SPSO decision report

Case: **202106553, Fife Health and Social Care Partnership**
Sector: Health and Social Care
Subject: Adult support and protection / adults with incapacity
Decision: not upheld, no recommendations

Summary

C complained about the care and treatment a close family member (A) received from the partnership. C complained that the partnership failed to ease restrictions to family visits in line with changes to national public health guidance and had unreasonably applied restrictions on indoor visiting at A's group home. Consequently, A had effectively remained in their home for the best part of a year without in-person family contact or social interactions, causing A's mental and physical wellbeing to decline significantly. C also complained that during restrictions the partnership failed to take reasonable steps to help A communicate effectively with family members, investigate concerns C had raised about A's welfare, or keep them updated regarding A's care and treatment, including decisions as to whether A should shield.

In response, the partnership explained that group home settings were not adequately provided for in the government's guidance but had sought advice to follow care home guidance. They acknowledged that in light of the competing and often conflicting guidance it may have been helpful to have sought clarity on the most appropriate guidance to use at an earlier stage in the pandemic but disagreed with C's assertions that their approach to indoor visiting had been overly restrictive or detrimental to A's health.

We took independent advice from a social worker. We found that relevant national and local guidance at that time had been constantly subject to change, making the situation extremely challenging. While there was no specific guidance for group homes, it had been reasonable for the partnership to follow guidance applicable to care homes and it had been at their own discretion to assess whether indoor visits could be reintroduced safely at A's group home. We did not find any evidence to support the view that visiting arrangements imposed by the partnership had been unreasonable or overly restrictive. Therefore, we did not uphold this part of C's complaint.

We also found that the partnership had made reasonable attempts to provide support to A to maintain communication with their family during restrictions. We also found that C's concerns regarding A's welfare had been taken seriously by the partnership, and in accordance with relevant adult support and protection practices and procedures. We did not uphold these parts of C's complaints.

We found there was evidence of ongoing communication between C and the partnership throughout the pandemic regarding A's wellbeing. However we identified that C, in their capacity as welfare guardian, had not always been included in discussions about A's forthcoming medical appointments. We found no evidence to suggest this failing was in any way harmful to A and it had been reasonable for the partnership to adhere to advice they had received from A's GP that A should shield. On balance, we did not uphold this part of C's complaint, however we did provide feedback to the partnership, specifically that it is considered good practice in residential care setting, that welfare guardians are informed on matters involving medical appointments.