Local Government & Social Care OMBUDSMAN

Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Derbyshire County Council (reference number: 16 006 195)

29 November 2019

The Ombudsman's role

For more than 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

Mr B	The complainant
Mrs C	The complainant's late sister
Officer X	A Council manager with responsibility for its residential care services

Report summary

Adult Care Services

Mr B complains about multiple failings in the care received by his late sister, Mrs C, when she was resident at the Grange Care Home between November 2015 and March 2016, which is owned and run by the Council. In particular, there were serious failings in its response after Mrs C died following a fall in the care home.

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).***

In addition to the requirements set out above, to remedy the injustice caused by this complaint the Council agrees that within three months of the date of this report it will:

- give an unreserved apology to Mr B accepting the findings of this investigation. It has said it will meet in person with Mr B to deliver this;
- make a payment of £1,000 to a registered charity of Mr B's choice;
- offer to pay for a memorial for Mrs C such as a park bench or tree planted in her memory, subject to agreement with Mr B about matters such as his preferences and location.
- undertake a further review to see what further lessons might be learned from this complaint. Full details are set out in the body of this report, but this will include the Council:
    - considering how it can ensure there is an audit trail of assessments left partially completed;
    - improve its record keeping in care homes using both electronic and paper records;
    - improve its capture of information when GPs visit its care homes;
    - reviewing several aspects of its current safeguarding procedures; and
    - how it can avoid gaps in service provision when undertaking restructuring of services.

The complaint

1. We have called the complainant 'Mr B'. He complains about the care received by his late sister 'Mrs C' who lived at The Grange Care Home ('the care home') between November 2015 and March 2016. The Council owns and runs the care home.

2. Mr B complains the Council:

   - did not tell him and other family members about a series of falls Mrs C experienced at the care home;
   - failed to carry out any falls risk assessment during Mrs C's time living at the home;
   - failed to inform paramedics of falls Mrs C experienced in January 2016;
   - failed to call paramedics when Mrs C experienced a fall on 25 March 2016 until the following day;
   - failed to adequately monitor Mrs C's weight while she lived at the care home or to ensure she maintained a healthy Body Mass Index (BMI);
   - did not investigate allegations made by Mrs C during her time at the care home that she was hit by members of staff;
   - did not inform Mrs C's GP that she may have chewed paint from the walls of her room around the time she suffered a mouth infection;
   - did not ensure safe staffing of the care home further to a re-organisation of its care services concurrent with Mrs C's time there;
   - failed to carry out an effective safeguarding investigation after Mrs C was admitted to hospital on 26 March 2016 and it raised concerns about serious injuries she had on admission. Mrs C subsequently died of her injuries; and
   - failed to carry out an effective investigation of Mr B's complaints about Mrs C's care.

3. Mr B says as a result of the above Mrs C received a poor quality of care during her time in the care home, causing her needless distress. Further the poor care she received contributed to her death, a finding supported by the Coroner who carried out an inquest in April 2018. Mr B says this in turn has caused him and the wider family distress, now believing Mrs C was inappropriately placed at the care home. Had Mr B realised the poor quality of care received by Mrs C, he would have taken steps to ensure her safety.

What we have investigated

4. Because there has been a Coroner's inquest in this case, we have not investigated the immediate circumstances surrounding Mrs C's fall on 25 March 2016 which led to her death. However, we have considered Mr B's wider complaints about poor quality care. We note the Coroner also considered some of the background to events on 25 March and criticised the Council's care planning as contributing to Mrs C's death. We consider there is public interest in investigating that care planning further. We have also investigated how the Council reacted to Mrs C's admission to hospital and subsequent death and

contacts from her family in response. These were not matters covered by the Coroner's inquest.

The Ombudsman's role and powers

5. 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)***

6. We produced this report after examining relevant documents and interviewing the Mr B. We also listened to statements given by key personnel for the Council at the inquest into Mrs C's death.

7. We gave Mr B and the Council a confidential draft of this report and invited his comments. The comments received were taken into account before the report was finalised.

What we found

Relevant legal and administrative considerations

8. The Council arranged care for Mrs C under duties set out in the Care Act 2014. In this case the Council was also the care provider being registered to provide residential care at the care home, including for those with dementia.

9. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out the 'fundamental standards' which all care providers should meet in delivering care. We consider the 2014 Regulations and the Guidance when determining complaints about poor standards of care.

10. Of relevance to this complaint are the following.

- Regulation 12 – "*Safe care and treatment".* This regulation aims to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment. Guidance says providers must do what is reasonably practicable to mitigate risks.
- Regulation 13 – *"Safeguarding service users from abuse and improper treatment".* The intention of this regulation is to safeguard people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. The Care Quality Commission (CQC) say providers must have a 'zero tolerance' approach to all kinds of abuse including neglect. Providers must take appropriate action without delay through having 'robust procedures' in place to investigate incidents.
- Regulation 14 – *"Meeting nutritional and hydration needs"*. Providers must ensure people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so. This is to reduce risks of malnutrition and dehydration.
- Regulation 15 – "*Premises and equipment".* This regulation aims to ensure premises where care and treatment are delivered are suitable, clean and well maintained.

- Regulation 17 – *'Good governance'.* This regulation requires providers have systems and procedures in place to meet other regulatory requirements. Systems and procedures should assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services. Providers must also maintain accurate, complete and detailed records for each person using the service.
- Regulation 20 – *"Duty of candour".* This says that providers should be open and transparent with people who use their services and other relevant persons acting lawfully on their behalf. The CQC says the regulation promotes openness and honesty at all levels as an integral part of a culture of safety that supports organisational and personal learning. It says care providers should apologise when things go wrong.

