Case Study Five: Mrs H – return home with family conflict

Summary
Mrs H, who had reached the end of her rehabilitation in hospital following a brain injury, was due to be discharged. However, there was disagreement amongst family members about where she should go as they were keen for her to return home. IMCA intervention meant that the decision was made for Mrs H to be discharged to a 24-hour residential care placement, as it was the only place where her complex needs could be met.

Background
Mrs H is a 61-year-old lady who suffered a hypoxic brain injury in November 2012, as a result of cardiac arrest caused by myocardial infarction. Initially Mrs H was a patient at one hospital but she did not settle. Her agitation was such that she only slept an hour a day and did not eat, losing significant weight. Mrs H was disorientated and her behaviour unstable. She was transferred to a different hospital, which is where she was residing at the time of my involvement. Since being at this hospital, Mrs H has been more settled but does still have periods of agitation. Mrs H is 100 per cent Continuing Health Care-funded and she has a case manager (decision-maker) from a specialist team. She has been at this hospital for nearly 12 months as part of her rehabilitation. It is felt that Mrs H has reached her potential and a best interests decision is required with regard to her discharge destination.

IMCA report
'I liaised with the decision-maker via telephone, I established they wanted Mrs H to have independent representation as it was felt that her family were no longer able to act in her best interests (as a result of a family conflict). I clarified the role and remit of an IMCA stressing that the IMCA does not act as a mediator. It was agreed that I would meet with Mrs H, try and establish her views and wishes as far as is possible regarding her discharge destination. I clarified that I would not actively contact family members so as to avoid being drawn into the conflict. However I provided POhWER's information, advice and advocacy support centre's number. I advised the decision-maker that the family could contact me via that number if they wanted to. My direct contact number was not to be given out. Timescales were agreed regarding the submission of my report. I identified that the discharge planning had come to a stop as a result of the family conflict and that if reports and assessments by other professionals and providers were not completed shortly, the discharge could go into the New Year. This was because of the high cost of care. The decision-maker has to submit a case to the high cost/risk panel: the panel approves funding. The panel only meets once a month. Discussion with the decision-maker and drawing up an action plan of who is to do what provided focus to the discharge planning. The aim was to get the case heard at the next panel. The options considered were:

- *Discharge home with a 24/7 commissioned care package possible with waking night staff*
- *Discharge home with a commissioned care package and support from the family to ensure the 24-hour period covered*
- *24 -hour care within a residential setting.*

One care home had already been identified and a further two possibly suitable. Whilst Mrs H had been deemed to lack capacity to make this decision, through my work I identified that she has been consistent in her wish to return home.'

Barriers which were overcome

It was difficult as family had to date been consulted. Although the family were aware of the IMCA instruction they did not fully understand the need for an advocate's involvement. However, a meeting was convened by the decision-maker to discuss with the family the proposal for re-looking at discharge planning - which was attended by all.

It was at this meeting that the role of the IMCA was explained as an independent person for Mrs H Louise, who would make sure that the decision-maker was following the best interests process in accordance with the Mental Capacity Act.

Outcome

Discharge home at this stage was not felt to be in Mrs H's best interests due to the environmental difficulties within her home, and the fact that her needs could not be met and her safety maintained via a commissioned care package at home.

Twenty-four-hour residential care was identified as being in Mrs H's best interests and the most appropriate. The location meant family could continue to visit relatively easily. The setting was near to local amenities allowing ongoing work to increase her experience and confidence in the community. Whilst the family members that attended the best interests meeting found it upsetting accepting that Mrs H at this stage is not able to return home, they did accept that 24-hour residential care is in her best interests.