The investigation of a complaint by Ms A against Aneurin Bevan Local Health Board and the Care and Social Services Inspectorate for Wales

A report by the Public Services Ombudsman for Wales

Case: 201100737 / 201103665

Contents

Introduction

This report is issued under section 16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act ("the Act"), the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Ms A, her mother as Mrs X and the care home as Blue House Care Home**.**

Summary

Ms A complained to me about the treatment and care provided to her mother, Mrs X, whilst she was a resident at “Blue House Care Home”. The Care Home had been contracted by Aneurin Bevan Local Health Board (“the LHB”) to provide Mrs X’s care on its behalf.

Ms A also complained about CSSIW’s actions following the investigation of her complaint. In particular its failure to undertake any enforcement action against the Care Home, and its reference to Ms A’s complaint as “resolved” in its annual inspection report, a comment Ms A felt was misleading.

Having reviewed all of the information available I found that Mrs X, a patient of the LHB, expected to be provided with a package of NHS care that met all of her needs in a manner that would promote wellbeing, independence, autonomy and self-worth. However the evidence available to me suggested that the care provided by the Care Home on behalf of the LHB failed to meet that expectation.

The LHB contracted with the Care Home that it would undertake a form of contract monitoring, which resulted in a reported annual inspection. In my view the monitoring undertaken at the Care Home was ineffective, and the provisions within the contract relating to complaints handling failed to meet the requirements of the NHS Guide to Handling Complaints in Wales 2003. Ms A’s complaint about the LHB was upheld.

With respect to Ms A’s complaints about CSSIW, I found that the investigation process had been so narrow that serious failings had not been identified. I also found that the CSSIW compliance process was not robust enough in this case to ensure that service user’s basic needs were being adequately met. Furthermore, despite CSSIW recognising that at the time of the investigation and publication of the investigation report, Ms A had not been satisfied with the findings and

intended to pursue the matter further, it used the term “resolved” when describing her complaint, this was disingenuous. I partly upheld this part of the Complaint.

The Ombudsman recommended that the LHB and CSSIW pay Ms A £500 and £250 respectively as an acknowledgement of the service failure identified in this report. He also made a number of systemic recommendations including a review of policies and procedures for contracted out care.

The complaint

1. Ms A complained to me about the treatment and care provided to her mother, Mrs X, whilst she was a resident at "Blue House Care Home" ("the Care Home"), a care home with nursing which specialised in the care of elderly patients with Dementia[1]. The Care Home had been contracted by Aneurin Bevan Local Health Board ("the LHB") to provide Mrs X's care on its behalf. Ms A was concerned that the care Mrs X received did not reflect what was written in her care plan. Ms A was also concerned that Mrs X's care plan failed to reflect any of the end of life care planning decisions that had been made. Furthermore, Ms A was concerned that despite deterioration in Mrs X's condition on 10 January 2010 there was a failure to notify her of any concerns or seek medical attention in a timely manner.

2. Ms A also complained about the regulatory body, the Care and Social Services Inspectorate for Wales ("CSSIW")[2]. Ms A was concerned that CSSIW had failed to undertake any enforcement action against the Care Home following its investigation into her concerns. Ms A also complained that CSSIW had referred to her complaint as "resolved" in its annual inspection report. Ms A felt that this comment was misleading because in her view her complaint had not been resolved at that point.

Investigation

3. Comments and copies of relevant documents were obtained from the LHB and CSSIW and were considered in conjunction with the evidence provided by Ms A. The Care Home however failed to provide any of the information that had been requested in relation to this matter, stating that they had provided all of the documentation to

[1] This is a term to describe the symptoms that occur when the brain is affected by specific diseases and conditions such as Alzheimer's Disease. Symptoms can include memory loss, confusion and problems with speech and understanding.

