Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Reading Borough Council (reference number: 18 001 676)

10 January 2019

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

Mrs B	The complainant (deceased)
Mr F	Her son
Ms X	The complainant's granddaughter

Report summary

Adult Care Services

Mr F complains about the quality of home care provided by the Council's care provider, Radis Group, to his late mother, Mrs B. In particular that the carers failed to call 999 when Mrs B was ill.

Finding

The Ombudsman upheld the complaint and found fault causing injustice.

Recommendations

When we have evidence of fault causing injustice we will seek a remedy for that injustice which aims to put the complainant back in the position they would have been in if nothing had gone wrong. When this is not possible, we will normally consider asking for a symbolic payment to acknowledge the avoidable distress and uncertainty caused. Mr F said he does not consider a symbolic payment to be appropriate; he wanted an acknowledgement that things had gone wrong and changes to prevent this happening again.

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)***

In addition, to remedy the injustice identified, the Council has agreed to:

- apologise to Mr F for the distress caused by the faults identified;
- discuss with him whether he wishes the Council to provide a lasting tribute (such as planting a tree) in memory of Mrs B; and
- pay him £100 to acknowledge the time and trouble he has had in pursuing his complaint.

Within three months of our final report, the Council has agreed to:

- ensure the care provider has:
    - trained all staff on the use of its emergency procedures and the procedures to follow when a service user is ill; and
    - trained all carers on accurate and complete record keeping;
- review its adult social care complaints procedure to clarify how it deals with complaints against commissioned care providers, and how it will ensure independent investigation of serious complaints;
- remind staff involved in adult safeguarding enquiries of the importance of ensuring enquiry reports are factual and accurate; and
- provide us with evidence it has taken these actions.

The complaint

1. Mr F complains about the quality of home care provided by the Council's care provider, Radis Group, to his late mother, Mrs B, in July 2017. In particular he complains the carers:
   - did not encourage Mrs B to move around or use her inhaler;
   - did not visit at lunchtime on 20 July 2017 or deal properly with the morning carer's concerns about Mrs B's health;
   - failed to call 999 on the evening of 20 July 2017.
2. Mr F says these actions contributed to his mother's ill health and death.
3. Mr F also complains about the way the Council responded to his and Ms X's complaints.

Relevant law and guidance

The Ombudsman's role

4. 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)***
5. We have powers to investigate adult social care complaints in both Part 3 and Part 3A of the Local Government Act 1974. Part 3 covers complaints where local councils provide services themselves, or arrange or commission care services from social care providers, even if the council charges the person receiving care for the services. We can by law treat the actions of the care provider as if they were the actions of the council in those cases. ***(Part 3 and Part 3A Local Government Act 1974; section 25(6) & (7) of the Act)***
6. We may investigate complaints from a person affected by the matter in the complaint, or from someone the person has authorised in writing to act for him or her. If the person has died or cannot authorise someone to act, we may investigate a complaint from a personal representative or from someone we consider suitable to represent the person affected. ***(section 26A or 34C, Local Government Act 1974)***
7. Under the information sharing agreement between the Local Government and Social Care Ombudsman and the Care Quality Commission (CQC), we will share this report with CQC.

Fundamental standards for care providers

8. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the fundamental standards those registered to provide care services must achieve. The CQC has issued guidance on how to meet the standards. The fundamental standards include:
   - safe care and treatment ***(Regulation 12(2)(b))***: The provider must have arrangements to take appropriate action if there is a clinical or medical emergency; and

- good governance ***(Regulation 17(2)(c))***: The provider must maintain securely an accurate, complete and contemporaneous record in respect of each service user.

Emergency procedures

9. Radis, the care provider in this case, has a procedure for emergency situations. This says, in relation to service users "who are in a deteriorated state of health, but appear not to require urgent medical assistance and are quite responsive":

"In clearly non-emergency situations the Care/Support Worker should contact the duty manager/supervisor to take advice and record their actions clearly in the diary record book. They should also remain with the Service User if they are instructed to do so.

The duty manager/supervisor MUST follow the procedure below:

- *The relevant social worker, Duty team or commissioner should be contacted immediately to report the problem. Any instructions that are given should be recorded and followed exactly.*
- *The Service User's GP should be contacted to obtain advice and a home visit if necessary. Any instructions given by the GP should be followed exactly.*
- *A decision made whether to ask the Care/Support Worker to remain with the Service User based upon instructions given by the GP.*
- *Notification to other Service Users that the Care/Support Worker has become delayed and alternative staff deployed if this delay is excessive.*
- *A full record made of the event and actions taken in the Service Users notes.*

It should be recognised that some Service Users may not wish to receive medical attention and may refuse any assistance. In these circumstances the above procedure should still be followed, as the Service User will still be able to refuse assistance if the GP attends. This policy is part of our duty of care for all Service Users and is balanced against the Service User's right to have choice and control."