11. Regulation 18 of the CQC (Registration) Regulations 2009 says care providers must report all incidents to the CQC which result in serious injury to a service user. Regulation 16 requires care providers to report the death of users of services which "*have, or may have, resulted from the carrying on of a regulated activity".*

12. The Council also has a wider legal responsibility to safeguard adults. It must set up a safeguarding adult board which has a strategic role in publishing plans setting out how it will meet its objectives and publishing an annual report. But it must also decide when a safeguarding adults review is necessary. This includes circumstances where an adult has died and the board "*knows or suspects that the death resulted from abuse or neglect*" **(Care Act 2014, section 44).** In addition, in any case where the Council has reasonable cause to suspect abuse of an adult who needs care and support, it must make whatever enquiries it thinks necessary to decide whether any action should be taken to protect the adult. **(Care Act 2014, section 42)**

13. The aims of adult safeguarding are to:

- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- stop abuse or neglect wherever possible;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities, as well as professionals, play their part in preventing, identifying and responding to abuse and neglect;
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- address what has caused the abuse or neglect.

(Care and Support Statutory Guidance, 14.11)

Key facts

The complaints about falls

14. Mrs C was a single woman who in 2015 was diagnosed as suffering from dementia. She also had diabetes and osteoporosis. Mrs C's dementia caused her

anxiety, agitation and affected her ability to communicate. She became fearful of falling and would often fall. Mrs C became known to the Council during 2015 when it arranged some home care for her. However, there were concerns for her self-care and in November 2015 Mrs C went to hospital after accidentally taking the wrong medication. After three days she was discharged to the Staveley Centre a respite care facility owned and managed by the Council. This was to assess if she needed residential care.

15. While in respite care, staff observed Mrs C suffering frequent falls, usually described as 'slides to the floor'. She experienced at least nine falls in under three weeks. However, the Staveley Centre did not undertake a falls risk assessment. At the end of November 2015 Mrs C was readmitted to hospital following one of these falls when she reported pain. Four days after that she was discharged again, this time to The Grange, the care home at the centre of this complaint.

16. Staff at the care home used two types of record keeping. There were electronic case notes which tracked Mrs C's involvement with the Council including the notes made in the respite care home. They also kept hand-written notes at times, for example in completing a daily care home log and recording a list of GP visits. During the inquest into Mrs C's death the manager at the care home said they had not checked the electronic records which showed Mrs C's history of falls.

17. The Council has a policy document for its care home staff called *"Falls Prevention in Residential Homes"*. In the introduction to the 2013 version, in force at the time of these events (subsequently revised) the document says that many falls, trips and slips can be prevented. It says care home managers should complete a falls risk assessment 'on admission'. They should put in place a plan to try and reduce the risk of falls for residents found at high risk.

18. The policy recommends managers consider a range of 'person specific' risk factors in risk assessments. For example, considering how matters such as medications, footwear or use of mobility aids may contribute to falls. It provides advice on such matters; for example, listing medications known to produce a higher risk of falls which included two medications taken by Mrs C. It provides detailed advice on how different medical diagnoses, such as dementia, can influence likelihood of falls. It says staff can consider measures such as hip protector pads or bedrails to try and prevent or minimise harm from falls. Sensor pads can also be used to alert staff when a resident gets out of bed. The policy provides detailed advice on using care planning to reduce the risk of falls. The policy encourages care homes to always keep under review residents at high risk of falls and measures in place to prevent this. It also explains staff can contact its specialist falls prevention team for advice and further assessment.

19. The policy also gives staff advice on legal requirements, including when care homes must complete a 'RIDDOR' form (the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) to the Health & Safety Executive (HSE). This includes where accidents result in residents having to attend hospital because of an injury.

20. During her first week in the care home, staff undertook some initial care planning for Mrs C. This comprised a central care plan document which identified Mrs C had a history of falls. The care home recorded Mrs C's medications. The main care plan document prompted the care home to undertake a falls risk assessment. However, the care home did not do so.

21. During her stay at the care home a care worker completed a 'monthly review' of Mrs C's care. The January 2016 review noted Ms C had experienced a number of falls and she had some bruising. But the care home recorded taking no further action.

22. In total, between November 2015 and March 2016 the care home recorded finding Mrs C on the floor on 25 occasions. In some cases care home staff completed a 'falls, trips and slips' record, which explained where and how they had found Mrs C and recorded any signs of injury. On several occasions the forms note 'family will be informed' of the incident. However, Mr B, who visited his sister frequently says that he was not told of the amount of times staff found Mrs C on the floor. Some falls were recorded only in the daily care home log with no 'falls, trips and slips' form completed.

23. Care home records detailed various injuries Mrs C sustained. During December 2015, care home records show Mrs C had bruising or swelling on both arms and elbows. On one occasion she had two grazes to her head. A GP recorded Mrs C having multiple bruises on her hips and leg. In January 2016 the care home recorded Mrs C having grazing on her back and shoulder. She also had a swollen elbow on one occasion and a swollen ankle on another. In March 2016 it recorded her having a small skin tear to her right leg and grazing to her elbow. A body map completed on 3 March showed a bruise and skin tear on her back. On 16 March the care home called Mrs C's GP following a fall and her complaining of pain in her left arm. It explained to the GP that Mrs C had fallen out of bed. However, there is nothing in the care home records that refers to this. The GP examined and described a soft tissue injury.