[2] A regulatory body acts in the public interest regulating professional activity or individual professionals. A regulator's powers are usually derived from legislation, and the services it reviews are usually checked against published standards, policies, guidance and regulations.

the LHB (whilst I was able to require the Care Home to comply with this request, on this occasion I judged that it would be unlikely that formal action would have secured any additional information. However, under other circumstances I would consider exercising my power under the Act). It also declined the invitation to respond to Ms A's complaint. I also took advice from one of my professional advisers. The Adviser is a senior nurse with many years nursing experience working in both acute and primary care settings. The Adviser has particular expertise in the care of older people and currently works as a nurse specialist in an older person's outreach and support team.

4. The relevant legislation, policy and guidance considered to be relevant to the complaint has been fully considered.

5. Ms A, the Care Home, the LHB and CSSIW were given the opportunity to see and comment on a draft of this report before the final version was issued.

6. Whilst the report does not refer to each and every detail or document considered, I am satisfied that nothing of significance has been overlooked during this investigation.

The background events

7. Mrs X was diagnosed with Vascular Dementia, which had resulted in cognitive impairment. She also had a history of Cerebrovascular Accident's ("CVA")[3] and Type 2 Diabetes which was diet controlled. Mrs X's needs were such that in 2009 she was assessed as being eligible for NHS continuing healthcare, and the LHB contracted the provision of Mrs X's care to the Care Home. This meant that the Care Home was responsible for providing Mrs X with her daily care in accordance with her care plan, the Monmouthshire Local Health Board Overarching Contract for the provision of

[3] This is also known as a Stroke. This occurs when the blood supply to the brain is disturbed in some way causing damage to some of the brain cells through the starvation of oxygen.

Continuing NHS Healthcare[4] ("the Contract"), The Contract's Statement of Aims[5] and Individual Service Specification[6]. However, the LHB, as the contractor, was ultimately responsible for the health care that was delivered on its behalf, making its duty of care and responsibility to Mrs X the same as any other of its patients such as those admitted to one of its acute hospitals. This responsibility also extended to the consideration of any complaints made about her care and treatment in line with the NHS complaints procedure. The LHB assured itself that the Care Home was meeting its contractual obligations to those LHB funded residents through annual contract monitoring inspections. Since 2008 reports following these inspections have been issued in several different formats which makes any meaningful comparison of the Care Home's service and facilities very difficult.

8. CSSIW, in its role of regulator, also had a responsibility to monitor the Care Home. This was met through its annual inspection process.

9. In April 2009 Mrs X was admitted into the Care Home and a care plan was produced stating that her health and welfare needs should be regularly monitored. I have only been provided with a copy of sleep monitoring forms completed between 26 May 2009 and 17 June 2009. These forms do not cover the whole period. This was the only evidence that I have been given of any monitoring undertaken at the Care Home. The plan also stated that Mrs X should be bathed twice a week, yet the Care Home's records show that Mrs X had 11 baths, one of which was a bed bath, in the nine months that she was at the Care Home. The care plan also stated

[4] This contract between the LHB and the Nursing Home was signed on 1 April 2008 and relates to the provision of continuing NHC health care for complex healthcare patients at the Nursing Home. The clauses include the obligations of the parties, termination of the contract and complaints procedures.
[5] This is Schedule A of the Contract and relates to funding.
[6] This is Schedule B to the Contract and relates to the values and care the resident should expect to receive.

that Mrs X was a vegetarian who did not eat pasta, fish and curry, yet Mrs X's weekly diet sheets often referred to meat, spaghetti and curry and only on one occasion is there a reference to the vegetarian alternative. There was also no record of Mrs X's end of life care wishes documented in the care plan or in Mrs X's Care Home record. Ms A informed the Care Home Manager that Mrs X wanted to remain at the Care Home in the event that she suffered a further stroke.

10. Mrs X was also risk assessed during her admission to the Care Home. However, despite the deterioration in her health, there was little evidence of any amendment to those risk assessments. Mrs X was to be moved using a hoist and a wheelchair, yet there was only one reference in her records to the use of a hoist to move Mrs X. There were however three entries in September and October 2009 referring to Mrs X "weight bearing well". Ms A said that when she had raised concerns about the way Mrs X had been moved with the Care Home Manager, he had stated that Mrs X's care plan had changed. No evidence has been provided to support the existence of an amended care plan.

