Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Liverpool City Council (reference number: 16 010 110)

26 February 2018

The Ombudsman's role

For 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Ms X	The complainant, who also complains on Mrs Y's behalf
Mrs Y	Ms X's late mother
Worker A	A worker at the care home
Worker B	A worker at the care home
Doctor Q	A doctor instructed by a solicitor to meet Mrs Y

Report summary

Adult social care

Ms X complains about the failure of staff at a BUPA care home, acting on behalf of Liverpool City Council, to respond properly when she complained about failings in her mother's care

Finding

Fault found causing injustice and recommendations made.

Recommendations

The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet, or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

BUPA has already apologised to Ms X for failings it identified in Mrs Y's care. We also welcome its confirmation that staff now record when they have washed residents' hair. The Council has already offered to apologise to Ms X for referring her back to BUPA instead of dealing with her complaint itself. It should do this, but to remedy the injustice caused, the Council has also agreed to, within three months of the date of this report:

- apologise to Ms X for:
  - the failings in her mother's care; and
  - the failure of staff at the BUPA care home to respond properly to her initial complaint of poor care, including banning her and her partner from visiting Mrs Y without any due process;
- pay Ms X £750, made up of £500 for the distress and anxiety caused by her poor treatment and inability to advocate for her mother when she complained on Mrs Y's behalf and £250 for her time and trouble in having to approach us after the Council failed to deal with her complaint;
- ask BUPA to review its own policies and procedures to make sure care home staff check residents' nutritional and continence needs on arrival;
- review its policies and procedures to ensure other service users who complain are not referred to a care provider where the Council should deal with the complaint itself; and
- check that care providers with whom it has commissioning arrangements have written procedures for banning visits by relatives that comply with guidance set out by the Care Quality Commission and provide for a written warning, a time limit and reviews and that their staff are aware of these procedures.

The Council has accepted these recommendations.

The complaint

1. The complainant, whom we shall call Ms X, complains on her own behalf and on behalf of her late mother, Mrs Y about care commissioned by Liverpool City Council.

2. Ms X complains on Mrs Y's behalf that the care Mrs Y received after her arrival at the BUPA Mersey Parks Princes Unit on 18 May 2016 was poor. This home has since been transferred to a new provider.

3. She says care staff:

    - allocated Mrs Y a different room from the one she had chosen and failed to move her to it later despite there being vacancies;
    - failed to provide a welcome pack, only providing a sheet of paper on 7 June 2016;
    - provided a room on 18 May 2016 where the bed linen and pillow were both soiled and stained;
    - dressed Mrs Y in other residents' clothing between 18 and 22 May 2016, also failing to ensure she had underwear and incontinence pads, causing her distress sitting in urine;
    - failed to have a care plan for Mrs Y;
    - failed to wash Mrs Y's hair for three weeks after her arrival;
    - failed to take account for Mrs Y's preference for brown bread sandwiches because of previous constipation;
    - failed on 22 May 2016 to respond properly to requests to call a doctor or district nurse to examine Mrs Y's swollen legs; and
    - failed on 7 June 2016 to arrange transport for Mrs Y's hospital appointment for diabetic eye screening.

4. Ms X also complains of the actions of staff at the unit after she complained of the matters above. She says:

    - Worker A reacted aggressively on 23 May 2016 in a face to face meeting and did not respond to her requests for a doctor to see Mrs Y and her request for a list of activities available for residents;
    - Worker B was adversarial in a face to face meeting on 31 May 2016, refused to supply a copy of the complaints procedure and later refused Ms X, her partner and a doctor (Doctor Q) entry to the building on 9 June 2016; and
    - other staff were rude and abusive to Ms X and her partner on 9 June 2016.

5. Finally, Ms X complains the Council has failed to deal with her complaint properly.

Legal and administrative background

The Ombudsman's role

6. We may investigate a complaint on behalf of someone who has died or who cannot authorise someone to act for them. The complaint may be made by: their personal representative (if they have one), or someone we consider to be suitable. ***(Local Government Act 1974, section 26A(2), as amended)***

7. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***

8. We investigate complaints about 'maladministration' and 'service failure'. In this report, we have used the word 'fault' to refer to these. We must also consider whether any fault has had an adverse impact on the person making the complaint. We refer to this as 'injustice'. If there has been fault which has caused an injustice, we may suggest a remedy. ***(Local Government Act 1974, sections 26(1) and 26A(1), as amended)***

9. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Care Quality Commission, we will share this report with the CQC as there are potential breaches of fundamental standards.

The right to complain without discrimination or victimisation

10. The Human Rights Act 1998 lays out at Article 8 the right to respect for private and family life. This right is not absolute, but is balanced against the rights of other people. So, there are circumstances in which the right to visit a family member in a care home can be restricted or removed.

11. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 state that "Complainants must not be discriminated against or victimised. In particular, people's care and treatment must not be affected if they make a complaint, or if somebody complains on their behalf". (Regulation 16(1)).

12. The CQC has published a guide, *Information on visiting rights in care homes, November 2016*. It states that making a complaint should not affect a visitor's ability to see their relative or friend. We take the same view.

How we considered this complaint

13. This report has been produced following the examination of relevant files and documents.

14. Ms X and the Council were given a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

What we found

Complaints about Mrs Y's care

Complaint - Mrs Y's room choice

15. Ms X said Mrs Y chose a room, but the care home gave her another, later failing to move her when it could have done. In its response to our enquiries, BUPA said Mrs Y had wanted to speak to her social worker before confirming a choice. It said the room was occupied when she expressed her preference a few days later. It also said it showed her an alternative room two months later that she rejected due to cost. We have not seen any evidence to confirm either version.

Complaint - the welcome pack

16. Regarding the welcome pack, Ms X said the care home only provided a sheet of paper on 7 June 2016. In its response to our enquiries, BUPA said staff said they had provided the welcome pack within 48 hours. It also said Ms X had had the

welcome pack by 23 May 2016 as she referred to it in an email of that date. We have checked Ms X's email. It does not state she had had the welcome pack. However, the Council confirmed in its response to Ms X's complaint that a welcome pack should be provided on the day of arrival.

Complaint - the condition of the room allocated

17. Ms X said the bed linen in Mrs Y's room was soiled and stained. BUPA wrote to Ms X on 22 July 2016. In the letter, it said it had not been aware of this, but apologised if it had not been up to standard. It also said it had told housekeeping staff to monitor the standard of bed linen more closely in future. We have not seen any corroborating evidence either way.

Complaint - Mrs Y's initial care

18. In its letter to Ms X of 22 July 2016, BUPA apologised to Mrs Y and said staff would check her clothing. It said she might have been wearing clothing that was not hers, possibly due to it not all being labelled. It also apologised because staff had not been aware of the usual process regarding Mrs Y's underwear and incontinence pad. It said it would try to follow the practices Mrs Y was used to once it reviewed her care plan with Ms X.

Complaint - the care plan

19. BUPA provided a copy of Mrs Y's care plan dating from April 2016. It also provided a copy of an assessment it carried out before her admission in May 2016. In its letter of 22 July 2016, BUPA told Ms X it would arrange for a member of staff to go through Mrs Y's care plan with Ms X.

Complaint - washing Mrs Y's hair

20. The daily care records show staff attended to Mrs Y's personal care. But they do not make specific reference to washing her hair. Not recording this was apparently standard practice at the care home, though this has now changed.

Complaint - Mrs Y's dietary needs

21. BUPA confirmed in its letter of 22 July 2016 that staff had not realised Mrs Y's dietary needs straight away. It apologised and said it would amend her care plan to include them.

Complaint - calling a medical professional

22. The daily care records show the condition of Mrs Y's legs concerned staff at the home. They show they contacted a doctor on 18 May 2016 and he saw her on 23 May 2016. The professionals' visits log also shows staff contacted a district nurse about Mrs Y's legs on 21 and 22 May 2016.

Complaint - hospital transport

23. In its letter of 22 July 2016, BUPA said two members of staff had had a misunderstanding about who would chase up transport that caused delay in Mrs Y attending a hospital appointment. It apologised and said it had reminded both staff about the need to be clear about who was doing a task.

Complaints about staff reactions to Ms X's complaints

Complaint - 23 May 2016

24. Ms X said Worker A was aggressive when she went to his office to complain about the matters above on 23 May 2016. Ms X provided a detailed account of the meeting.

25. In its response to her complaint, BUPA said it could not tell who said what to whom where the two parties disagreed.

Complaint – 31 May and 9 June 2016

26. Ms X said Worker B made several adversarial statements during a meeting on 31 May 2016 after she pursued her complaint. As with the meeting of 23 May 2016 referred to earlier, she provided a detailed account of the meeting.

27. In its response to Ms X's complaint, BUPA said it could not say what had been said in the meeting between Worker B and Ms X as there was no witness. Ms X agrees there was no witness.

28. Regarding the incident on 9 June 2016, BUPA said Worker B did not deny Ms X, her partner and Doctor Q access to the home. BUPA also said staff had banned Ms X and her partner because of an earlier incident involving calling police.

29. Doctor Q was an independent witness. We made enquiries of him. He confirmed staff prevented him and Ms X from visiting Mrs Y on 9 June 2016.

30. Ms X told me staff had not told her the reason for the ban when she asked. We asked the Council about the ban. The Council has not provided us with any evidence to support BUPA's assertion that there was an incident when police were called. Nor have we seen any evidence that staff warned Ms X, or time-limited the ban, or provided for any review, or told Ms X what the conditions were for it to be lifted.