Safeguarding adults

10. A council must make necessary enquiries if it has reason to think a person may be at risk of abuse or neglect and has needs for care and support which mean he or she cannot protect himself or herself. It must also decide whether it or another person or agency should take any action to protect the person from abuse or risk. ***(section 42, Care Act 2014)***

11. There should be a multi-agency strategy discussion to decide whether the criteria are met for a formal Section 42 safeguarding enquiry. When a safeguarding case is closed, individuals should be told how matters will be followed up. The Safeguarding Procedures say enquiry reports "need to be concise, factual and accurate".

Complaints about social care

12. Councils should have clear procedures for dealing with social care complaints. Regulations and guidance say they should investigate a complaint in a way which will resolve it speedily and efficiently.

13. The complaints regulations say if a complaint is about the actions of a care provider, councils must send the complaint to the provider as soon as reasonably practicable.

14. The complaints guidance says for some serious complaints it may be necessary to ask an independent investigator to look into the case. But most complaints will be investigated by someone from within the organisation, who should be appropriately trained and independent of the part of the service that is being complained about.

15. The Council's complaints procedures say if the complaint involves one of its partner services it may arrange a joint investigation.

How we considered this complaint

16. We produced this report after examining relevant documents, including:

- the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations");
- the Care Act 2014 and the Care and Support Statutory Guidance;
- Berkshire Safeguarding Adults Procedures ("the Safeguarding Procedures");
- Radis Group, Emergency Policy and Procedures;
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009;
- Listening, Responding, Improving 2009 ("the Complaints Guidance"); and
- the Council's Adult Social Care Complaints, Compliment and Comments procedures.

17. We gave the complainant and the Council a confidential draft of this report and invited their comments. We took the comments received into account before the report was finalised.

Findings

What happened

18. Mrs B was elderly with health conditions including lung disease. She had been known to the Council's social services department since 2009. She lived alone, but her granddaughter (Ms X) helped care for her.

19. In 2017 Mrs B's GP referred her for a care and support needs assessment as he was concerned she was struggling to take her medication or care for herself. Mrs B went into hospital. When she was discharged she received support from the Council's Community Reablement Team. One of the aims was to encourage Mrs B to become more mobile.

20. The team discharged Mrs B and arranged a package of home care in June 2017. The support plan was for three calls a day (morning, lunch and evening) to help Mrs B with personal care, nutrition and prompting with medication. The Council commissioned Radis Group to provide the home care.

21. Ms X told the Council on 17 July 2017 that Mrs B had not had a bath since June, the carers had left the front door open, the toaster had set off the smoke alarm, she had run out of milk, the call times varied and the care folder was a mess.

22. A carer visited the next day to give Mrs B a bath. The carer then emailed the Council. She said she had called Mrs B's GP as she appeared to have a chest infection. The daily log for the carer's evening call notes she prompted Mrs B to use her inhaler.

23. The GP visited on 19 July 2017. We have not seen a note of his visit, but the Council later recorded the GP had found Mrs B's chest to be clear. The carer's log does not record whether Mrs B used her inhaler but says she was given medication. It notes she had not eaten lunch and declined dinner.

24. The next morning at about 8.45am, Mrs B told the carer she felt unwell but the GP had already visited and he had said all was ok. The carer called the on-call duty manager. The daily log says the manager was "going to ring later see how she is when lunch carer comes". In its complaint investigation, the provider found the duty manager had not agreed to personally ring Mrs B and it was unclear if the message about Mrs B feeling ill had been passed on to the office. The provider's investigation also found the carer had offered to call 111 or the GP but Mrs B had declined. This was not recorded in the log.

25. The carer missed the lunchtime call that day. The provider accepts this was in error.

26. The evening carer on 20 July 2017 arrived at 6pm. She found Mrs B was wheezy and did not want to eat. The log says "tried hard with inhaler" and that Mrs B said she had tried to call 999 earlier that day but could not. It also notes "she has had a really bad day waiting for on-call to phone her back".

