mr C's case was complex. When he was admitted to PCH he was only able to communicate by blinking his eyes, nodding or giving the 'thumbs up' sign. The mental health nursing adviser said that staff correctly began with the assumption that Mr C had capacity. However, staff soon became unconvinced that Mr C could understand or communicate his needs in respect of more complex information and they were also concerned about his safety given his inability to swallow.

125. The mental health nursing adviser said that as soon as any emergency treatment had been carried out following Mr C's admission, and given the obvious concerns about his communications deficit, consideration should have been given to his capacity to agree to any of the proposed treatments, especially with regard to resuscitation.

126. Best practice dictates that discharge planning starts at the point of admission and it would have been reasonable for a Mental Capacity Act 2005 assessment to have taken place at the earliest possible opportunity. The mental health nursing adviser said that the Act is clear about the duties it places on those in caring professions

and that having considered the principles of the Act, the staff did not wholly comply with their duties in this respect.

127. The mental health nursing adviser said that although there is evidence in the records to confirm that the nursing staff, on several occasions, requested a second opinion with regards to capacity none of the staff took the lead to ensure that this was done. Further, other than when administering life saving treatment, there was no evidence that staff took all practical steps to assist Mr C to communicate his needs before deciding on his care.

128. The mental health nursing adviser said that although the staff were acting in Mr C's best interests it was uncertain on what authority they were making decisions about his care. The nursing adviser said that at times the staff treated Mrs C as if she had the authority to consent to the proposed treatments.

129. There is no evidence that the nursing staff asked Mr C if he wanted to stay in hospital and receive treatment on 27 February, so they may have deprived him of his liberty.

130. With regard to POVA, the mental health nursing adviser said that shortly after Mr C's admission, concerns were raised about Mrs C's ability to safely care for her husband. It was reasonable for Health Board staff to raise concerns with social services.

131. Although a discussion was held with social services' staff, the mental health nursing adviser said that a POVA referral was not made on the basis that Mr C was not at risk whilst in hospital. This contradicted social services policy and procedure which states that where there was any doubt as to whether the adult protection procedures should be invoked the matter should be referred to the designated lead manager. The mental health nursing adviser said there was no evidence that the POVA system was used to threaten

Mrs C or that the staff believed that Mrs C was the subject of a POVA investigation or that a POVA was in place.

132. The mental health nursing adviser noted that social services visited Mr C and carried out an excellent adult services assessment although this was frustrated due to Mr C's limited capacity to communicate his more complex feelings.

Cwm Taf HB's further response

133. I referred the mental health nursing adviser's opinion (Appendix C) to Cwm Taf HB for its comments on the failings identified by him. The Health Board's response is at Appendix D, and I have summarised this below.

134. The Health Board said that the mental capacity assessment required for Mr C went beyond the ward staff's capability and knowledge base. It was therefore correct to ask Mr C's consultant physician to undertake the capacity assessment. However, the consultant physician had no experience in this field and the Clinical Director at the time was asked for professional input and guidance. Support was also sought from mental health professionals.

135. The Health Board disagreed that no staff member had taken the lead with regard to Mr C's capacity assessment and said that the matter was referred to Mr C's consultant physician, the Clinical Director and the Head of Nursing to resolve the issue. [Note: This is the first time that the involvement of the Clinical Director and Head of Nursing has been mentioned, and I have seen no written evidence of this.]

136. The Health Board said that staff acted in Mr C's best interests and were correct in not working outside of their level of capability in what was a very serious and unusual case. Staff carried out their

duties by requesting an in-depth assessment in light of the complexity of Mr C's condition. Staff made a daily on-going assessment of Mr C.

137. The Health Board said that Mr C's condition was very poor for a long period of this admission and his inability to understand information was an important factor in trying to obtain his opinion about resuscitation and other aspects of his care. The Health Board was unsure what steps it could have taken to assist Mr C in communicating his needs before deciding on his care due to his very limited physical capabilities.

138. The Health Board said that nursing staff consulted with Mrs C about her husband's care as she was his next of kin and main carer. Nursing staff include a patient's carer and family when difficult decisions have to be made with regard to their care.

139. Mr C was not deemed medically fit for discharge until 3 April so it was incorrect for the mental health nursing adviser to suggest that he may have been deprived of his liberty from 27 February onwards.

140. With regard to POVA issues, the Health Board said that social services visited the ward to assess Mr C and further discussion was held at the time. However, at no time was a request made to complete a POVA referral form and no strategy meeting was arranged by social services to discuss any of the issues raised.

The mental health nursing adviser's further comments

141. I referred Cwm Taf HB's further response to the mental health nursing adviser for his comments. His additional comments are at Appendix E and are summarised below.

142. The mental health nursing adviser said that Cwm Taf Health Board failed to recognise that its staff members did not have the required level of awareness or basic knowledge regarding the Act

and its five principles including how and when to carry out an assessment.

143. The mental health nursing adviser did not dispute that Mr C was very unwell during his admission at PCH. However, he had highlighted the actions of the staff with reference to the Act and the difference between supplying care that is necessary to immediately sustain life and longer term care. Staff providing care to Mr C had a duty to refer to the Act but there was no evidence to confirm that this was done. Even though they did attempt some form of capacity assessment, this was not enough to conclude that their actions were reasonable.

144. The mental health nursing adviser said it was responsibility of nursing staff to ensure that important issues were raised and pursued. Although the issue of Mr C's capacity was raised it was not acted upon.

145. The mental health nursing adviser referred to the ward round discharge plan of 27 February which recorded 'For discharge as soon as he is fit to go'. The mental health nursing adviser said that there was no evidence of any attempt to communicate with Mr C about his discharge when this entry was made.

146. Regarding POVA issues, the mental health nursing adviser referred to the entry of 2 March contained within the clinical notes. This recorded that social services advised nursing staff to make a vulnerable adults referral.

Cwm Taf HB's response to the draft report

147. Regarding capacity and the need for an IMCA, Cwm Taf HB wrote:

'… the Assistant Director of Nursing has confirmed that the Health Board has procedures in place allowing staff to access IMCAs, however in Mr C's case the involvement of an IMCA was not appropriate as he was more than capable of making his own decisions as he had capacity. The Head of Nursing agrees with this and has confirmed that Mr C would communicate very effectively with staff via a 'blinking' method. Additionally, his wife was present on a very regular basis and would advocate on his behalf.'

