Scottish Parliament Region: North East Scotland

Case 200600745: The Scottish Commission for the Regulation of Care

Summary of Investigation

Category

Scottish Executive and devolved administration: The Scottish Commission for the Regulation of Care; Complaints handling

Overview

The complainant (Mrs C) complained that, during the review of their investigation into her complaint against a care home (the Care Home), The Scottish Commission for the Regulation of Care (the Care Commission) failed to take into account all relevant evidence and they used witness statements out of context.

Specific complaints and conclusions

The complaints which have been investigated are that, within their review process, the Care Commission:

(a) did not consider documentary evidence provided by Mrs C *(not upheld)*; and

(b) did not refer to one of the witness's statements and used the remaining witnesses' statements out of context *(not upheld)*.

Redress and recommendations

While the specific complaints brought by Mrs C are not upheld, the Ombudsman recommends that the Care Commission offer Mrs C an apology for their failure to confirm, during both their initial investigation and the review, that the documentary evidence, which she provided, had indeed been considered.

The Care Commission have accepted the recommendation and will act on it accordingly.

Main Investigation Report

Introduction

1. On 24 July 2006, the Ombudsman received a complaint from a woman (referred to in this report as Mrs C), regarding The Scottish Commission for the Regulation of Care (the Care Commission)'s handling of her complaint against a care home (the Care Home). Mrs C expressed her dissatisfaction with their failure to take into account all relevant evidence.

2. The complaint which has been investigated is that within their review process, the Care Commission:

(a) did not consider documentary evidence provided by Mrs C; and

(b) did not refer to one of the witness's statements and used the remaining witnesses' statements out of context.

3. Mrs C reiterated concerns regarding the Care Commission's original investigation into her complaint, however, the consideration of these concerns was the function of the Care Commission's review process and is outwith the scope of this investigation.

Investigation

4. The investigation of this complaint involved obtaining and reading the correspondence between Mrs C and the Care Commission. In addition, I also considered the Care Commission's complaints procedure, the Care Home's Daily Report sheets and Accident Report forms as well as the investigation report of 6 June 2006, written by the Care Commission's Professional Adviser, Palliative Care (Officer 5).

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Care Commission were given an opportunity to comment on a draft of this report.

Background

6. Mrs C telephoned the Care Commission on 24 January 2006 and advised that her father (Mr C) had been admitted to the Care Home on 18 February 2005 for three weeks' respite care. She advised that he suffered from vascular dementia and that, upon admission, he had blood in his urine and a hernia. She was assured that the staff at the Care Home would attend to him, however, she stated that he required a wheelchair when he was discharged,

despite having been able to walk upon admission. She also said that Mr C was badly bruised, although she did concede that he had been unsteady on his feet.

7. Mrs C also advised that, during Mr C's stay in the Care Home, his family requested that a general practitioner (GP) attend him and they were advised that he would have to consult his own GP. As his own GP was outwith the area of the Care Home, Mr C's son had to collect a urine sample from Mr C and take it to the GP.

8. At the end of the respite admission, Mrs C stated that staff at the Care Home had wanted to send Mr C home. When the family expressed their concern that he was too ill for this, they were advised that they would need to provide 24 hour nursing care for him until he was admitted to hospital. This was not required in the end, as Mr C was discharged to hospital on 11 March 2005.

9. Mrs C expressed her belief that Mr C was treated 'very callously' and that 'the staff were appalling'. An invoice for Mr C's care was received on 24 June 2005 but Mrs C did not wish to make any payment until the Care Home admitted failures in Mr C's care.

10. A member of staff from the Care Commission telephoned Mrs C (undated) to clarify the details of her complaint. She communicated her concerns regarding Mr C's physical health care needs not being adequately met, reiterating details of his inability to walk upon discharge, the lack of access to a GP, the level of bruising, the advised need to employ a 24 hour carer after the respite period and the attitude of staff. With regards to the latter and Mrs C's view that staff acted 'callously', she advised that they had referred to Mr C as a 'nuisance'.

11. A response was issued to Mrs C, on 22 March 2006, by a Care Commission Team Manager (Officer 1), advising the method of investigation and concluding that the overall complaint had been 'partially upheld'.