11. Mrs X was also at risk of pressure sores, and required a special chair and cushion to reduce that risk. Ms A said that she had to buy Mrs X the chair and cushion she needed because the Care Home did not have the equipment available to meet Mrs X's needs.

12. Whilst living at the Care Home, Mrs X sustained a number of injuries. There was no evidence of additional risk assessments or lessons learned as a result of these injuries. Furthermore, there was no evidence that information about these injuries was communicated to Ms A.

13. Mrs X also had several periods of illness whilst at the Care Home which included a period in November 2009 when she had three strokes or mini strokes. Despite references in the Care Home's record to subsequent problems with Mrs X's speech and swallowing

after these incidents, Ms A said that she had had to request Mrs X be referred for a speech and language therapy ("SALT") assessment[7].

14. On 12 December 2009 Mrs X wrote to the Care Home outlining some of her concerns about Mrs X's care.

15. On 6,7,8 and 9 January 2010 the Care Home's record shows that Mrs X was "sounding chesty". On 9 January 2010 it was also recorded that Mrs X's left hand appeared "more swollen".

16. On 10 January 2010 the record's show that Mrs X was short of breath, had swollen feet, and when asked how she was feeling, had complained about her chest. Observations were made of Mrs X's pulse, temperature and respiration and it was decided that she would be monitored regularly with a referral to the G.P. the following morning should she remain short of breath. Mrs X was put to bed early with a recommendation that she be checked every half an hour. However, there is only one further record of Mrs X's full observations being taken prior to her referral to the out of hours GP ("OOH GP") service in the early hours of the following morning.

17. On 11 January 2010 Mrs X's condition deteriorated and the Night Staff Nurse called the OOH GP service. The OOH GP referred Mrs X to hospital without an examination. Ms A was informed of the Doctor's recommendation. Ms A said that she outlined Mrs X's end of life care plan to the Night Staff Nurse and the OOH GP, but there was no documentation available to support her wish that Mrs X remain at the Care Home and not be transferred to hospital. Furthermore, the Night Staff Nurse explained that acting against GP advice might be construed as withholding treatment and could result in insurance liability issues for the Care Home. Ms A accepted Mrs X's admission to the Hospital, because in her view she had no choice.

[7] This is the assessment of the communication, eating and swallowing problems in patients with either neurological impairments or a degenerative condition such as a stroke.

18. Whilst in hospital, Mrs X was seen by two doctors and a consultant. It was agreed that given Mrs X's condition, no further tests would be undertaken, and that she would be allowed to return home for conservative treatment and tender loving care either with or without subcutaneous[8] fluids. The Care Home Manager agreed to Mrs X's return home and requested that she be discharged with the venflon[9] in situ and a supply of intravenous[10] ("IV") fluids. The Care Home Manager subsequently contacted the Hospital stating that Mrs X could not return home because the District Nurse had not been trained to administer IV or subcutaneous therapy.

19. Mrs X died at 2:05pm on 12 January 2010. The cause of death was recorded as Cerebrovascular Event, Cerebrovascular Disease, end stage Dementia and Ischaemic Heart Disease. Ms A described the circumstances surrounding Mrs X's final days as "deplorable", "unforgivable" and a "complete circus". Ms A said that the confusion and the uncertainty of whether Mrs X could be returned to the Care Home for palliative care resulted in her missing out on spending quality time with her mother in her final hours.

Complaints to the Care Home

20. Between 22 March 2010 and 27 August 2010, Ms A wrote to the Care Home on a number of occasions expressing her concern about the care that Mrs X had received whilst a resident . She also complained about the events surrounding Mrs X's death, in particular the failure to document and adhere to her end of life care wishes. The Care Home Manager considered Ms A's complaint under the Care Home's complaint process. In his response to Ms A's initial concerns, the Care Home Manager stated that he had conducted an investigation into the complaint and found that the Night Staff Nurse had done all in his power to consult Ms A that night.

[8] The technique used to hydrate patients for whom intravenous action may be difficult or cannot tolerate sufficient oral intake. The fluid is administered via a small needle inserted into the subcutaneous tissue just under the skin.
[9] A small flexible plastic tube that is inserted through the skin into a vein.
[10] Fluids administered into the vein.