148. In light of this, I spoke to Cwm Taf Health Board's Head of Nursing to clarify the HB's position. The Head of Nursing told me that Mr C could communicate yes/no through blinking and this was adequate for the HB. However, social services asked for his capacity to be assessed for higher level decision making. The Ward Manager subsequently confirmed that that was her recollection of the events. The Head of Nursing said that the consultant felt unable to undertake this level of assessment himself which was why he contacted psychiatry colleagues.

149. The Head of Nursing also said that Mr C remained in hospital because he had health needs. There were three weeks at the end of his stay when he was well enough to go home, but he remained in hospital as his home was not ready at that time.

Analysis and conclusions

150. In reaching my conclusions, I have been guided by the helpful advice provided by the Ombudsman's professional advisers.

<u>Complaints 1 and 2 – Delayed discharge</u>

151. Mr C was admitted to PCH as an emergency on 21 February 2009. He was transferred to a ward the following day. He was unable to swallow and therefore all, including Mrs C, agreed on 26

February that it was unsafe for him to be discharged. However, he was noted to be clinically ready for discharge on 24 and 27 February.

152. An MDT meeting was to be convened which was an entirely appropriate way forward to agree a safe discharge plan. Unfortunately, Mr C was taken ill on 10 March, but by 23 March he was noted once again to be medically fit to be discharged. This was confirmed by the consultant physician on 3 April. However, Mr C remained in hospital until 17 June.

153. Some of this delay was due to the need to assess Mr C's eligibility for CHC. I note Mrs C's view that as he was already known to the CHC service this should have speeded the process up, but I cannot agree as his needs had changed and he needed to be fully re-assessed. Following the assessment, it would have taken time to put the care arrangements in place. So, there was inevitably going to be some delay. However, his discharge took almost three months (from 23 March to 17 June).

154. I have carefully considered whether that length of time is reasonable. From the perspective of those inside the service, who are familiar with the procedures involved, I imagine it was a reasonable timeframe. From Mrs C's point of view, visiting the hospital and waiting for news every day, I can see that it was not a reasonable timeframe. On 24 April, when asked by the discharge liaison nurse, Mr C specifically indicated his wish to go home.

155. The MDT/matrix meeting took place on 24 April (32 days after the medical entry on 23 March) when all the attendees agreed that Mr C met the criteria for CHC. A report was submitted to the decision panel on 14 May (20 days later), and was considered by the panel on 22 May (8 days later). The panel seems to have agreed in principle, although requested additional information which was supplied on 4 June (13 days later). Mr C was discharged on 17 June (a further 13

days later). It is notable that most of the delay was in arranging the MDT meeting and in the panel convening (60 days in total).

156. I am aware from experience of other complaints that this is not outside the norm. The process requires much information to be collected and collated. I also take account of the fact that Mr C had extensive needs and needed to be safe at home. However, I think that three months is too long for a patient to wait in hospital, particularly when the equipment he needed was already in place at home. I know there is no simple solution and that delays are inbuilt in the assessment, approval, and discharge process, but I would ask the Health Boards and Council to think hard about whether Mr C's discharge could have been achieved more quickly and whether the process can be speeded up for others.

157. Also compared to what I have seen in other cases, the three organisations appeared to work effectively together to achieve Mr C's discharge. I have seen no evidence of confusion of boundaries, and there should not have been any as Mr C's care clearly became a health care, not a social care, responsibility.

158. I **uphold** this complaint.

Complaints 1(a) and 1(c) – Capacity Assessment

159. Mr C's ability to communicate was very limited, and it was understandably difficult to gauge his awareness of the situation or to obtain his specific consent to care and treatment. In this situation, the view of the mental health nursing adviser is that Mr C's capacity should have been assessed under the Mental Capacity Act. I agree. Although Mr C was in PCH for just over two months and in YMH for almost another two months, no such assessment was done.

160. The need for an assessment of Mr C's capacity was first explicitly recorded in the clinical notes by medical and nursing staff on

3 March. The discharge liaison nurse was in agreement with the need for this. Although there is no evidence to indicate that the Council requested a capacity assessment, I am willing to accept Cwm Taf HB's assertion that the need for a capacity assessment was first raised by social services. However, there are key points to make here:

- clinical staff clearly agreed to the need for an assessment and took on the responsibility for taking this forward;
- had social services not requested an assessment, Cwm Taf HB would, in any event, have had had to satisfy itself whether Mr C had sufficient capacity; and
- the responsibility for assessing Mr C under the Mental Capacity Act lay with Cwm Taf HB as Mr C was a patient in hospital and the HB was providing his care and treatment.

Cwm Taf HB's Nurse Director, in responding to the draft version of this report, has again failed to acknowledge the HB's responsibilities in this regard.

161. The need for an assessment was mentioned in clinical notes on several occasions and some efforts were made to arrange an assessment. On 4 March, a nurse contacted the mental health team in another health board. On 5 and 9 March, doctors wrote to colleagues for an assessment. There is no record of any response. On 16 April, a nurse spoke to a senior doctor within the Health Board. The consultant physician declined to assess Mr C himself as he not done this before, yet a junior doctor was asked to do so on 16 April.

162. My view is that there was no informed, focussed or cohesive approach to assessing Mr C's mental capacity. Limited efforts were made to arrange an assessment; the referral to psychiatric colleagues was particularly relevant. However, I am left with the impression that when difficulties were encountered in arranging an assessment, the impetus was lost and no-one continued to move it forward. In the meantime, Mr & Mrs C and staff were in limbo not

knowing what Mr C could and could not understand or what he could and could not consent to.

163. An assessment was clearly required under the Mental Health Capacity Act. Without it, none of its five principles[15] could be applied. There is no mention at any point in the notes of a statutory basis for an assessment and I therefore concur with the view of the mental health nursing adviser that health board staff did not appreciate their duties under the Act.

164. I am particularly disappointed that even recently, Cwm Taf HB has argued that staff carried out their duties by requesting – not securing - an assessment. Cwm Taf HB also argues that nursing staff were continually engaging with Mr C and thereby assessing him. Having seen the draft version of the report, Cwm Taf HB has again failed to recognise its responsibilities to Mr C. The arguments it has put forward are superficial and fail to recognise or respect Mr C's rights.