12. The response firstly dealt with the alleged attitude of the staff and their description of Mr C as a 'nuisance' and stated the following:

> 'All care staff interviewed expressed surprise that this allegation had been made and spoke of [Mr C] in positive terms. Due to the difference in views regarding this allegation there was no evidence to uphold this part of the complaint.'

13. With regards to the advised need for the family to employ a 24 hour carer after the period of respite, this aspect was 'not upheld' and Officer 1 stated:

> 'The Director of Care and the Home Manager both stated that this had been looked at, as one of a few options, to allow for a continuation of [Mr C's] care at [the Care Home]. This had been raised as a possibility at the Social Work review meeting held at [the Care Home] on 10 March 2005 when, it is minuted, that all parties were in agreement that [Mr C] was inappropriately placed in [the Care Home].'

14. Moving on to Mr C's wheelchair requirement upon discharge, despite his ability to walk when admitted, part of the complaint was partially upheld. The response stated:

> 'The pre-admission assessment completed at [Mr C's] home on the day prior to his admission to [the Care Home], stated that [Mr C] required assistance with mobility and had a wheelchair at home for his aid. It is documented throughout the progress noted [sic] that the staff recognised that there was a deterioration in his mobility during his stay at [the Care Home]. This was attributed, in part, to his increased level of disorientation and subsequent agitation and poor sleep pattern. It is documented that [Mr C] required constant supervision for his own safety. Staff confirmed that this had been the practice during [Mr C's] stay. This part of the complaint is being partially upheld as no care plan on mobility had been developed following [Mr C's] admission to highlight his specific needs.'

15. The complaint aspect relating to the failure to provide access to a GP was also 'partially upheld' and Officer 1 stated the following:

> 'The Care Home had no written procedure relating to access to medical support during respite admissions. A protocol had not been established between the local General Practitioners and the Care Home for those residents who normally resided outwith the catchment area of the local GP practise [sic]. However, [Mr C's] own GP was accessed to assess his physical health care needs and on one occasion the Home facilitated a visit by [Mr C] to his own GP. On one occasion [Mr C's] son was asked to take a specimen of urine to his GP and staff reported that this appears to have been done willingly. There was no evidence of the family raising concerns at the time of this incident.
>
> The Care Home staff made a referral to the Community Psychiatric

Nursing service to allow an assessment of future care needs to be carried out.'

16. Finally, in relation to the observed bruising, this aspect was 'not upheld' and Officer 1 stated:

'It was noted in the progress notes and appropriate accident reports that [Mr C] had six falls, all at night, during his stay in [the Care Home]. [Mr C] appears to have fallen out of bed on four of these occasions. [Mr C] had been assessed for the use of bed rails. However, it was felt that this would increase the possibility of further injury to [Mr C]. It is documented that frequent checks were made to [Mr C] over night as a result of his poor sleep pattern and increased confusion. All accidents and injuries were appropriately recorded and assessed.'

17. The response concluded by recording a requirement to develop an individual personal plan for all residents, including those admitted for a period of respite care. The advised purpose of this plan was to:

'… outline the assessed care needs, how they are to be addressed and the evaluation of all care given …'.

A recommendation was also noted to give consideration to the development of written information, including healthcare arrangements, for residents admitted to the Care Home for a period of respite care.

18. On 10 April 2006, Mrs C wrote to the Care Commission's Comments and Complaints Co-ordinator (Officer 2) requesting a review on the grounds of evidence, provided by her, not being fully investigated. She advised that she had provided documentary evidence and that she had spoken with the investigating officer (Officer 3), advising of witnesses who could be called upon. The documentary evidence was in the form of copies of the hospital admission notes and a letter from the family GP. Mrs C stated that this evidence had been disregarded and that the advised witnesses had not been interviewed.

19. Officer 2 replied to Mrs C on 11 April 2006 to advise that he had passed the review request to the Care Commission's Director of Adult Services Regulation (Officer 4) for consideration.

20. The review was completed by Officer 5 and her report, to which I have referred in paragraphs 21, 22 and 28 to 39, was sent to Officer 2 on

6 June 2006. The content of this report was, in turn, communicated to Mrs C, by Officer 4, in a letter dated 7 June 2006.

(a) The Care Commission did not consider documentary evidence provided by Mrs C

21. Officer 5's report outlined the evidence she considered in carrying out the review and this included 'Evidence sent by [Mrs C]'.