21. On 27 August 2010 the Care Home's Managing Director wrote to Ms A stating that the Care Home had responded with honesty and openness and had endeavoured to act positively and proactively to achieve the outcomes Ms A and CSSIW required, which included the implementation of the requirements in the CSSIW report.

22. Ms A said that in her view the Care Home Manager and the Care Home Managing Director had failed to adequately address her complaints and provide her with a meaningful apology.

Complaints to the LHB

23. Since 22 March 2010 Ms A has also submitted a number of similar complaints to the LHB, as well as concerns about the Care Home's inability to meet Mrs X's nursing needs. Ms A wanted the LHB to accept responsibility for the failings and explain not only why those failures occurred but why they had been allowed to continue.

24. It was noted in a letter from the LHB's Chief Executive dated 1 July 2010, that with the benefit of hindsight, Mrs X should have been allowed to stay at the Care Home to die peacefully. However given the additional factors such as the reluctance to allow her to stay where she was, the NICE clinical guidance and the absence of an advanced directive[11], it was his view that the same decision would have been made again. In a subsequent letter dated 21 October 2010 the LHB's Medical Director said that he had made further enquiries into Ms A's concerns about the Nursing Home and "recognise that we have a duty as a health board to react to any concern regarding nursing homes we contract with….". This resulted in Ms A being referred to the Deputy Divisional Lead Nurse and the Primary Care Nurse. However, it took almost four months for Ms A to be contacted by either nurse.

[11] This is a statement detailing the medical treatment a person would not want in the future should that person lack the mental capacity to make such a decision in the future.

25. On 9 February 2011 the Primary Care Nurse conducted an audit check of the Care Home's patient notes and found that information including end of life wishes had not been recorded. There was no evidence of staff being trained in particular pain management techniques such as syringe drivers. The audit also found that there were reports from carers who had identified unsafe practice to the Care Home Manager, but no action was undertaken. There were reports of very unsafe recommendations by the Care Home Manager including carers being told to use a stand aid to move a resident despite the fact she needed to be moved with a hoist as she was too frail to stand.

26. Since 3 March 2011 Ms A has been engaging with the Deputy Divisional Lead Nurse and the Primary Care Nurse, in an attempt to resolve her concerns. Furthermore, since January 2012 the LHB has conducted unannounced visits at the Care Home. On 15 March 2012 the Deputy Divisional Lead Nurse wrote to Ms A updating her on the monitoring visits that had been undertaken. In her letter she said that progress had been made at the Nursing Home with relative communication sheets being used and regularly completed, risk assessments completed and reviewed as required, the development of a new filing system and accident reporting system, and 100% completion of training of all staff, with all staff also undertaking basic food hygiene training.

27. Ms A said that in her view the LHB's response to her complaint was inadequate. Her concerns about the care Mrs X had received had not been fully addressed and despite assurances given by the Medical Director, the LHB failed to monitor the Care Home adequately. Ms A said that this was evident in October 2011 when during a discussion with the LHB she was informed that it was not aware of the content of the July 2011 CSSIW report which had documented a number of failings at the Care Home, particularly in relation to the health and welfare of the residents. Ms A added that she was disappointed that despite being aware of these concerns the

LHB did not take any additional action until January 2012. Ms A said that she was glad that work had been undertaken and improvements made at the Care Home, however that work had not answered her questions about the quality of Mrs X's care and the circumstances surrounding her death.

Complaints to CSSIW

28. Between 9 April 2010 and 29 September 2010 Ms A raised her concerns about the Care Home with CSSIW. CSSIW investigated the management of the complaints process, a failure to adhere to Mrs X's wish not to be admitted to hospital, poor communication between the Care Home and relatives and a possible failure to seek medical attention in a timely manner. The draft investigation report was issued on 15 July 2010 detailing three requirements. The first related to the content of residents' care plans including the recording of end of life care wishes. The second requirement related to adherence to the Care Home's complaint policy and the final requirement related to robust communication systems and documentation to ensure that in the event of a patient's deterioration timely intervention could be taken.