165. I am concerned that the lack of an assessment meant that, <u>at best</u>, Mr C was given very little choice about his care and treatment, and about whether he remained in hospital, and, <u>at worst</u>, he was detained in hospital against his will. This is therefore a significant failing. Mrs C remains adamant that her husband had capacity but my view is that we cannot definitively establish retrospectively whether Mr C was detained or treated against his will.

166. Had anyone tried to properly establish Mr C's views, Mrs C may have not have perceived them to be in such a powerless situation.

167. Mrs C has said that the idea of an assessment was 'quietly dropped' when Mr C was transferred to YMH, and that does seem to

[15] See Appendix F

have been the case. While this is unsatisfactory, I am less critical of YMH as the intention by that time was to assess Mr C with a view to him returning home.

168. I am not sure whether the lack of an assessment delayed Mr C's discharge. It may have done, as the notes repeatedly suggest that staff were waiting for this to happen. However, it is not possible to be definitive on this. The greater concern, in my view, is that no assessment took place, and I criticise Cwm Taf HB for this failure.

169. Mrs C has also complained that an IMCA was not appointed for her husband and thus he had no-one to speak on his behalf. An IMCA would only be appointed when a person is known to lack capacity and on a specific matter. As Mr C's capacity was not assessed, the point of considering the need for IMCA was never reached.

170. I **uphold** Mrs C's complaint to the extent that an assessment did not take place. I cannot uphold the complaint about the lack of an IMCA, but this is part of the wider failing by Cwm Taf HB.

<u>Complaints 1(b) and 3 - POVA</u>

171. Mrs C was aware during her husband's admission to PCH that POVA action had been mooted. She felt stigmatised by this, also believing that nursing staff did not accept her as an advocate for her husband.

172. The records show that nursing staff raised the possibility of a POVA referral with social services on 2 March, because of concerns for Mr C's safety. It appears that he was left alone on occasions and given his problems with swallowing this would not be safe. Mrs C has pointed out that social services were well aware that Mr C was left alone as carers only visited during the time that Mrs C was out at work. However, the advisers' view is that initial consideration of

POVA proceedings was reasonable at this time, and I agree as Mr C's circumstances had changed.

173. There is no evidence of any consideration of POVA beyond this. The mental health nursing adviser has commented that the Council did not comply with its own policy in relation to this.

174. I can understand why Mrs C was upset at the suggestion of POVA proceedings. Perhaps better information could have been provided to her about this, or the issue could have been aired more openly. I ask Cwm Taf HB to consider whether more information could have been shared with Mrs C. But I **do not uphold** these complaints.

Complaint 4 – Complaint handling

175. A Welsh Government Minister told Mrs C that she could expect to receive a joint response to her complaints from the three bodies involved. The Minister wrote to ABHB's Chief Executive asking him to ensure that this happened. However, it did not.

176. ABHB noted that in a telephone conversation with Mrs C, she had agreed to receive separate responses, to be followed up by a joint meeting. This information was passed to Cwm Taf HB and the Council. The joint meeting did not happen.

177. Not only was there no joint approach, but information in letters from Cwm Taf HB and the Council about the need for a capacity assessment presented different accounts of the events. This was clearly unsatisfactory. The Council wrote to Cwm Taf about this, but I have not seen any response.

178. The upshot was that Mrs C, who had a full time job as well as caring for her husband, ended up dealing with three different complaints procedures and attending three different resolution

meetings. I have seen no attempts at any joint working to address Mrs C's concerns. Again this was unsatisfactory.

179. The NHS's very recent guidance, 'Putting Things Right', along with 'Listening and Learning' make clear that a joint approach should be adopted. This, and the potential revisions to the social services complaints procedures, make me cautiously optimistic that bodies will work more closely to address joint complaints in the future.

180. I **uphold** this complaint

Complaint 5 – Aspects of clinical care at PCH

181. There are four aspects to this complaint which I will address individually. In reaching my conclusions on these issues, I have been guided by the advice of the medical and nursing advisers.

(a) Poor bowel management

182. Mrs C complained that Mr C became constipated while in PCH, and this led to faecal impaction and the severe rectal bleeding he experienced on 10 March. The medical adviser's view is that Mr C should not have been allowed to remain constipated for an extended period. However, it is rare that faecal impaction would cause rectal bleeding and it appeared that the eventual cause of Mr C's bleeding was a polyp. This was not diagnosed until after Mr C's discharge from hospital. I **uphold** Mrs C's complaint that Mr C should not have been allowed to become so constipated, but note that this was unlikely to have caused the rectal bleeding.

(b) Antibiotics

183. Prior to his admission to hospital, Mr C's resistance to infection had been maintained on a rotation of antibiotics and bladder washouts. This routine was not maintained at PCH. The medical adviser has said that Cwm Taf HB's response to this issue (at the complaints meeting on 29 October 2009) was reasonable. It had

been correct to use different antibiotics for a chest infection to which urinary bacteria were also sensitive, and tests had shown that Mr C had become resistant to the usual antibiotics. While I can appreciate Mrs C's perception of this situation, I conclude that the clinical care was reasonable and I **do not uphold** this complaint.

(c) Mouth care

184. Mrs C complained that oral care was frequently not undertaken. The nursing adviser has identified that the need for oral care was noted in Mr C's nursing plans (she has detailed this in her advice note at Appendix B). She had seen evidence that oral care was carried out, and that this was part of his regular care. I **do not uphold** this complaint.

(d) PEG

185. There was clearly a problem with the PEG port, and reference to this is first noted in the records on 31 March. The problem was not resolved until 9 April, which does appear to have taken longer than might be expected. However, both the medical and nursing advisers have confirmed that Mr C's feeding regime was not interrupted. I am therefore **unable to uphold** this complaint as there was no detriment or hardship to Mr C.

Recommendations

186. I **recommend** that:

(a) within two weeks of the date of this report, Cwm Taf HB provides a full written apology to Mrs C for the failures identified in this report;

(b) within two months of the date of this report, Cwm Taf HB and ABHB put in place a programme to provide clinical staff with training on their responsibilities under the Mental Capacity Act; and

(c) within two months of the date of this report, Cwm Taf HB and ABHB ensure they have procedures in place to access IMCAs where that is appropriate.

187. I have also asked:

(a) the Health Boards and Council to think hard about whether Mr C's discharge could have been achieved more quickly and whether the process can be speeded up for others, and.

(b) Cwm Taf HB to consider whether more information could have been shared with Mrs C about possible POVA proceedings.