24. Care home records also documented that on 23 January 2016 staff called paramedics after finding Mrs C slumped while on the toilet in her room, describing her as unresponsive. Mrs C went to hospital but returned to the care home later that day. Her medical discharge notes did not state the cause for her unresponsiveness, but staff believed it was connected to her diabetes.

25. On 25 March 2016 Mrs C suffered an unwitnessed fall in the care home lounge. Care home staff reported Mrs C saying she had pain in her left side but they could not detect any injuries. So, they did not seek any medical help for Mrs C.

26. In the early hours of 26 March 2016 Mrs C was found unresponsive. Staff believed this was similar to the previous episode. Paramedics were called. They were not told of Mrs C's fall the previous evening.

The complaint about monitoring weight

27. The care plan completed by the care home when Mrs C moved in noted she had lost weight and needed prompting to eat meals. It also noted Mrs C had diabetes and would need healthy meals with a comment that she needed to watch her sugar intake. The form prompted the care home to complete a nutritional assessment.

28. The Council says a deputy home manager began completing the nutritional risk assessment but did not finish it. There is a completed assessment in Mrs C's care records but this is dated 3 April 2016, when she was in hospital. The Council says it is not possible to say how much of the document it had completed before 3 April.

29. The assessment documentation required the care home to record Mrs C's Body Mass Index (BMI). The BMI is a measure using height and weight to calculate if someone has a healthy weight. A healthy BMI is one between 18.5 and 24.9. The

assessment records Mrs C's BMI once at 25 and once at between 18.5 and 20. It has no reference to her height or weight. The lower reading would mean Mrs C was considered at medium risk of malnutrition. The assessment paperwork says this should trigger further action, including providing a high calorie and high protein diet. The notes accompanying the risk assessment also say the Council should monitor and record food and fluid intake for at least four days and undertake weekly checks of weight, as well as regularly reviewing the nutritional assessment.

30. The care home weighed Mrs C occasionally, with it recording her height as 5ft 1inch (or around 1.55m). Mr B says this was not correct and her height was 5ft 3inches. On admission to the care home at the beginning of December 2015 Mrs C weighed 53kg giving her a calculated BMI of 21. On 27 December 2015 the care home recorded Mrs C weighed 46kg. It did not record her BMI, but we calculate it to be around 18.5 based on Mr B's statement of her height. A week later Mrs C's weight increased to 48kg and stayed the same when next recorded on 17 January 2016. By 14 February 2016 it had dropped again to 45kg, but the care home recorded Mrs C's BMI as 20. We calculate it would be 18.5 based on the care home's measurement of height and 17.5 based on Mr B's understanding of her height. There was no further recording until 17 March 2016 when the care home recorded Mrs C's weight was 49kg (all figures rounded up or down to the nearest kilogram). This would give her a BMI of between 19 and 20 depending on which height measurement is used.

31. The care home kept weekly logs of food and drink taken by Mrs C, although these did not always record quantities.

32. Mr B says the family noted Mrs C's weight loss while at the care home. In February 2016 they bought new clothes for her, because Mrs C had dropped two dress sizes. Mr B says he asked to see records of Mrs C's weight but these were not provided.

33. In the care home notes are references to Mrs C eating sugary foods and sometimes having raised blood sugar levels. It is not recorded if the home offered her diabetic snacks. There is no record of staff being given any specific advice on monitoring Mrs C's diet in view of either her diabetes or weight.

34. During the inquest into Mrs C's death the care home manager reported that she did not consider Mrs C at risk of malnutrition. She said that Mrs C always appeared to eat well while in the care home.

Complaints about other incidents while at the care home

35. On 11 December 2015 Mrs C reported to a night care worker that she had been hit by someone in the care home and this happened 'all the time'. The care worker put a note on the electronic record saying they found Mrs C on the floor in her bedroom with 'no injuries'. They did not complete a falls, slip or trips record. The note says they asked Mrs C what she was saying but she did not repeat the comment about being hit. A hand-written log entry later that day reported Mrs C being unsettled and asking for help.

36. Managers at the care home did not take any action in response to the report. During the inquest into Mrs C's death the care home manager denied knowing of any specific allegation made by Mrs C that she had been hit. However, the deputy home manager said she thought all staff knew of Mrs C making the allegation. During our investigation the Council said the manager had spoken to Mrs C and asked her to repeat the allegation but that she could not do so.

37. On 18 December 2015 Mrs C's GP visited as Mrs C had a swollen and sore mouth. He diagnosed thrush. The GP was not told Mrs C had potentially swallowed paint from the wall of her room having been observed to have picked at that. Mr B says the paint was recent and still soft. A care home worker told the inquest into Mrs C's death she had reported this to a manager at the care home.

38. Council safeguarding procedures in force during the events covered by the complaint drew attention to the standards set out in the Care Act 2014. It said that an *"alert"* is a *"concern or allegation which has been reported by a member of staff to their lead/manager within their agency"*. It said managers should decide within 24 hours of a concern being reported whether it met the threshold for a safeguarding referral, justifying enquiries. However, the procedures did not give guidance to managers on what concerns met the threshold.

Complaint about restructuring and staffing levels

39. At the time Mrs C entered the care home it was undergoing changes as a result of a restructuring exercise. In June 2015 the Council had approved a plan to restructure its care homes. This followed CQC inspections which identified that its "*care staff time [was] being used to cover other tasks and that this reduced the amount of time available to focus on resident care"*. The report also noted it was a time of "*extreme budget pressures and limited resources*" and that restructuring would be *"more effective and efficient"*.

40. The central part of the restructuring was to introduce a senior care worker role in Council care homes alongside existing care workers. The senior care workers would work more with users of services than existing managers. Management across care homes would be cut with the loss of around two thirds of Deputy Unit Manager jobs from the service.