29. The Care Home's Managing Director accepted all of the recommendations made by CSSIW. He added that he had discussed Ms A's informal complaint with the Care Home Manager, and had been informed that Ms A had felt that a "satisfactory outcome had been achieved", and they had not considered it necessary to reply to Ms A's informal complaint in writing. However, in retrospect he accepted that that was "clearly a mistake". The Care Home's Managing Director also said that in his view the Night Staff Nurse had acted correctly on 11 January 2010 and that he could not understand how the Night Staff Nurse could have, or should have, prevented Mrs X's transfer to hospital, particularly as in his view it was debateable whether at the time of the transfer that Mrs X was in an "end of life" situation.

30. The CSSIW investigation report was published on 13 August 2010.

31. On 23 August 2010 the Care Home Manager submitted his response to the inspection report to CSSIW. In his response the Care Manager set out the changes which had been implemented at the home as a consequence of the complaints. I have seen that CSSIW accepted the Care Home Manager's response to the requirements, and it appears that the corrective actions to which the Care Home Manager had referred had taken place several months before the investigation.

32. On 29 September 2010 Ms A informed the CSSIW Regulation Manger that she had additional information in her possession that had not been available at the time of the CSSIW investigation and that that there were issues that remained outstanding. However, the Regulation Manger informed Ms A that the investigation was complete, the report of the findings had been issued and the Care Home had not only accepted that the events could have been handled better, it had agreed to review its policies and procedure particularly in cases where end of life issues or choices were concerned. The CSSIW Regulation Manger said that the case to revisit the matter was not evident from what Ms A had described as new information, because shortfalls had already been established along the lines she had outlined.

33. In January 2011 CSSIW published its inspection report. In its report it stated that there had been one complaint made against the Care Home and that the complaint had been "resolved".

Ms A's evidence

34. Ms A said that the Care Home Manager's omissions in his documentation and failure to adequately communicate had impaired her ability to act in Mrs X's best interests as her advocate. Ms A said that when she did act on Mrs X's behalf and complain about certain

issues such as nutrition and fluids little action was taken and certainly no immediate action.

35. Since the death of Mrs X, Ms A has raised her concerns with a large number of bodies in an attempt to seek an explanation to the circumstances surrounding Mrs X's final days. Ms A said that in her view it was ridiculous that she had to complain to all of these separate bodies in order to seek answers. She felt that the Care Home's independent status made the actions of its staff almost untouchable. Ms A said that it was only because of her strong nature that she had been able to go through the process, in her view people who were more vulnerable would not have coped with the complaints process. Ms A said that this whole process has had a detrimental effect on her physical and emotional health and without the closure she had been seeking since January 2010 she had not been able to bury her mother's ashes and move on. Ms A said that a result of the Care Home Manager's actions her mother's death had not been what either of them had wanted, and that was something that could not be undone.

36. In her response to the draft report Ms A reiterated her concerns and the frustration and disappointment she felt towards the LHB and CSSIW.

The Care Home's response to the draft report

37. The Care Home's new Managing Director ("the new Managing Director") said that since changing hands in July 2011 a concerted effort had been made to upgrade the Care Home both physically and administratively. The new Managing Director said that since Ms A made her complaint, staffing levels at the Care Home had increased and new staffing structures, care practices and comprehensive training had been implemented. Furthermore, a complete review was taking place to ensure that all aspects of the care at the Care Home could be continually monitored through a robust quality assurance system.

38. With respect to the specific care issues mentioned within this report (see paragraphs xx) the Care Home Manager said that Mrs X's care plan was reviewed every four weeks, and the care given corresponded with that plan.

39. The Care Home Manager said that the bathing routine at the Care Home was for therapeutic rather than hygiene purposes, and although it is not always recorded, all residents have one or two baths a week. The Care Home Manager said that residents who are doubly incontinent are washed when their incontinent pads are changed as well as given thorough strip washes when they get up in the morning and when they go to bed. The Care Home Manager said that in his view this was the equivalent of two baths a day.