22. The report also stated the following:

'The evidence gathered from an interview with [Officer 3] … concluded that 2 items of evidence supplied by [Mrs C] were taken into consideration … whilst investigating the original complaint.

The two items that had been taken into consideration were the copy of the Admission Notes from [the Hospital] and the copy of the General Practitioner letter.

1st Item of evidence, Admission notes to [the Hospital].

[Officer 3] could recall the admission and progress notes from [the Hospital] sent to her by [Mrs C] where [Mrs C] –

- had highlighted her areas of concern
- [the Hospital] notes stated that the bruising was extensive and an x ray was taken which concluded that there were no fractures sustained by [Mr C]
- [Mr C] had a fall whilst in [the Hospital] after his admission …
- [Mr C] at one point had to be restrained with a lap strap.
- The fall after the admission may in [Officer 3's] opinion have also caused further bruising which was taken into consideration by [Officer 3] … during the original complaint investigation.

2nd Item of evidence, Copy of General Practitioner Letter.

[Officer 3] could recall the GP Letter which confirmed that [Mr C's] own GP was asked to visit but did not as this was outwith his area. [Officer 3] did say that during the course of the complaint investigation she did ascertain that [Mr C] was seen by a GP on one occasion and transport in the form of a minibus had been arranged by [the Care Home] to take [Mr C] to his own GP …'.

23. Although Officer 5 satisfied herself that the documentary evidence, provided by Mrs C, was considered during the initial investigation, Officer 1's letter of 22 March 2006 made no reference to the consideration of this documentary evidence. In addition, Officer 4's letter of 7 June 2006 stated that the review had included 'Examination of correspondence related to [Mrs C's] request for a review of the complaint investigation', but, again, did not make any specific reference to the documentary evidence in question. Officer 4's letter communicated the findings in relation to the witness statements but failed to communicate Officer 5's finding in relation to the documentary evidence.

(a) Conclusion

24. I am satisfied that the review considered whether the documentary evidence, ie the hospital admission notes and GP letter, had been taken into account during the initial investigation and I am satisfied with the conclusion reached in this regard. However, I have concerns regarding the communication of the findings, as neither the investigation nor the review conveyed details, to Mrs C, regarding the inclusion of the documentary evidence in their considerations.

25. This is particularly concerning in relation to the review, as this was part of Mrs C's grounds for requesting it. The review failed to identify that the investigation outcome did not communicate the consideration of the documentary evidence and failed to offer an apology in relation to this. In addition, whilst the review report, completed by Officer 5, concluded that the evidence was indeed considered, this finding was not communicated to Mrs C in the final response of 7 June 2006.

26. Notwithstanding the communication failure, I am satisfied that the review outcome was correct and that the decision not to alter the original findings was appropriate. I, therefore, do not uphold this complaint.

(a) Recommendation

27. Although I do not uphold the specific complaints brought by Mrs C, the Ombudsman recommends that the Care Commission offer her an apology for their failure to confirm, during both their initial investigation and the review, that the documentary evidence, which she provided, had indeed been considered.

(b) The Care Commission did not refer to one of the witness's statements and they used the remaining witnesses' statements out of context

28. Officer 5 contacted Mrs C on 11 May 2006 and was given the details of two witnesses who were not interviewed during the initial investigation. On 24 May 2006, Mrs C called Officer 5 with details of a third witness and in a return telephone conversation between the same parties, on 26 May 2006, details of a fourth witness were provided.

29. Officer 5's review report concluded that evidence supplied to the Care Commission by Mrs C was not fully investigated as details of witnesses were not taken into account during the original complaint investigation. Although it was noted that Officer 1 had sent an email to Officer 3 asking that she find out details of the said witnesses, Officer 3 confirmed that she had not contacted Mrs C to request this information.

30. Officer 5 subsequently contacted all four witnesses (Witnesses 1, 2, 3 and 4) by telephone and carried out interviews. Whilst the review was not a reinvestigation of the complaint, the objective of those interviews was to identify whether the resultant information would have had any significant impact on the original decision, had it been ascertained by Officer 3 in the first instance.