41. Deputy Unit Managers affected by the changes were made redundant by 9 January 2016. The Council anticipated having recruited senior care workers to replace them. However, this did not happen in all cases. In this case, the care home had made redundant one deputy manager by 9 January. While it had retained a single deputy manager post this manager had some leave of absence after January 2016. No senior care workers were recruited to the care home until July 2016. Between January and March 2016, the home therefore ran with only a single manager and an occasional relief manager. It had up to 25 residents.

42. During the inquest into Mrs C's death the manager of the care home said that reduced staffing levels contributed to the decision not to complete care planning paperwork. This included the falls risk assessment and nutrition assessment for Mrs C.

43. During the inquest a senior manager for the Council, 'Officer X', said that from September 2015 it knew of delays in recruiting senior care workers. Although they considered the delay in recruiting senior care workers to this care home exceptional. Officer X explained the Council sought to use agency staff or relief managers to help short-staffed care homes but this was not always possible. The manager also said that they recognised care home managers found it difficult to maintain records during this period. Officer X said senior managers had advised care home managers to focus on delivering care to residents more than completing care planning documents. In comments on the draft report the Council has also said that it made additional resources available to care homes that needed support during the transition period and were short-staffed as a result.

Complaints about events following Mrs C's hospital admission on 26 March 2015

44. Following an x-ray and examination at hospital Mrs C was found to have four fractured ribs and serious chest injuries. The hospital raised a safeguarding alert with the Council on the day of Mrs C's admission.

45. The Council's safeguarding team made some initial enquiries with the care home, which reported Mrs C experiencing regular falls. It recorded the Deputy Manager of the Care Home saying Mrs C had reported being "*in pain all week"* but a GP had assessed her a week before and not taken further action. The safeguarding team suggested Mrs C's case should be referred to the falls prevention team. It also referred the case to Officer X, who had responsibility for its care homes and asked her to make enquiries. But it did not make clear to Officer X if they were undertaking a safeguarding investigation on behalf of the Council or providing information to help with a safeguarding investigation. Officer X said at Mrs C's inquest she understood it was the latter.

46. Safeguarding procedures in force at the time of this alert advised Council officers of the purpose of making enquiries into safeguarding alerts. This listed *"the objectives of any enquiry into abuse or neglect"* including*:*

- ensuring the safety and wellbeing of the adult;
- establishing facts;
- establishing details about whether there are any risks to other adults in need of care and support; and
- making decisions about what follow-up action should be taken regarding the person or organisation responsible for the abuse or neglect.

47. Officer X sent an email to a social work manager at the hospital on 29 March further to a visit to the care home and discussion with the care home manager and deputy. This described events on 25 March. It also noted Mrs C having had "*numerous falls*" while in the Council's care and the home had been "*discussing the benefit*" of referring Mrs C to its falls prevention team. Officer X said *"I do not have any concerns regarding [Mrs C's] care".* The social work manager at the hospital then closed the investigation.

48. On 2 April 2016 Mr B and Mrs C's niece attended a meeting at the care home with the manager as they were concerned about the injuries Mrs C had sustained. They discussed events on 25 March and asked if the care home considered it could meet Mrs C's needs on discharge. The family were not reassured by that discussion and by 6 April had indicated a reluctance to let Mrs C return to the care home, wanting further investigation into her care. Mr B wrote to the Council the same day expressing concern at the circumstances surrounding Mrs C's admission to hospital and extent of the investigation into this.

49. In response, on 6 April 2016, the Council agreed to re-open the safeguarding investigation.

50. On 12 April 2016 Mr B contacted the CQC with his concerns. It acknowledged his contact and said it had not been told by the Council of Mrs C's fall or admission to hospital.

51. On 14 April 2016 the Council sent the CQC notification of Mrs C's fall on 25 March and details of the safeguarding alert. The CQC asked the Council if it had completed a RIDDOR notification.

52. Mrs C did not recover from her injuries and died in hospital on 16 April 2016.

53. On 19 April 2016 the Council submitted a RIDDOR notification to the HSE and sent notification of Mrs C's death to the CQC.

54. On 9 May 2016 Mr B and relatives attended a meeting with a senior safeguarding manager and others from the Council. The Council said as part of the safeguarding investigation it would consider any comments or concerns raised by the family. It would interview staff at the care home about events on 25 and 26 March. Mr B also received a report at that meeting which included:

- that Mrs C had reported pain in her left side from the time she arrived at the care home. The GP had not identified the cause;
- she had experienced frequent falls at the care home;
- a more detailed account of events on 25 March 2016;
- a recommendation that care home staff consider summoning medical help when a resident with dementia suffers an unwitnessed fall; even if they do not appear to have sustained injury; and
- a further recommendation that referrals are made to the Council's falls prevention team.

55. On 15 May 2016 Mr B submitted a detailed statement and list of questions from the family around Mrs C's care. This included questions about events on 25 and 26 March. But Mr B also raised concerns about Mrs C experiencing weight loss while in the care home. He also asked for more details about the frequent falls and asked what steps the Council had taken to assess these or prevent them. He queried if the care home had the necessary experience and expertise to meet Mrs C's needs.

56. The Council had a further meeting with Mr B on 26 May 2016. The meeting again discussed the family's concerns. Mr B asked if the Council had completed a RIDDOR following Mrs C's death. The family expressed concern that they were 'making the running' in pushing for an investigation into Mrs C's care. They remained concerned at the initial safeguarding investigation which they considered inadequate.