40. With respect to the decision to refer a resident for a SALT assessment, the Care Home Manager said that whilst there was no specific policy in place, should a member of staff or relative observe a resident having difficulty swallowing the GP would be contacted. It would be for the GP to decide whether an assessment would be appropriate. The Care Home Manager said that this process was part of the caring, everyday observation and monitoring at the Care Home. With respect to Mrs X the Care Home Manager said that in his view the Care Home did not wait for Ms A's intervention before requesting a SALT assessment, rather Ms A as a qualified nurse suggested it before the Care Home's nurses did. The Care Home Manager said that the SALT assessment made little difference to the way food and drink was administered to Mrs X but allowed Ms A and staff to feel that all bases had been covered by an expert.

41. The Care Home Manager said that there had been numerous conversations between himself and Ms A regarding Mrs X's health and end of life care. He said that in his view to document all conversations would have been a mammoth task in itself. The Care Home Manager said that conversations were generally documented in the notes and passed on during shift handover. The Care Home

Manager accepted that "more documentation could have been done to ensure [Mrs X's] end of life wishes was evidenced". The Care Home Manager said that a relatives communication sheet has been implemented and that Advanced Directives were being used to ensure residents wishes were documented and respected.

42. The Care Home Manager accepted that certain aspects of the care Mrs X had received was lacking but efforts had been made to improve services.

The LHB's evidence

43. The LHB said that the CSSIW reports were available via the CSSIW website, and were considered during the pre-placement check on a new provider. The LHB also said that the most recent CSSIW report would be accessed and reviewed prior to any contract monitoring in order to ensure that there were no existing or outstanding requirements under the Care Standards Act 2000. However, we have seen no evidence of any action being undertaken by the LHB in response to these requirements.

44. The LHB said that the Care Home's obligations were monitored through the medium of contract monitoring and the Nurse Assessor's assessments and reviews. Any action points would be brought to the Care Home Manager's attention for rectification, and the Nurse Assessor would return to the Care Home within the agreed timescale to ensure the recommendations had been implemented.

45. The LHB said that it did not have any authority to approve the Care Home's policies and procedures. The Care Home was expected to have an appropriate,[12] clear and accessible complaints procedure[13] and inform the LHB of any complaints,[14] however it was the duty of CSSIW to monitor its compliance through its inspection

[12] Care Standards Act 2000 Regulation 23
[13] Clause 15 the Contract
[14] Clause 15.4 the Contract

process. The LHB said that the Care Home had implemented a complaints policy and reintroduced a complaints book which was open for inspection.

46. The LHB said that the Care Home had access to core NHS services, including doctors and district nurses as well as palliative care services that provide care in symptom control, and hydration therapy. The LHB said that during the period that Mrs X was unwell the only service the district nurse had been unable to provide was the delivery of subcutaneous and IV therapy. This matter has since been resolved as the district nursing team have been trained and is now competent to deliver these therapies.

47. The LHB said that the Care Home was fully aware of the All Wales Protection of Vulnerable Adults ("POVA") policy and procedures, and that based on the January 2012 contract monitoring 80% of staff were up to date in their POVA training. Additionally, the LHB said that most mandatory training at the Care Home had a 100% completion rate, and end of life care pathway training was also being delivered.

48. The LHB said that in addressing Ms A's more recent concerns a correctional action plan had been developed to monitor progress. The Assistant Divisional Nurse monitored the progress through monthly visits. The LHB said that the Assistant Divisional Nurse was not aware of recurring or systemic issues in the contract monitoring reports, and that timescales for compliance with recommendations may lengthen due to problems experienced by the Care Home e.g. obtaining training courses.

CSSIW's evidence

49. CSSIW said that contract monitoring reports were only available to it upon request. CSSIW said that it had information sharing protocols in place with partner agencies under the safeguarding and escalating concerns procedure, which meant that

information regarding services where concerns were identified, was shared to ensure the ongoing safety and wellbeing of service users. Therefore, any concerns arising as a result of the contract monitoring would be shared with CSSIW under these arrangements. I have seen no evidence of action being taken by the LHB or CSSIW under the safeguarding and escalating concerns procedure.