I am pleased to note that in commenting on the draft of this report the bodies have agreed to implement these recommendations.

Jenny Strinati
Acting Investigation Manager 9 May 2012

Appendix A

Medical Advice

Dr R McGonigle
Consultant Physician

A1. As a Consultant Renal and General Physician of more than twenty years experience I am appropriately qualified to review this complaint.

A2. I can confirm that there is no conflict of interest, and I do not know any of the individuals involved in this complaint.

Documentation Reviewed

A3. I can confirm that I have reviewed the nursing and mental health nursing advice. I have reviewed Cwm Taf HB's response of 7 August 2009 and the notes of the meeting held on 29 October 2009.

Clinical Summary

A4. Mr C, who has progressive multiple sclerosis, was admitted to Caerphilly District Miners Hospital on 16 February 2009 for the insertion of a PEG feeding tube. He was discharged on 20 February, but unfortunately was readmitted the following day to Prince Charles Hospital with aspiration pneumonia. He then suffered a further chest infection whilst in hospital, two urinary infections and constipation with faecal impaction. There were problems with his discharge, which have been addressed by the other advisers.

Issues and Advice

Poor bowel management resulted in faecal impaction.

A5. Mrs C in her complaint comments that her husband had a small bowel movement on 21 February, but then did not open his bowels for the following two weeks, which was considered partially reasonable during a critical phase of his illness.

A6. There were apparent delays in arranging a sigmoidoscopy. A sigmoidoscopy (telescopic examination of the rectum) in January 2010 showed a nodule, which may have been the source of rectal bleeding.

A7. Mr C should not have been allowed to remain constipated for fourteen days but I understand this issue has been addressed by clinical nurse advice.

A8. Faecal impaction would rarely cause rectal bleeding, but it is a possibility. It appears from the medical records that the eventual cause of rectal bleeding was a polyp.

Mr C acquired a urine infection because antibiotics were stopped.

A9. The consultant physician has responded to this issue during the minutes of the meeting held on 29 October 2009.

A10. Trimethoprim was being used as long term antibiotic prophylaxis (prevention) against urinary infections for Mr C, who had a urinary catheter in situ. It is my understanding from the patient's wife that Mr C was on a three month rotating antibiotic cycle. It is controversial whether antibiotic prophylaxis is effective in patients with urinary catheters in situ. Antibiotics can be prescribed, and can be effective, in this situation, usually in conjunction with bladder irrigation/washouts as indicated by Mrs C.

A11. It was appropriate to discontinue the Trimethoprim antibiotic in hospital if a urinary infection was diagnosed with organisms resistant to this antibiotic. Antibiotics were concurrently prescribed for a chest infection to which the urinary bacteria were sensitive. It was probably appropriate to not restart the antibiotics immediately, to avoid resistance to the antibiotic prophylaxis. The consultant physician

states that antibiotics were restarted on 17 April 2009 (Trimethoprim). This response does appear reasonable.

Recommendations

A12. None

Appendix B

Nursing Advice

Mrs R McKay
Registered Nurse

B1. I am a senior nurse with extensive experience in acute care and am competent to offer advice in some aspects of this complaint. However the aspects around Mr C's disability and the processes of the POVA referral, mental capacity review and the complexities of the discharge are outside my capability in this instance.

B2. I have no conflict of interest.

Documentation Reviewed

B3. I have reviewed the Ombudsman's files and the relevant clinical records.

Background

B4. Mr C had advanced multiple sclerosis and though usually cared for at home he was admitted to hospital with aspiration pneumonia. Mrs C was her husband's main carer with intensive support but until this admission, it was possible to sometimes leave him at home alone.

B5. Mr C needed full care and communicated by blinking or finger movements. Assessments during this admission indicated that Mr C's swallowing reflex had deteriorated to such an extent that he could not be left alone. It was assessed that Mr C's home care package needed to be changed and for there to be full time care in place from 0800 until 1900. It is evident that staff were concerned that Mrs C was so keen for her husband to return home that she may take him home before this care package was increased, and so they were concerned for his safety. Indeed, the nurse recorded on 28 February

that Mrs C stated “she would rather have [her husband] at home and at risk rather than being away from her..”

B6. The conversation with Mrs C on 28 February had raised the nurse’s concerns that there would be periods of time when Mr C would be alone and because of his deteriorated condition, he would be placed at risk. The nurse raised the concerns with the senior nurse. This led to a discussion with social services regarding the need for intervention but it appears that as Mr C was in hospital he was at no risk but if there were still concerns nearer discharge that the situation would be reviewed.

B7. Mr C’s capacity to understand complex issues was questioned and a formal review was requested from a psychiatrist. This did not happen.

Issues and Advice

Delays in discharge from PCH

B8. It appears from the clinical records that whilst Mr C was medically fit for discharge on 27 February**,** the dietitian noted that Mr C’s swallowing reflex was so poor that he could not swallow his saliva. This meant that he would be unsafe for discharge until there was full time support at home.

B9. There is evidence that a full review of mental capacity was requested and there are notes throughout the nursing records that nursing staff have repeatedly reminded medical staff about the need for the assessment. There is no evidence that medical staff pursued the request made on or around March. However, reviewing all the documentation I believe this delay in assessment did not cause the delay in discharge.

B10. There is evidence that there were delays whilst arrangements were made to ensure Mr C would be discharged to a safe

environment. The arrangements for extra support to be input at home were complex involving multiple care teams and it is inevitable that there will be delays.

Confusion regarding the need for a mental capacity assessment, and about who requested it

B11. The first note within the clinical records regarding the need for a mental capacity assessment is in the records on 3 March when the Nurse Case Manager has recorded 'we need a full capacity assessment regarding [Mr C's] ability to make an informed decision regarding his future care. This gentleman is unable to express his needs'

B12. The social services' notes of 6 March state 'when asked straight forward questions requiring yes/no answer he did appear to have capacity however when he needed to be given larger amounts of information to support the decision making process it was apparent that he became confused as he frowned and it is questionable that he has capacity when he needs to make decisions based upon using large amounts of information'.

B13. This indicates the opinion of two professionals that they believe a full capacity assessment should be undertaken.

B14. The undated letter to the consultant psychiatrist, written by a junior doctor on behalf of the consultant physician, asks for an assessment to be 'carried out within the next few days'. I believe this may have been written on 4 March as there is reference to it in the medical records.