Complaint - the actions of other staff

31. Doctor Q did not say staff at the home were rude and abusive to Ms X and her partner on 9 June 2016. However, it is possible he did not witness all the exchanges between Ms X and staff. He said the member of staff at the door had been forthright, but he did not feel this was aggressive. As with the earlier complaints, in the absence of an independent account of all that was said, it is not possible to say if staff were rude and aggressive to Ms X.

Complaint handling

32. In its response to Ms X's complaint, the Council failed to deal with the specific points she raised. In response to our enquiries it accepted it should have dealt with these itself rather than referring Ms X to BUPA. It apologised for this.

33. BUPA issued its final response to Ms X's complaints on 13 October 2016. It told her "I need to inform you going forward that, if you are unable to work with the management team in the home, and the relationship between you and the management team continues to be disruptive, we may have to make a decision on your mother's future at Mersey Parks".

34. Mrs Y remained at the home. She died in January 2017.

Conclusions

Complaints about Mrs Y's care where no finding of fault is possible

35. Regarding Mrs Y's choice of room, we have not seen any corroborating evidence of any commitment or intention by either party. We are not able to make a finding.

36. This is also the case regarding the condition of the room allocated to Mrs Y. Without corroborating evidence, we cannot say if the bed linen was soiled and stained. However, we note BUPA has apologised.

Complaints about Mrs Y's care where there was no fault

37. There is clear evidence the care home had maintained a care plan for Mrs Y. We do not find it at fault.

38. There is also clear evidence staff at the care home sought medical assistance due to concern about Mrs Y's swollen legs in May 2016. We do not find the Council at fault.

Complaints about Mrs Y's care where there was fault

39. It is not clear when Mrs Y received the welcome pack. But Ms X's email of 23 May 2016, some five days after Mrs Y's arrival, suggests this had not happened after five days. However, even if this were not so, the Council states this should have been provided on the first day and BUPA confirms it took up to 48 hours. This was delay. We therefore find the Council at fault.

40. BUPA also confirmed there had been problems with Mrs Y's initial care, particularly her continence needs and clothing as referenced in paragraph 18. These were fault.

41. There were also problems with recognising Mrs Y's dietary needs and in arranging hospital transport. These were fault.

42. Finally, it is not possible to say if staff washed Mrs Y's hair regularly. This is because it was not previously the care home's practice to record this separately. While we cannot say if staff washed Mrs Y's hair, the care home's practice of not recording it was fault. This is because it created the potential for residents to go longer than they should without having their hair washed as carers would not know when it had last been done.

Fault in complaint handling and obstructing visits

43. We are not able to say what was said between Ms X and Worker A or Worker B in meetings as there is no independent corroboration. And we cannot say if Worker B refused to supply a copy of the complaints procedure.

44. Based on Doctor Q's account, we do not find the behaviour he witnessed was fault, other than the refusal to allow entry. This was fault. But we note it is not possible to say what happened in events he did not witness.

45. However, we find the Council at fault because staff at the home banned Ms X and her partner from visiting Mrs Y without warning, without giving them reasons, without any duration for the ban, and without conditions for its lifting. We also find the Council at fault because staff at the home prevented Ms X, her partner and Doctor Q from visiting Mrs Y on 9 June 2016 without good reason. As we have not seen any evidence for the claim that Ms X or her partner acted in a way that that led to police being called, we are led to the conclusion that staff at the care home banned them because they made valid complaints about the care of Mrs Y.

46. This was perpetuated in the letter from BUPA of 13 October 2016, which warned Ms X that if relationships with the management did not improve it would consider evicting Mrs Y.

47. These actions meant the Council failed to meet its duty under Regulation 16(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It also failed to have regard to Article 8 of the Human Rights Act 1998.

48. Finally, the Council was at fault for referring Ms X back to BUPA rather than dealing with her complaints itself.

Injustice

49. It is not possible to remedy the injustice caused to the late Mrs Y.

50. The action of the care home in banning Ms X from visiting her mother without good reason and without following any procedure was distressing. This is more so as she found out about it when trying to visit with Doctor Q. She says she did not let Mrs Y know what had happened. In these circumstances, Ms X was left with anxiety that staff might take further arbitrary action against her or her partner that prevented them visiting Mrs Y if they again had cause to complain about her care.

51. By referring her back to BUPA and declining to deal with the complaint itself, the Council caused Ms X unnecessary time and trouble in having to approach us.

Recommendations

52. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet, or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

53. BUPA has already apologised to Ms X for failings it identified in Mrs Y's care. We also welcome its confirmation staff now record when they have washed residents' hair. The Council has already offered to apologise to Ms X for referring her back to BUPA instead of dealing with her complaint itself. It should do this, but to remedy the injustice caused the Council has also agreed to, within three months of the date of this report:

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