27. The provider's investigation found the carer had rung the duty manager to report the lunchtime call had been missed. She told the duty manager Mrs B felt unwell but had stopped wheezing. The carer had offered to call a doctor but Mrs B declined. They decided Mrs B appeared well enough not to need medical help and there was no urgent need to override her refusal of medical assistance. These discussions are not recorded in the log.

28. When the morning carer visited at 10am on 21 July 2017 she found Mrs B slumped in her armchair. She called an ambulance which took Mrs B to hospital. She was treated for advanced sepsis, likely to have been caused by a chest infection or her lung disease. Mrs B sadly passed away the next day. There was no referral to the coroner.

The complaints

29. Ms X called the Council at lunch time on 21 July 2017. She said she was concerned the carers had not prompted Mrs B to be mobile or use her inhalers. She noted Mrs B had been in hospital previously as her oxygen levels were very low and she had not been taking her inhalers properly. There is no evidence of a response to this complaint.

30. Mr F made a formal complaint to the Council on 27 July 2017 that there had been a 16 hour delay in getting Mrs B to hospital. He said the hospital doctor had told him they could have helped Mrs B if she had been taken to hospital sooner.

31. The Council passed the complaint to the care provider. The manager reviewed the records and spoke with team members. She responded to Mr F's complaint on 5 October 2017. The response apologised for the lunchtime call being missed. It found the evening carer "had carried out her duties appropriately and … that medical assistance at that time had not been needed". However, the carer should have recorded what had happened more clearly in the log. It also found "it would have been appropriate to ask the service user's permission to inform a member of the family". Staff involved had attended training on recording, reporting, and the operation of the on-call duty manager service, and the findings from the incident had informed the provider's internal processes and procedures. The letter told Mr F he could escalate his complaint to us.

32. The Council opened a safeguarding enquiry. It asked the provider to investigate what had happened. After the provider had investigated, the safeguarding outcome was partially substantiated as the investigation had found that "all bar one member of staff acted appropriately". The Council accepts it did not tell Mr F the outcome of the safeguarding enquiry.

33. In November 2017, Mr F asked the NHS and the provider for a copy of his mother's health and care records as he wished to pursue a legal claim in relation to her death. Some documents were provided in April 2018, but correspondence continued about which records Mr F was entitled to see until May 2018. Dissatisfied, Mr F complained to us.

34. The Council held a retrospective safeguarding strategy discussion in July 2018 to ensure all appropriate actions had been taken. This noted the hospital had not recorded what impact an earlier hospital admission may have had on Mrs B's health.

Conclusions

Carers did not encourage Mrs B to move around or use her inhaler

35. The daily logs record carers prompted Mrs B to use her inhaler on the evening of 18 July 2017 and 20 July 2017. We cannot say whether at other times carers prompted use of the inhaler but did not record this, or if they did not prompt it. The lack of proper recording is fault and a possible breach of Regulation 17 of the fundamental standards.

36. There is no reference in the daily logs to encouraging Mrs B to be mobile. The Community Reablement Team had identified this need and the Council's Assessment Planning Tool records it. However, this need was not in Mrs B's care and support plan or the care provider's support plan for Mrs B. We consider this to be fault in the way the care and support plan was written, as it has not fully reflected Mrs B's needs.

Carers did not visit at lunchtime on 20 July 2017 or deal properly with the morning carer's concerns about Mrs B's health

37. The Council and care provider have accepted the carer missed the lunchtime call on 20 July 2017. This is fault.

38. The provider's investigation found the morning carer had called the duty manager and had offered to call 111 or the GP but Mrs B declined. The carer did not record this in the log. This is fault. We cannot say whether the duty manager had agreed to call Mrs B and then failed to do so, or whether the log was inaccurate.

39. In its complaint investigation, the provider said if a service user feels unwell but refuses medical help, the carer should tell the carer for the next visit and ask them to update the office. There is no evidence the message about Mrs B feeling ill was passed on to the lunchtime carer, albeit she did not visit. This is fault.

40. On 20 July 2017 there is evidence Mrs B was in "a deteriorated state of health" and the carer and duty manager should have followed the provider's emergency procedure. This says, in non-emergency situations, the carer should contact the duty manager for advice. The duty manager **must** contact the relevant social worker and GP to obtain advice and a home visit if necessary. There is no evidence the duty manager or carer contacted the social worker or GP. This is fault.

41. The provider says the carer and duty manager "did not feel it was necessary to override the service user's choice to decline assistance". This decision was flawed because it is not in line with the provider's policy, which says the GP must be contacted even if the service user has not agreed to this.