B15. Any clinician who has undergone training can carry out a basic mental capacity assessment. However, it is apparent that the clinical team requested a more in depth assessment stating that they 'feel it

is difficult to make an accurate assessment of Mr C's capacity status and ability to make an informed decision'.

B16. On 6 March the medical records indicate that the general assessment information would be used to inform a future decision about whether or not to resuscitate Mr C if he deteriorated. Mrs C was present at this discussion.

B17. It is reasonable that this referral was made, and whilst both the Nurse Case Manager and the Social Worker have documented the need for the assessment, it was the doctor who made the referral for the more general assessment.

Mrs C was unable to discharge her husband as she believed this would result in POVA action

B18. There is evidence in the clinical records of concerns by nursing staff in relation to ensuring a safe discharge for Mr C. The nursing records indicate that the concerns were discussed with a case worker with the adult disability team who suggested that the nurses make a vulnerable adult referral. It is reasonable to conclude that this led the nurse to have a discussion with a social worker. The social worker notes indicate that she was already aware that there may be a potential for a POVA but that as Mr C was in a place of safety and no abuse had occurred there would be no risk.

B19. There is no evidence that any POVA action was taken, the evidence indicates that the nurses sought advice on genuine concerns. If Mrs C had insisted that her husband be discharged before a safe package of care was in place, it is likely that there would have been further involvement of social services and an escalation of the process.

Care at PCH:
Lack of mouth care

B20. An assessment form partially completed on Mr C's admission indicates that of personal care which includes oral hygiene, he is totally dependent. I also note that the assessment nurse has documented 'lips, mouth dry, sore'

B21. Mr C had a PEG feed and was not able to take any fluids by mouth. He was prescribed Hyoscine to dry his oral secretions.

B22. The daily input-outtake charts which have a section 'instructions for 24 hour (oral)' and it is noted on a daily basis that oral hygiene is to be given.

B23. The 'prescribed nursing action plan for personal care', number 14, indicates 'provide mouth care as necessary to ensure patient's mouth is kept clean and moist. Observe and report any signs of soreness, dryness or infection'. This sheet has been signed on a daily basis indicating that the care has been given. However, this signing is for the whole aspect of personal care and does not separate mouth care.
There are some 'weekly fluid balance charts' which do actually document the daily totals and these also indicate that oral care has been given.

B24. There is also a 'personal care monitoring form' where the nurses tick and signs for specific aspects of care delivered. Although there are some blanks, generally the mouth care section has been signed.

B25. In conclusion there is evidence that nurses had assessed Mr C's need for oral care and that this was given on a regular basis.

Delays in provision of new PEG tube

B26. It is noted in the nursing records, on 31 March that the 'PEG port leaking as a split in tube will need to RI V (review)? change port'. There is no further mention of the tube until 3 April when a nurse asks the endoscopy department for advice but the endoscopy unit wanted to know the type of PEG. This was a Friday and there is a note that the hospital inserting the PEG was to be contacted for the information on the Monday. It then appears on Monday that initially they would await for PEG from the previous hospital until the dietitian said that the part could be replaced at PCH and the item would be ordered. There is a further note that day that a doctor states a new PEG would have to be inserted. The dietitian has documented a visit on 2 April when she noted 'no concerns'. The medical and dietetic records for 6 April note the need for a 'piece'.

B27. On 8 April the dietitian noted that 'Gwent dietitians will send us a replacement Y adaptor'.

B28. The doctor noted that this new piece was fitted on 9 April.

B29. Reviewing the fluid intake charts for that period there is no evidence that Mr C did not receive his PEG feeds.

B30. There is evidence that there was a delay in replacing the necessary connector but no evidence that the feeding regime was interrupted because of this.

Recommendations

B31. I have no recommendations but the Health Board may wish to indicate how they can clarify how often mouth care is given.

Conclusions

B32. I am limited in the advice I can offer on this complaint and believe that more specialised advice is needed. However, I have

addressed the issues of mouth care and the PEG feeds and have attempted to clarify what occurred. The clinical records indicate that the need for mouth care was assessed and was given on a regular basis, though I cannot find how often this was done during the day.

B33. There was a delay in accessing a replacement piece for the PEG feed but it does appear that the feeding regime was not interrupted.

Appendix C

Mental Health Nursing Advice

Mr J Murphy
Registered Mental Nurse

Clinical Adviser's Name and Qualifications

C1. I am a Registered Mental Nurse (RMN) and a UKCP accredited Group and Individual Psychotherapist. I have a background in, amongst other areas, Acute Mental Health Nursing and deliver teaching on a range of Mental Health Nursing related subjects. I am able to give generalist advice regarding the Mental Capacity Act 2005 (MCA2005) and the Protection of Vulnerable Adults (POVA) issues involved in this case.

Relevance of qualifications and/or experience to clinical aspects of this case

C2. I have 19 years experience in Acute Adult Psychiatric Nursing. I specialise in Psychiatric Liaison and Consultation Nursing and Group Psychotherapy. I am suitably qualified to give generalist advice in this case.

Conflict of Interest

C3. I have no conflict of interest in this case.

Issues and Advice

C4. My colleague the Nurse adviser has answered some of you questions and indicated those which she feels are better addressed by me. I will not repeat the chronology here but move to answer the questions directly.

1. Confusion regarding the need for a mental capacity assessment, and about who requested it

C5. In answering this question I think it is useful to look at first of all what should have happened, what did happen and any variance.

C6. This is a complex case with several interrelated strands. Essentially Mr C had a long term condition, Multiple Sclerosis (MS) this was the progressive form of the condition which means that Mr Cs physical condition progressively deteriorated over time, there is also a suggestion that he had experienced other problems, possibly a stroke.

C7. When he was admitted to PCH on 21 February 2009 with a chest infection, Mr C's physical condition was such that he was already being fed with a Percutaneous Endoscopic Gastrostomy (PEG) tube. Staff soon became aware that he was also at risk due to his inability to swallow. At this point I understand that Mr C was only able to communicate by blinking his eyes, nodding or giving the thumbs up sign.

C8. Although it seems staff were aware that Mr C could communicate like this and correctly began with the assumption that he had capacity they soon found that they were not convinced that he could understand or communicate his needs in respect of more complex information. They were also concerned about his safety given his inability to swallow.