57. On 9 June 2016 Officer X provided a document which further explained events on 25 and 26 March 2016 based on interviews with staff. This was sent to the CQC the same day and described as a 'preliminary investigative report'. It commented on its weight monitoring of Mrs C saying she would sometimes not sit on the weighing scales when asked to. It noted records of 18 falls, although pointed out these were when staff found Mrs C on the floor and she may sometimes have 'slid' to the floor. It acknowledged the failure to complete a falls risk assessment or referral to the falls prevention service. The report said Mrs C experienced *"a good overall standard of care"* but "*there are areas of practice that require review"* including understanding of the falls prevention procedure and better or improved training to meet the needs of users with dementia.

58. On 21 June 2016 a safeguarding meeting took place attended by representatives from the Council, hospital trust, ambulance service, police and family. The organisations represented said they were not aware of any concerns raised about care standards at the home in the months before Mrs C passed away. During the meeting Officer X described Mrs C as *"the most advanced dementia client"* admitted to the care home. The meeting went over investigation into events on 25 and 26 March as well as hearing contributions from the other services. The

Council acknowledged at the meeting that its 'trips, slips and falls' forms had not contained all the information they should. Also, that it had not shared details of its initial safeguarding investigation. Further actions focused on co-operation being provided to the Coroner to aid their inquiry into Mrs C's death.

59. The Council sent Mr B a copy of the minutes and he made some comments on the same. On 21 July 2016 the Council closed its safeguarding investigation. It did not write to tell him this.

60. In August 2016 Mr B contacted us wanting to complain about the circumstances surrounding Mrs C's death and the Council's subsequent investigation. We decided we could not investigate the complaint until the Council had opportunity to consider the complaint and respond. We also decided we would not begin an investigation until the Coroner inquest was completed.

61. During our investigation we have also learnt that in August 2016 the Council received an anonymous letter raising concerns about the care home. We do not find the majority of those concerns engage with matters raised in this report. However, we note the author expressed concern at staff's completion of food and hydration charts. They also referred to Mrs C in the following terms: "*Staff had concerns about a resident [Mrs C], she has now died and her family made a complaint. Staff told […] about the problems".*

62. Officer X prepared a report into the content of the letter a few days after it was received. While the report noted the comment about Mrs C it did not address it. A few days later Officer X met with social workers with clients at the care home and a senior manager to discuss the letter. There are no comments recorded about Mrs C's case either in general discussion about standards in the care home or when those attending discussed the content of the letter.

63. On 8 November 2016 the Council produced a "Regulation 20 - duty of candour" report in response to further enquiries from the CQC. It set out the background to Mrs C's admission to the care home and explained the Council's understanding of events on 25 and 26 March. The Council acknowledged it did not implement its safeguarding procedure properly following Mrs C's admission to hospital. It said it had acknowledged to Mrs C's family that its communications had been poor and it had not followed the correct procedure of risk assessment and referral for Mrs C. It also acknowledged not signposting Mr B to its complaint procedure sooner.

64. But the Council defended how it had shared information with Mr B since becoming aware of his concerns and the family's involvement in the safeguarding investigation. It described *"the initial report submitted by [Officer X] as a preliminary report broadly providing the information gathered and was not meant to be definitive and full report".* It therefore considered it had largely met the expectation to be open and transparent with Mr B. It also said that separately it had carried out a learning review.

65. The learning outcomes from that review highlighted:

- the failure to carry out a falls risk assessment or nutritional assessment for Mrs C;
- the lack of detail contained on 'slips, trips and falls documentation';
- the lack of detail contained in weight charts;
- the lack of detail contained in food charts; and
- that both care logs and case notes were also not as detailed as they could be.

66. The Council said as a result of the learning review:

- it had revised admission procedures with more formal discussion with families during the early weeks of a resident's stay;
- there would be more "shift reflection" between care staff, more audits of care records and more training for staff on completing documents;
- senior care workers would address with care home staff how they recorded and responded to behaviour by users of services;
- it would adhere to its safeguarding procedures and had revised its practice on sending RIDDOR notifications to the HSE; and
- it had changed practice and adopted a more precautionary approach; calling GPs or other medical professionals following unwitnessed falls. It had also booked all staff on refresher training in falls prevention and reminded them of the existing policy.

67. On 15 November 2016 the Council sent its first response to Mr B's complaint. It acknowledged some poor practice in the care given to Mrs C, going over the findings highlighted by its learning review and the procedural improvements referred to. It repeated the information given to the CQC on 8 November in response to Mr B's concern the Council had not met the duty of candour. It apologised to Mr B for its failings.

68. In April 2018 an inquest took place into Mrs C's death, conducted by the Coroner for Derbyshire. In a narrative verdict he recorded the following:

- Mrs C's death resulted from the effects of the injury she sustained from a fall on 25 March 2016. A low BMI had also contributed;
- required assessments for her care plan had not been completed and actioned before 25 March 2016;
- unexplained bruising had not been investigated and there had been no analysis or review of 25 falls recorded while at the care home;
- the Court considered on balance the fall on 25 March would have been avoided had such review taken place and preventable measures taken; and
- the reduction in senior staff at the care home contributed to the inadequate care planning.

69. In May 2018 the Council wrote again to Mr B providing a final response to his complaint further to the inquest. The Council said it did not consider it could add to its earlier correspondence or the matters raised at the inquest and so signposted Mr B back to us.

70. In April 2019 the CQC began a prosecution of the Council for failing to provide safe care and treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm under Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 12 Social Care and Treatment). In June 2019 the Council submitted a guilty plea to this charge.