31. With regards to the allegations that staff had spoken to Mr C in a 'callous fashion', Officer 5 established that Witness 2 and Witness 4 had had no contact with Mr C whilst he was in the Care Home and, therefore, could not have witnessed any staff behaviour. Witness 1 and Witness 3 both stated that the staff had been 'very nice' and they did not confirm having witnessed any negative staff behaviour. The original decision not to uphold this aspect of the complaint, therefore, remained as the witnesses could add no further substantive evidence.

32. In respect of the Care Home's request that the family employ a 24 hour carer at the end of the period of respite, Witness 2 and Witness 4 again had nothing to add as they had no contact with the Care Home. Witness 1 and Witness 3 confirmed that they were not witness to any such request and the decision, therefore, remained as 'not upheld'.

33. The decision to partially uphold the issue relating to Mr C's mobility and his wheelchair requirement also remained unchanged. Witness 2 advised Officer 5

that Mr C's health, in his opinion, had been deteriorating prior to his admission to the Care Home and he was both mentally and physically very frail. He advised that Mr C had been having falls downstairs at home prior to admission, although he did observe that his condition had 'nose dived' after the period of respite care.

34. During the interviews, Witness 3 also confirmed the deterioration in Mr C's condition during the respite period and Witness 1 confirmed that Mr C had required a wheelchair when he was discharged, having walked in upon admission. Witness 4 referred to the possibility that Mr C had suffered a cerebral vascular accident (stroke) prior to his admission to the Care Home.

35. Officer 5 observed that the witnesses' statements and the documentation at the Care Home did indeed indicate that deterioration in Mr C's condition was evident during his period of respite care. However, the report concluded that it was very difficult to attribute this directly to the care given in the Care Home.

36. In relation to GP access, this aspect also remained 'partially upheld'. Witness 1 stated that she had witnessed bruising on Mr C's back during the third week of his stay in the Care Home. She advised that, when a doctor was requested, the staff informed the family that Mr C had been having falls and that a doctor would not be necessary as he was going to the Hospital.

37. Officer 5 telephoned the GP surgery and confirmed that Mr C had access to a GP on 3 March 2005 when it was thought there may have been a urinary tract infection.

38. Finally, with regards to Mr C's bruising, Witness 2 advised that Mr C had been falling downstairs prior to his admission to the Care Home (see paragraph 33). However, it was noted that the pre-admission nursing assessment did not record any bruising on his skin and pressure areas were noted as being healthy.

39. As stated in paragraph 36, Witness 1 confirmed that she observed Mr C's bruising and the staff had informed the family about his falls. Witness 3 also confirmed that she noticed the bruising and she advised that Mr C was unsteady on his feet. As the relevant accident and falls were recorded on the accident report forms and assessed, the review concluded that this aspect of the complaint remained 'not upheld'.

40. Officer 5's findings were communicated to Mrs C, by Officer 4, in a letter dated 7 June 2006. She confirmed that the original findings remained unchanged, however, she offered an apology for any distress caused by the failure to contact the witnesses during the initial investigation.

(b) Conclusion

41. I am satisfied that the Care Commission's review process took appropriate action in addressing the original investigation's failure to obtain witness statements. They rectified this omission by interviewing the relevant witnesses and reviewing the original decisions reached, on each complaint aspect, against any new information obtained. They also offered an appropriate apology for the failure of the original investigation.

42. The accounts of all witnesses appear to have been considered during the review process and I can find nothing to indicate that any statements were used out of context. I, therefore, do not uphold this complaint.

43. The Care Commission have accepted the recommendation and will act on it accordingly.

22 August 2007

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
Mr C	Complainant's father
The Care Commission	The Scottish Commission for the Regulation of Care
The Care Home	The Care Home to which Mr C was admitted for respite care
GP	General Practitioner
Officer 1	Care Commission Team Manager
Officer 2	Care Commission Comments and Complaints Co-ordinator
Officer 3	Care Commission Officer
Officer 4	Care Commission Director of Adult Services Regulation
Officer 5	Care Commission Professional Adviser, Palliative Care
Witness 1	Mr C's carer
Witness 2	Friend of Mr C's family
Witness 3	Friend of Mr C's family
Witness 4	Mr C's psychiatrist

Annex 2

List of legislation and policies considered

The Regulation of Care (Scotland) Act 2001

The Care Commission's complaints procedure