C9. When Mr C was admitted to the ward on 21 February 2009 what should have happened is that as soon as any immediate risk to his life was over i.e. when any treatment done in emergency on the basis of necessity was completed and given the obvious concerns about his communications deficit then consideration should have been given to his capacity to agree to any of the proposed treatments that staff were carrying out and especially with regards resuscitation.

C10. If we consider that best practice in Nursing and Medical care dictates that discharge planning starts at the point of admission then at this point I think it would have been reasonable for Mr C to have expected from staff that a Mental Capacity Act 2005 assessment should have taken place at the earliest opportunity. This is because he clearly had a lot to consider about his current and future care.

C11. The law is quite clear about the Mental Capacity Act 2005 and the duties it places on those in the caring professions. If we think about each of the principles as they should have been applied to Mr C we will see where staff did and did not comply with their duties as laid down by the Act.

C12. Section 1 of the Act sets out the five 'statutory principles' - the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

C13. The five statutory principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.

I think it is reasonable to think that initially staff assumed Mr C had capacity. However if any member of staff felt that there was doubt about Mr C's ability to understand and give consent to any aspect of his care this should have triggered a Mental Capacity Act 2005 assessment. It could be argued from a reading of the nurse's notes at this time that several members of staff who were treating Mr C carried out some sort of capacity assessment but were not aware of their duty to carry it out themselves. That they also failed to do what little assessment they did thoroughly enough and failed to record it as well as could have been reasonably expected.

It would appear that these same members of staff concluded through interaction with Mr C that he did not have capacity. They even went so far as to fax over a letter to Mental Health staff at St Tydil's Community and Mental Health Hospital to request a Mental Capacity Act 2005 assessment. It appears nothing came of this request which is unfortunate.

There does seem to have been a consensus that beyond a certain level of being able to agree or disagree to certain processes there was a difficulty for Mr C in communicating his needs and it would in this instance have been a good idea to get a second opinion.
I can see this was attempted when a nurse spoke to the Psychiatric Liaison team (in another Health Board) on 4 March. However the response that later came back from the psychiatric Liaison Team was that this was outside their remit. I find this unusual as in England I would expect this to be a core part of the team's remit. There were other occasions when nursing staff recorded in the notes that they wanted a second opinion with regards capacity and there seems to have been a leadership vacuum in relation to who should have made sure this was done.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
Other than when administering life saving treatment I cannot see in the documentation supplied how staff took all practical steps to help Mr C communicate his needs before deciding on his care.

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
It may have been that Mr C was willing to go home around 27 February 2009 and take the risk he would get ill and possibly die but I

can see no evidence that he was asked or helped to make an informed choice.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
It would seem that staff members were operating as if they had Mr C's best interest at heart. However I am uncertain on what authority they were making decisions about his care. It would seem they consulted his wife who we now know had an enduring power of attorney (which governs financial affairs)

Staff also appeared to treat Mrs C at times as if she were more than her husband's advocate and had the authority to consent to the treatments proposed to her partner. The reality is that even with an enduring power of attorney Mrs C could only exercise her powers over finance if it were proven that Mr C did not have capacity.

I think it could also be argued that because nursing staff did not document that they had asked him if he wanted to stay in hospital and receive treatment on 26 February 2009 that they deprived Mr C of his liberty unlawfully. I say this as it would seem that they exercised more or less complete control over him.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.
I cannot see any documented consideration of this issue.

C14. Overall the Trust in their letters of response to Mrs C's complaints do not show evidence of how the practices of their staff had reflected the 5 principles outlined above. However that is not to say that staff were uncaring or mistreated Mr C. Their documentation

simply reflects lack of understanding of the law and their roles in relation to it.

With regards the confusion surrounding the Protection of Vulnerable Adults (POVA) issue

C15. Shortly after admission concerns were also raised about Mrs C's ability to safely care for Mr C. This is recorded after a conversation on 28 February 2009) between a nurse and Mrs C in which Mrs C is reported to have said that she sometimes left her husband alone in the car when she went shopping.

C16. Given his physical situation at the time this was extremely worrying and the nurse did the correct thing in raising an alert. This was taken up by other nursing staff and a discussion was held with a social worker from the Adult Disabilities Team. It appears that the social worker then suggested that a Protection of Vulnerable Adults referral be made by the staff. This seems reasonable based on what had been said.

C17. The conversation was then forwarded to the social services' Protection of Vulnerable Adult (POVA) team who came back with some questions about whether Mr C had capacity or not and his view of how he would like to proceed. It was suggested that social services' staff gather more information at this point.

C18. Although a discussion was held with social services' staff it would seem that a POVA referral was not acted upon on the basis that Mr C was not at risk whilst in hospital, which although it appears reasonable does seem to be in contradiction to the social services' own policy and procedures[16] which stated that:
'In circumstances where there may be an element of doubt as to whether the adult protection procedures should be invoked, the matter must always be recorded on a VAI Referral form and referred

[16] South Wales Adult Protection Forum Policy and Procedures, revised 2004, on page 176

via your immediate line manager to the designated lead manager in your organisation'.

C19. Although staff members from the Social Services Adult Disability Team do seem to have remained in contact and a discussion held about whether to fill in a VA1, I am concerned about the fact that when nursing staff contacted Social Services staff to raise their concerns, no referral was taken and the POVA alert does not seem to have been acted upon. However that said social services staff did visit Mr C on 3 March and carried out an excellent Adult Services Assessment although it is clear that they too ran into the wall of his limited capacity to communicate his more complex feelings.

2. Mrs C unable to discharge her husband as she believed this would result in POVA action

C20. I cannot see any documented mention of staff using the POVA system to threaten Mrs C.

3. Mr C had no advocate, and no independent mental capacity advocate was appointed

C21. This is a good point and merely reinforces that staff failed at the first hurdle (a documented assessment of capacity) and did not get as far as considering whether Mr C needed an Independent Mental Capacity Advocate (IMCA)

4. Confusion about possible POVA proceedings' health staff proceeded as if a POVA was in place; Mrs C felt stigmatised and her husband was not allowed home.

C22. I cannot see any documented evidence that staff felt that a POVA plan was in place or that an investigation was under way.

5. Why was she no longer accepted as husband's advocate

C23. I am uncertain as to whether the hospital staff refused to accept

Mrs C as an advocate. However, they were confused about their roles and responsibilities and Mrs C's rights in relation to her husband in the context of the MCA 2005.