71. In reply to our enquiries and our draft report the Council has sent details of how it aims to ensure good care standards in its care homes, including improvements made since the events covered by this complaint. These include the following:

- it has revised its audit procedures. Home managers undertake monthly client file audits, infection control audits and medication audits. They must also complete annual reports and annual health and safety audits. They must

complete a ‘falls monitoring spreadsheet’ to identify and support users at risk of frequent falls. Senior Care Workers audit logs made by care workers within care homes. Senior staff specifically review pre-admission assessments, risk assessments and care plans;

- it has made changes to its falls policy. It reviews all residents considered at risk of falls. It refers residents at risk to healthcare professionals. It encourages staff to ‘double-check’ with senior staff where they have concerns for an adult considered at risk of falls or at increased risk of falls;
- that service managers from outside care homes undertake monthly quality visits which review care home documents. They also undertake six-monthly infection control and medication audits;
- that health and safety officers collate care home health and safety reports. They also undertake their own monitoring of matters such as fire safety and environmental health;
- using its audit team to carry out annual inspections. The Quality and Compliance Team will draw up service improvement plans if needed;
- ensuring safeguarding investigations are kept open if these identify improvements are needed;
- maintaining an up to date training record for staff; including identifying when they need to attend refresher courses;
- liaising with residents and relatives through user questionnaires. The Council also regularly reviews complaints to identify themes and trends;
- the Council also says that it works with external organisations. For example, the CQC and Healthwatch;
- it has established a quality and improvement board with one of its service directors as the Chair. The Board outlines projects for service improvements. It has a task force to help with any service at risk of failing; and
- it has commissioned a further independent expert review of the management of The Grange.

72. In response to our enquiries the Council has sent us details of audits carried out as well as a Healthwatch Inspection carried out in October 2017. These show the Council carries out audits of individual care records as well as policies and procedures more generally. A CQC Inspection in October 2017 found the care home had appropriate safeguarding and whistle-blowing procedures in place as well as good care planning procedures.

Findings

The complaint about falls

73. We note with concern the multiple falls experienced by Mrs C in the care home. The Council missed many opportunities to assess and try to prevent Mrs C’s pattern of falls.

- First, when it failed to take account of the information already on its records when Mrs C moved to the care home. This was not the only occasion when care home managers did not pick up on important information being kept on the electronic notes. We find the Council failed to carry out a satisfactory pre-admission assessment of the suitability of The Grange for Mrs C.

- Second, it failed to carry out a falls risk assessment once Mrs C moved into the care home despite its initial care planning procedures requiring this. The Council's falls risk policy has since been revised and improved, but it was still a useful policy guide for care home staff.
- Third, when it failed to carry out such a risk assessment in response to over 20 falls Mrs C experienced subsequently at the care home. We note how many of these falls were not adequately documented.
- Fourth, when it failed to act in response to a monthly review of Mrs C's care noting how often she fell.
- Fifth, when it failed to tell Mr B about the extent of Mrs C's pattern of falls. Had Mr B had opportunity to express concern this might have led the care home to revisit its management of Mrs C's care.

74. This repeated failure to carry any assessment of Mrs C's pattern of falls is fault. We do not consider Mrs C received safe care and treatment in line with the CQC fundamental standards; particularly Regulation 12 (see paragraph 10). The Council also failed to have adequate systems and procedures in place to ensure it mitigated any risks to Mrs C's health and safety in line with Regulation 17 (see paragraph 10).

75. This caused Mrs C significant injustice. Care records show Mrs C experienced repeated minor injuries as a result of her falls. We query also if these were complete noting the Council's failure to record the reason for the GP call out on 16 March. Ultimately, Mrs C suffered major injuries which led to her death, something the Coroner found avoidable. The Council's falls prevention policy explained the many steps it could have taken to reduce the risk of further falls and injuries associated with that.

76. The pattern of failure also caused injustice to Mr B and other members of Mrs C's family. They experienced their own distress learning of the poor care Mrs C received.

The complaint about monitoring weight

77. We note a further pattern of failure in the Council's care planning.

- First, the Council failed to complete an adequate nutritional assessment for Mrs C when she entered the care home.
- Second, it failed to respond and complete such an assessment after Mrs C's weight dropped significantly in her first month in the care home.
- Third, its records of Mrs C's weight were inconsistent and incomplete. A recording of her BMI taken in February 2016 was wrong. The Council did not keep any record of any occasion when Mrs C could not be weighed.
- Fourth, while it monitored Mrs C's food and fluid intake many of the records of that were inadequate to make a judgment if this was satisfactory.
- Fifth, it is not clear how the Council sought to manage Mrs C's diet in view of her diabetes.

78. These repeated failings lead us to find fault. We do not consider the Council met Mrs C's nutrition and hydration needs in line with the fundamental standards or kept adequate records (Regulations 14 and 17 - see paragraph 10).

79. The fault caused injustice to Mrs C. Her low BMI was a contributory factor to her death. While it is not clear if Mrs C had a low BMI at the point of her admission to

hospital, she may have maintained a healthier BMI in the care home had it followed basic good practice.

80. The fault also causes further injustice to Mr B and other members of Mrs C's family. They have experienced their own distress learning of how poorly the Council managed these matters while Mrs C was in its care.

81. This part of the complaint has also highlighted an issue in how the Council keeps an audit trail of assessments, such as the nutrition assessment. Where staff partially complete an assessment, it should be possible to highlight what parts they complete on what day. We are concerned to note in this case the partial completion of Mrs C's nutrition assessment only after she entered hospital. We do not say it happened in this case, but the Council should take steps to guard against the possibility that staff might look to amend documents in the wake of poor care, to cover up mistakes.