Carers failed to call 999 on the evening of 20 July 2017

42. The evening carer on 20 July 2017 found Mrs B was wheezy, did not want to eat, had already tried to call 999, and had "had a really bad day".

43. The provider's investigation found the carer had rung the duty manager to report the lunchtime call had been missed and that Mrs B felt unwell. The carer said she had offered to call a doctor but Mrs B declined. It was decided there was no urgent need to override her refusal of medical help. It was fault not to record those discussions in the log.

44. As we have set out above, it was also fault not to contact the GP and social worker as required by the care provider's emergency procedure.

The way the Council responded to Mr F's and Ms X's complaints in July 2017

45. There is no evidence the Council responded to Ms X's complaint of 21 July 2017. This is fault, however the injustice to her was mitigated as the Council dealt with Mr F's complaint, which was about similar matters.

46. The Council passed Mr F's complaint to the care provider for investigation. We find this investigation was flawed as it did not establish that staff had not followed the provider's emergency procedures. As the commissioner of the care, we would expect councils to ensure complaints against providers are investigated properly. In this case, the Council may have considered whether an independent investigation or a joint investigation was appropriate.

47. When the Council received the complaint it opened a safeguarding case and asked the provider to investigate, but it did not hold a strategy discussion to decide whether it needed to carry out a formal safeguarding enquiry. This was fault. We note it has now done so.

48. When the safeguarding enquiry considered the provider's complaint investigation report it failed to establish that the provider's emergency procedures had not been followed correctly. The Safeguarding Procedures say enquiry reports "need to be concise, factual and accurate". We therefore find fault with the safeguarding enquiry report.

49. In response to our enquiries, the Council accepted it had not told Mr F the outcome of the safeguarding enquiry. This was fault, however the injustice to him was mitigated as he received the provider's complaint investigation report.

Did the fault cause injustice?

50. We cannot say what the outcome would have been if the provider had contacted Mrs B's GP on the morning or evening of 20 July 2017. We cannot say if the GP would have visited or whether Mrs B would have gone to hospital. We cannot say whether earlier hospital treatment would have improved her health. Our role is not to establish a cause of death. We cannot therefore say the fault identified caused Mrs B's death.

51. However, we find the failure to follow the emergency procedure caused injustice to Mrs B. She was clearly unwell. She had tried to call an ambulance but had been unable to. It is likely therefore she was unable to do so again as her health

deteriorated and we consider this would have caused her considerable distress. As Mrs B is now deceased, we are unable to remedy the injustice to her.

52. But the failures identified also caused significant injustice to Mr F and the family. The failure to keep adequate records has led to uncertainty over whether the care in relation to Mrs B's inhaler was adequate, and whether any failures in care led to the decline in Mrs B's health.

53. The failure to follow the emergency procedures has left the family with uncertainty, anxiety and distress about whether there may have been a better outcome for Mrs B. This is unnecessary additional distress at a time when they had to cope with Mrs B's death.

54. The fault in the complaint investigation caused Mr F time and trouble as he had to bring his complaint to us.

Recommendations

55. When we have evidence of fault causing injustice we will seek a remedy for that injustice which aims to put the complainant back in the position they would have been in if nothing had gone wrong. When this is not possible, we will normally consider asking for a symbolic payment to acknowledge the avoidable distress and uncertainty caused. Mr F said he does not consider a symbolic payment to be appropriate; he wanted an acknowledgement that things had gone wrong and changes to prevent this happening again.

56. 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)***

57. In addition, to remedy the injustice identified, the Council has agreed to:

- apologise to Mr F for the distress caused by the faults identified;
- discuss with him whether he wishes the Council to provide a lasting tribute (such as planting a tree) in memory of Mrs B; and
- pay him £100 to acknowledge the time and trouble he has had in pursuing his complaint.

58. Within three months of our final report, the Council has agreed to:

- ensure the care provider has:
    - trained all staff on the use of its emergency procedures and the procedures to follow when a service user is ill; and
    - trained all carers on accurate and complete record keeping.
- review its adult social care complaints procedure to clarify how it deals with complaints against commissioned care providers, and how it will ensure independent investigation of serious complaints;
- remind staff involved in adult safeguarding enquiries of the importance of ensuring enquiry reports are factual and accurate; and
- provide us with evidence it has taken these actions.

Decision

59. We have completed our investigation into this complaint. There was fault by the Council which caused injustice to Mrs B and Mr F. The Council's agreement to take the action identified in paragraphs 57 and 58 remedies that injustice.