50. CSSIW said that following an investigation its procedure was to attach the summary of the investigation report to the most recent inspection report, in this case that was the March 2010 report, which was publically available on the CSSIW website. CSSIW said that the January 2011 inspection report did not include a reference to the requirements made in the investigation report because it was satisfied that the Care Home had complied with those requirements.

51. CSSIW said that requirements were enforced through the issue of compliance notices. An inspector would conduct a "follow up" in the event that a service provider had failed to respond to a notice and confirm that compliance has been achieved. Where the regulatory breaches were of a less significant nature, compliance would be confirmed at the next inspection of the service.

52. With respect to the investigation of complaints under CSSIW's new procedure, it said that public and professional concerns would be logged then either considered at the next inspection, referred to adult protection or result in a focussed inspection of the service. In the first instance CSSIW would expect the registered person to investigate the complaint.

53. CSSIW said that when it met Ms A to provide feedback following the investigation, she was understandably distressed by not only Mrs X's death, but by the circumstances surrounding it. CSSIW said that it would be difficult to say that Ms A had accepted the matter as "resolved" from her own point of view.

Professional advice

54. The Adviser said that Mrs X's initial care planning at the Care Home was of an extremely high standard reflecting her assessed needs and providing evidence of a person centred approach to her care. There was also evidence of on-going review and updating of some care plans. However, there were significant gaps in care planning particularly in response to Mrs X's episodes of diarrhoea, sleep monitoring or deteriorating condition. Significant records were also missing including food and fluid charts and sleep and behavioural charts. Furthermore, there was no record in the care plan of any end of life preferred place of care decisions, and no evidence of any advanced care planning. This was contrary to national guidance and a serious failing.

55. The Adviser said that when considered overall, the Care Home's record was not unreasonable. There were at least daily entries in the clinical records and the entries were dated and signed. There was also a generally good standard of documentation of the evaluation of care delivered. However there were no recorded actions in respect of Mrs X's injuries or periods of ill health. Also there was no evidence of any discussion with family members concerning untoward events such as the swelling on Mrs X's left hand, any change or deterioration in her condition.

56. The Adviser said that although there were daily entries in the Care Home's record indicating that Mrs X's personal hygiene needs were met, she was not bathed in accordance with her care plan. Furthermore, there was no reason for this departure documented in Mrs X's care plan.

57. The Adviser said that the initial risk assessment was appropriate and actions were planned in response to Mrs X's identified risks, with pressure sore risks being re-evaluated on a monthly basis. However falls, manual handling and nutritional risk assessments were not reviewed and updated as specified in the care

plan. These are failings. The Adviser said that whilst Mrs X's falls and manual handling risks would not have changed, her risk of malnutrition would have increased as her condition deteriorated, however the identified actions in the nutrition care plan would have addressed these increased risks.

58. The Adviser said that the nutritional risk assessment and care plan clearly indicated that Mrs X had pre-existing swallowing problems due to previous CVAs. Following a TIA in November 2009 Mrs X was noted to have drooping on the right side of her mouth and she was "pocketing food".[15] This combined with Mrs X's poor dietary intake should have prompted Care Home staff to have considered a SALT referral. The Adviser was also surprised that despite Mrs X's continued difficulties Care Home staff did not identify this problem during Mrs X's GP visit, particularly given the potential risk of aspiration.[16]

59. The Adviser said that the safe moving and handling of patients was essential to avoid not only injury to patients but also to those staff caring for them.[17] Mrs X's care plan specified that she be moved using a hoist. Therefore, it was entirely inappropriate for nursing staff to have attempted to check whether Mrs X could carry her own weight on the dates identified. Their actions put both Mrs X and themselves at risk.

60. The Adviser said that Mrs X was recorded as sounding "chesty" between 7 and 9 January 2010 yet there are no recorded physiological observations. As a result no determination could be made on whether there were any signs of acute deterioration in her condition at that stage. Mrs X appeared to have responded well to nursing staff, and diet, fluids and medication were being taken well.