Complaints about other incidents while at the care home

82. It was not until after Mrs C's death that Mr B leant of certain incidents while Mrs C lived in the care home which caused him concern. Addressing these in turn it would appear the care home manager was not aware of the allegation made by Mrs C that someone had hit her.

83. This concerns us, as staff did complete an electronic record of the report. So, this is the second occasion we have found that managers have failed to check appropriate electronic records. We also note that staff who found Mrs C on the floor, failed to complete an appropriate separate record of that fall. We also find the care home failed to tell Mr B of the allegation.

84. It was fault for the Council not to consider if the allegation justified a safeguarding investigation. However, we cannot say this fault caused injustice. While Mrs C's suggestion could have triggered enquiries, the circumstances where she was found on the floor did not support the allegation. We note when asked, she did not repeat the statement or add detail. We do not think she could have therefore contributed further to enquiries. And there is no other evidence to suggest she suffered non-accidental injuries.

85. We also note Mr B's concern the care home did not tell Mrs C's GP of the suggestion she may have eaten paint scraped from the wall of her room. This highlights a wider flaw in the Council's record keeping as while the care home did keep records of GP visits, it made only brief notes of these. So it was not always possible to form a clear picture of why it called the GP or how it recorded their advice. So the Council did not meet standards of record keeping required by Regulation 17 of the fundamental standards. The circumstances where Mrs C could pick paint off the wall also calls into question whether the Council met the fundamental standards required by Regulation 15 to maintain clean and hygienic premises (see paragraph 10).

86. But we do not consider any failing here caused injustice to Mrs C. The GP acted in response of Mrs C's swollen mouth and tongue based on their own first-hand examination. We have not seen any evidence to say their diagnosis or treatment would have differed if told of Mrs C picking paint from the wall.

Complaint about restructuring and staffing levels

87. We accept the Council found itself under financial pressures in 2015 and wanted to re-focus its direct care services in response to comments made by the CQC following inspections. We understand therefore why the Council wanted to

re-structure staffing in its care homes. We consider had that re-structuring gone to plan then this need not have affected the care Mrs C received.

88. However, the restructure clearly did not go to plan. The Council must have known this by Autumn 2015 when it issued redundancy notices to deputy managers without yet having senior care staff to replace them. By early 2016 the Council clearly knew of the pressures this created in the care home, with managers neglecting to ensure essential risk assessments were completed. Although we also note in the case the Council had several weeks to complete care planning and risk assessments for Mrs C before any redundancies took effect.

89. We understand the Council took some actions to try and mitigate the impact of the short staffing in the care home. Yet these were clearly ineffective. So, for at least six months the care home ran without enough managers or senior care workers in place. Senior managers both within and overseeing the care home service knew the Council was not carrying out basic care planning required as part of the fundamental standards of care. Yet they turned a blind eye to that and instead created a false distinction that completing mandatory risk assessments would take away from frontline care. This was fault. The risk assessments were fundamental to safe care provision, not an optional extra.

90. The injustice this caused for Mrs C was that of missed opportunity to address the shortfalls in care planning we have already detailed. It also adds to Mr B's distress that the Council knew basic care planning was not taking place yet allowed this to continue.

Complaints about events following Mrs C's hospital admission on 26 March 2016

91. Our findings above reinforce what the Coroner's investigation found. There were failings in Mrs C's care planning which were not acted on by the Council, that meant her death was avoidable. But the Council then compounded these failings through an inadequate response when alerted to Mrs C's injuries by the hospital.

92. The Council's safeguarding policy made clear it needed to conduct an enquiry into the circumstances surrounding Mrs C's admission to hospital with serious injuries. It needed to understand properly what had happened to Mrs C and consider consequences for other residents in the care home. As well as knowing of Mrs C's injuries on admission to hospital, it quickly became apparent she had suffered a pattern of falls in the care home.

93. Yet despite this the Council initially conducted only the most cursory of investigations. Its initial finding that there were "*no concerns*" for Mrs C's care flew in the face of the evidence we have detailed above. It did not explore Mrs C's care planning, its staff's awareness of its falls prevention procedure, their completion of risk assessments and so on. It failed to meet the requirement set out in the fundamental standards to have a robust safeguarding procedure to investigate potential neglect. (Regulation 13 – see paragraph 10). It also wrongly recorded Mrs C had seen a doctor a 'week before' her fall when more than a week had passed.

94. We recognise there may have been some confusion on the part of Officer X about what her role was when passed the safeguarding enquiry and the depth of enquiry needed. This in turn formed part of a wider procedural failing by the Council. Because it should not have been possible for it to close the safeguarding enquiry based on such an inadequate investigation. Indeed, it is arguable the circumstances of Mrs C's death justified referral to the Council's Safeguarding

Adults Board to undertake a safeguarding adult review. But there is no indication that was ever considered. That was fault.

95. The Council's cursory and inadequate initial response led to a loss of trust by Mr B and members of Mrs C's family. The Council not only had a duty to Mrs C and other residents to properly investigate her injuries, but it had a legal duty to be candid with Mr B about the failings in its care. We recognise the Council made greater efforts after 9 May 2016 to investigate Mrs C's care and communicate with the family. But from the first few days after his sister's admission to hospital Mr B felt he had to *"make the running"* to ensure the Council properly fulfilled its legal duties. There is evidence for this as follows:

- it was only after Mr B's intervention the Council re-opened the safeguarding investigation. That it was only at this point the Council involved the family in the safeguarding investigation;
- it was only after Mr B contacted the CQC the Council carried out its legal requirement to notify it of Mrs C's fall and injuries; and
- it was only after Mr B contacted the CQC the Council completed a RIDDOR notification having confirmed it needed to. This was despite the requirement being set out in its falls risk policy.