6. Were her views, opinions, knowledge properly taken into account

C24. It would seem that Mrs C's views were regularly sought by staff and there is evidence that in February, March and April 2009 staff consulted her about her husband's needs. However due to the lack of understanding on behalf of the staff her role and the rights she had in relation to her husband were not properly understood or acted upon.

Recommendations

C25. All staff involved receive training in their roles and duties under the Mental Capacity Act 2005.

Conclusions

C26. Lack of awareness of several key aspects of the law in relation to capacity and consent meant that Mr C was not properly consulted about his care and was possibly deprived of his liberty.

Appendix D

Cwm Taf HB Further Response

Comments by the HB's Head of Nursing, Acute Medicine and A&E, and by the senior nurse

Mr C was an MS patient who was very ill at the time and could only communicate via blinking, which he did on a regular basis, and was able to respond to yes and no commands. Staff were however very concerned whether Mr C was able to analyse and synthesise information to make an informed decision. I strongly believe that the assessment required for this went beyond ward staff's capability and knowledge base. It is my professional opinion that it was the correct decision to request the medical consultant in charge of his care to undertake a capacity assessment. It is my understanding that the consultant physician felt unhappy to carry this out due to no experience in this field, therefore the Clinical Director at the time was asked for her professional input and guidance. I strongly refute the Clinical Advisor's response that staff did not act in Mr C's best interest. I strongly believe that they were correct in not working outside their level of capability/competence. I would also highlight that support from colleagues within Mental Health was sought for what can only be described as a very serious and very unusual case. It is my professional opinion that this was the correct action to be taken to best meet Mr C's needs. I have been through the Clinical Advise document with [the] Senior Nurse and have documented our response in bullet points to each point raised in the attached document.

Comments re Clinical Advisor's Comments

I am unsure as to why the Clinical Advisor was of the opinion that Mr C could communicate by putting his thumb up as he was unable to move his body. He was also unable to support his head. I do not feel this is a true representation of Mr C's capabilities to communicate.

I would suggest that the opinion of the staff re Mr C's ability to understand information is a part of assessing his capacity, which was ongoing throughout his inpatient stay.

Mr C's condition was very poor initially and also for a long period of time after his admission. Also his inability to understand information would have been a factor in seeking his opinion re DNAR[17] and other aspects of his care.

It appears from the comments that the Clinical Advisor is contradicting himself. Initially he states that several members of staff were carrying out a capacity assessment but he then states they were not aware of their duty to carry out an assessment.

The nursing staff did carry out their duties. Numerous requests were made for an in-depth capacity assessment as the nursing staff did not feel they had the expertise to undertake this type of assessment in this complex case.

Their concerns related to Mr C's ability to understand and also synthesis the information he was being asked to comment on. This informed the decision to request an in-depth assessment.

I'm not sure what/whose leadership vacuum this refers to. The ward manager asked Mr C's consultant - the consultant physician - to undertake the assessment.

As Senior Nurse, I sought the advice/assistance of the Clinical Director to ensure the assessment was carried out. I also discussed this issue with the Head of Nursing who also discussed the complexity of this case with the Clinical Director again requesting her input to resolve the issue of capacity assessment.

[17] Do Not Attempt Resuscitation

I'm unsure what steps could have been taken due to ensure communication was achieved by Mr C due to his very limited inability to move. I do not feel this comment takes into account the daily, ongoing assessment being undertaken by the nursing staff.

Mr C remained very unwell for a long period of time - I am unsure how the advisor has come to the conclusion that he was well enough for discharge on 27 February. Mr C was not deemed medically fit for discharge until 3 April.

The nursing staff were in a very difficult position as Mrs C was very confrontational, this opinion was also held by social services staff. The nursing staff were correct in consulting Mrs C with regard his care as she was his next of kin and main carer. It is the nurses' philosophy to include patient's carers/family and not exclude them when difficult decisions have to be made.

POVA issues

Social Services were contacted to discuss the potential POVA issue. They visited the ward to assess Mr C and further discussion was held at this time. At no time was a request made to complete a POVA referral form and at no time was a strategy meeting arranged by social services to discuss any of the issues raised.

Appendix E

Supplementary Mental Health Nursing Advice

Mr J Murphy
Registered Mental Nurse

E1. Thank you for letting me see sight of the Health Board's response (Appendix D) to my original advice.

E2. I will respond to the comments individually but overall I think the response misses the point which is that staff members were not as aware of the Mental Capacity Act 2005 as the patient could reasonably have expected.

E3. The evidence for this is in the notes and it shows a lack of knowledge of the five principles of the Act as well as the basic knowledge of how and when to carry out an assessment and how it should be recorded.

Responses

E4. The 'Enquiry, Contact, Assessment and Referral Form to External Agencies' dated 21 February 2009 on page 6 states in the box marked Communication Domain 'Communicates by blinking or thumbs up'.

E5. Staff clearly had some knowledge of the MCA 2005 and were concerned about Mr C's capacity but did not seem to have a good enough knowledge of the Act and did not record and act on the issues correctly.

E6. I am not disputing that Mr C was very unwell whilst in hospital. I was trying to draw attention to actions of staff in respect of the MCA 2005 and the difference between supplying care that is necessary to

immediately sustain life and longer term care however critical that may be.

E7. Staff nurses providing care for Mr C had a duty to make reference to the MCA 2005. Without them doing so even with the kindest interpretation of their actions which, was to say they were making some sort of capacity assessment, I cannot conclude that their actions were reasonable.

E8. As the treating clinicians it is the responsibility of ward nurses and their seniors to ensure that important issues were raised and pursued. Although the issue was raised it was not taken up hence a failure of leadership. This response again shows no reference to the framework of the MCA 2005 or the principles involved.

E9. With reference to the principles of the MCA 2005 and in particular what steps were taken to help Mr C communicate, was a communication board attempted?

E10. In the clinical notes there is an entry dated 27 February 2009 which states:

> 'Ward round Discharge plan
> For discharge as soon as he is fit to go'

E11. My remarks were made in this context and I was trying again to make the point that I did not see any evidence of any attempts to communicate at the point in time the entry was made about the issue of discharge.

E12. I refer you to previous comments I have made about the reasonableness of the steps taken to communicate with Mr C. The entry of 26 February 2009 states that a discussion was had about discharge with Mrs C but no attempt made to communicate with Mr C

is recorded.

POVA issues

E13. An entry dated 2 March 2009 in the nursing notes reports a discussion with the duty social worker who is recorded as stating that following the concerns that were raised about Mr C that the advice to staff was to make a vulnerable adults referral.