96. The above suggests the Council still did not react appropriately to news of Mrs C's injuries and death. This view is reinforced by consideration of the safeguarding investigation which concluded in July 2016. This acknowledged some deficiencies in care. But it failed to consider the following:

- the reasons why staff at the care home had not been aware of the Council's own falls prevention procedure or failed to complete basic assessments;
- if completing falls risk assessments may have helped reduce the risk to Mrs C's health and safety;
- flaws in the care home's management of Mrs C's nutrition;
- potential implications for other users of the service; and
- the failure to send the CQC prompt notification of Mrs C's fall in line with Regulation 18 of the fundamental standards (see paragraph 11).

97. The safeguarding investigation which concluded in July 2016 therefore remained inadequate. This was fault. In addition, the Council then failed to tell Mr B the outcome of the safeguarding investigation, which was further fault. Mr B comments that throughout it was never explained to him the purpose of safeguarding investigations or how the Council carried these out.

98. It was only because of Mr B's persistence in complaining and further enquiries from the CQC, the Council undertook further investigation into Mrs C's care. This was despite also receiving an anonymous letter which referred to Mrs C's case in August 2016. We note the Council did not use that opportunity to consider any wider implications for care at the home. It strongly appears from the records that not all officers who knew of the letter were told relevant information about Mrs C's case. We have not seen any evidence the Council shared with relevant officers:

- details of Mr B's complaint made about the circumstances surrounding Mrs C's death;
- details of the safeguarding investigation it had carried out into Mrs C's care following her death and its findings;

- that Mr B's complaint had also extended to concerns about Mrs C's weight loss and so had relevance to the concerns about food and hydration management raised in the letter; and
- any investigation it undertook into the letter writer's suggestion that staff at the care home had informed a named individual about 'problems' with Mrs C's care. There is no evidence to suggest any enquiries were made into this.

99. It was only later the Council undertook its 'learning review' and completed the 'Regulation 20 - duty of candour' response that acknowledged some of the wider failings in its practices. This included its failings around its risk management of Mrs C's falls, management of her nutrition, communications with her family and its safeguarding and reporting procedures. It also clearly reflected on how it could improve staff training for users of its service with more advanced dementia.

100. We are satisfied therefore that from late 2016 onward the Council began to take steps to improve the quality of care in this care home and apply good practice more widely across its care homes. We are satisfied the Council has learnt appropriate lessons around management of care for individual users of its services. For example, in making sure it follows its own falls risk procedures. It has shown it now has a comprehensive system of audits and quality monitoring in place. It can demonstrate satisfactory reviews by the CQC and Healthwatch.

101. But we have published this report as it is also important the Council learns lessons around openness and transparency when mistakes happen in its care services. The Council must also ensure it has a robust safeguarding culture and meets the legal requirement for candour if things go wrong. Its failures in this case caused injustice for Mr B. He was caused unnecessary distress and put to unnecessary time and trouble in ensuring there was a proper investigation into the care given to his sister and explanation for what went wrong.

Agreed action

102. 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)***

103. In addition to the requirement set out above, to remedy the injustice caused by this complaint the Council agrees that within three months of the date of this report it will:

- give a further unreserved apology to Mr B accepting the findings of this investigation. It has said it will meet in person with Mr B to deliver this;
- make a payment of £1,000 to a registered charity of Mr B's choice. We have taken account of Mr B's wishes here as he complained to make sure there is no repeat of the events covered by this complaint and did not wish any financial remedy be paid to him;
- offer to pay for a memorial for Mrs C such as a park bench or tree planted in her memory, subject to agreement with Mr B about matters such as his preferences and location.
- undertake a further review to see what further lessons might be learned from this complaint. This should cover:

- how the Council can make sure there is an audit trail of assessments which are left partially completed and then completed later to show what changes are made between versions;
- whether it can improve record keeping for staff in its care homes using both electronic and paper records to ensure that records are not missed. We note the unhelpful practice of some daily care logs being completed electronically and some by hand in this case;
- its current capture of information when GPs visit its care homes. It should audit to check these are clear in understanding why GPs have visited and to record advice given;
- a review of safeguarding procedures to consider whether they currently contain enough information to managers on what cases meet the threshold for beginning safeguarding enquiries;
- a review of safeguarding procedures to ensure that managers who are asked to complete enquiries are clear about the form in which these should be made and presented;
- a review of safeguarding procedures to make sure they take account of the views of families and what standards are expected with regard to communications with families either during or on completion of an investigation. This includes providing explanations to families on what safeguarding procedures entail and how they work;
- a review of how the Council undertakes restructuring of services to avoid gaps in care provision. The Council should reflect on how it can deliver restructuring projects without adversely affecting users of services and react when it identifies problems. For example, at the point it becomes clear that recruitment targets will not be met. Or when it receives reports from front-line services that key statutory services are not being carried out. It should consider what extra scrutiny it can give to the delivery of restructuring to avoid such gaps as occurred here; and
- any recommendations arising from the independent expert report commissioned to review the management of The Grange referred to at paragraph 71 above.

104. The Council should present the outcome of the review (see paragraph 103) above to a relevant committee of elected members within two months of completion (i.e. within five months of the date of this report) and provide us with a copy of the minute of that meeting.

Final decision

105. For reasons explained above we uphold this complaint finding fault by the Council causing injustice.