Appendix F

Legislation, Policy and Guidance Note

Human Rights

The Human Rights Act 1998 (the HRA) incorporated the European Convention on Human Rights into UK Law. Article 8 specifies that:

> 'Everyone has the right to respect for his private and family life, his home and his correspondence.'

Article 8 is not an absolute right; it may need to be balanced against the competing rights of other people, and can be circumscribed by the state in certain circumstances including where it is necessary in the interests of public safety, the protection of health, or the protection of the rights and freedoms of others.[18]

Mental Capacity

The five statutory principles of the Mental Capacity Act 2005 are:

> '1...
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
> (6) Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be as

[18] A Guide to the Human Rights Act, Dept for Constitutional Affairs, Oct 2006

effectively achieved in a way that is less restrictive of the person's rights and freedom of action.'

'Protection of Vulnerable Adults – Implementing the *In Safe Hands* Guidelines for the Protection of Vulnerable Adults in Wales'[19] includes:

'8.7 Capacity – the Basic Principles

8.8 The basic principle which underpins both current law and medical practice with regard issues of mental capacity, is that people should be 'enabled and encouraged to take for themselves those decisions which they are able to take'.

8.9 Every adult has the right to make his/her own decisions and must be assumed to have capacity to do so unless proved otherwise. In approaching the issue of capacity, the following principles should be borne in mind:

- The need to promote an individual's autonomy and freedom by being encouraged and enabled to make their own decisions or to participate as fully as possible in decision making by being given help and support to make and express choice.
- The need for an individual to be given information in a way that facilitates their comprehension and that promotes their understanding.
- The need to be clear about the specific matter about which a person needs to make a decision

[19] In September 2000, the Welsh Assembly Government launched a guidance document called 'In Safe Hands'. In 2004, the South Wales Adult Protection Forum produced the 'Inter-Agency Policy & Procedures for responding to alleged abuse and inappropriate care of vulnerable adults in South Wales'. This was updated in November 2010 after the events considered here.

- That the mental capacity of an individual is not a global absolute. … a person may have capacity to make some decisions and not others.
- In protecting an individual's autonomy and freedom, professionals look for the least restrictive alternatives – interventions that cause the least disruption or change in the person's circumstances. At the same time, the right to make what might seem to be eccentric or unwise decisions must be protected.

…

8.13 Therefore the test of capacity to give consent to medical treatment varies from the test of capacity to make a gift or draw up a will for example. It is essential that in situations where the vulnerable adult is thought to lack capacity, both medical and legal advice is sought as the earliest opportunity.

…

9.5 … The safety and welfare of vulnerable people is paramount at all times.'

Discharge

Welsh Health Circular (2005) 035 entitled 'Hospital Discharge Planning Guidance' at paragraph 22 under the heading 'The Discharge Process – Key Principles' includes:

'The individual's interests and wishes are central to the hospital discharge planning process and are taken into account when considering future care options. The assessment and discharge process must be person centred and involve regular consultation with the patient and his family/carer/advocate …'

Healthcare Standards

The Healthcare Standards for Wales[20] provide a common framework of standards for NHS care. It includes the following:

> 'First Domain: The Patient Experience
> …
> Standard 8
> Healthcare organisations ensure that
> a) ....staff treat patients, service users, their relatives and carers with dignity and respect
> b) …
>
> Standard 10
> Healthcare organisations ensure that people accessing healthcare are not unfairly discriminated against on the grounds of age, gender, disability, ethnicity, race, religion, or sexual orientation.'
>
> 'Second Domain: Clinical Outcomes
> …
> Standard 12
> Healthcare organisations ensure that patients and service users are provided with effective treatment and care that:
> …
> c) Is integrated to provide a seamless service across all organisations that need to be involved, including social care organisations.'

Complaints Handling

In 2005 the Welsh Government introduced a new complaint handling process for Local Authority Social Services departments. It also issued guidance on this new process entitled 'Listening and Learning

[20] Issued by the Welsh Assembly Government (now the Welsh Government) in 2005

- A guide to handling complaints and representations in local authority social services in Wales.' Paragraph 5.4 of this guidance sets out the Welsh Government's expectations in terms of 'a model of good practice' when there is a complaint about both NHS and Social Services. Paragraph 5.4.4 states that:

> 'In most cases, the amended regulations will give local authorities and NHS bodies the job of agreeing who will take the lead. This will include cases where services are provided in a "package" but delivered separately, some by the NHS and some by a local authority. The role of each body will depend on which acts as the "lead body" …. The lead body must make sure that they keep the complainant informed and, wherever possible, pull together a single joint reply. The body not the lead will simply contribute to the investigation and response. However, nothing in the regulations or guidance removes the duty of care that each body has for the person using the service.'

On 29 July 2011 (so after these events) the Welsh Government issued a model concerns and complaints policy for adoption by public service providers in Wales which I shall call the 'Complaints Wales Guidance'. This included:

> 'There are occasions when a complaint received will involve more than one organisation. In this case the role of the central complaints handler will be slightly different. Having established the elements of the complaint and which organisations are involved, they should contact their counterpart(s) in the other organisation(s) involved. The complaints officers should then decide which of them should lead on co-ordinating the response to the complainant. It would seem sensible that this should be the organisation with the greatest involvement in the complaint. However, it may be appropriate for the organisation with the largest complaints handling resource to undertake this role.

The role of the complaints officer allocated to the complaint in question is to co-ordinate the investigations in each of the service areas involved. The ultimate aim, therefore, is to provide the complainant with a single comprehensive “joint” response on behalf of all of the organisations involved.

There will be complaints where each element is sufficiently distinct and separate so that all that will be required is to set out the details and outcome of each investigation strand and then add an overall conclusion to the response.

However, it is recognised that there will be some cases where the resolution and remedy of a complaint will involve agreement by all involved and that this could lead to tensions and disagreement. Where such disagreements lead to an impasse, it may mean having to refer the problem to senior management within each of these organisations (depending on the seriousness possibly Chief Executives) in order to try to resolve the situation.

Where the impasse still cannot be resolved, it may be prudent to refer the matter at this point to the relevant external independent complaint handler at Stage 3 (e.g. the Public Services Ombudsman for Wales). However, the complainant should be told of this intention, together with the reason for it, and their agreement should be sought before such a referral takes place.’