[15] Food remaining in the mouth after swallowing
[16] Fluid entering the lungs rather than the stomach
[17] Welsh Assembly Government National Minimum Standards for Care Homes for Older People Revised March 2004, paragraphs 17, 18.1 and 18.2

From the evidence available it is the Adviser's opinion that there was no need to contact a doctor during that period.

61. The Adviser said that on 10 January 2010 it was noted in the Care Home's record that Mrs X did not sound "chesty"' but was complaining of her chest, and was short of breath. She also had an increased respiratory rate, a raised pulse rate and her feet were very swollen (an indication of heart failure). The Adviser said that the plan of care was to observe Mrs X and refer her to the G.P. in the morning if she remained short of breath, yet there was no indication that any physiological observations were taken and recorded after the initial observations. The Adviser said that Mrs X was showing signs of acute deterioration in her condition at that stage and a GP referral should have been made.

62. The Adviser said that at 4.00pm it was noted that Mrs X was very short of breath and very distressed, her breathing remained laboured and her feet remained swollen. The Adviser said that a G.P. referral should have been made due to Mrs X's distress and continued symptoms yet the OOH G.P. was not contacted. Instead, it was noted in the Care Home's record that Mrs X be checked every half hour, although there were no physiological observations recorded after 5.30pm. At 1.00am Mrs X was found to be unresponsive. The Adviser said that these are serious failings in the care of an acutely deteriorating patient, and would expect registered nurses to have the necessary knowledge and skills to recognise and respond to acute deterioration.

63. The Adviser said that the Care Home provided "excellent" care to Mrs X in terms of meeting her mental health needs. The documented entries provide evidence of a person centred, sensitive and dignified approach to Mrs X in response to her low mood, anxiety and concerns expressed about her future. It is apparent that when necessary Mrs X received one to one care and supervision.

64. The Adviser concluded that the way that a person dies remains in the memory of their families. An underpinning theme in this complaint is poor communication. Clearly, there were failings in advanced care planning and the documentation of the wishes of Mrs X and her family, as Mrs X was unable to be cared for in the Care Home in the last days of her life. Advanced care planning and end of life discussions including "preferred place of care options" should be clearly documented. Finally recognising and responding to acute deterioration in a patient, is a fundamental and essential aspect of nursing care and nursing staff must ensure that they have the necessary knowledge and skills to do this.

Analysis and conclusions

65. When the NHS contracts with a care home, it requires that care home to meet the needs of patients as though they were in receipt of the same services directly from the LHB. However, the day to day management of that care is undertaken by the care home under contract to the LHB. LHBs, through the provisions in their contracts and through their contract monitoring and other contact with the care home, need to ensure that the standards achieved are appropriate. Good feedback from any complaints dealt with by the home can help to alert the LHB to any causes for concern and the process for dealing with complaints needs also to be covered in the contract. I address these points in more detail below. When considering complaints about care which is contracted out by a body in my jurisdiction the Public Services Ombudsman (Wales) Act 2005 requires me to consider it as though it were directly provided, and any shortcomings identified are treated as though they were failings of the contracting body. These conclusions have been drafted accordingly.

66. The Contract states that basic human rights to dignity, privacy and informed choice must be protected at all times with account being taken of the individuals needs, abilities and wishes.

67. Mrs X was a patient of the LHB, and as such expected to be provided with a package of NHS care that met all of her needs in a manner that would promote wellbeing, independence, autonomy and self-worth. However it is clear from the evidence available to me that the care provided by the Care Home on behalf of the LHB failed to meet that expectation. In the absence of alternative evidence I must express my concern that when addressing Mrs X's nutritional (see paragraph 9), hygiene (see paragraph 9) and safety needs (see paragraph 10), her care plan was ignored and Mrs X's wellbeing and choice were disregarded. These failings had a detrimental effect on the fundamental aspects of Mrs X's care and dignity.

68. I am also concerned about the failure of the nursing staff to recognise the deterioration in Mrs X's condition both after her strokes in November 2009 (see paragraph 13) and then again in the days before her death in January 2010 (see paragraph 16). Following Mrs X's strokes in November 2009 there were clear references in the Care Home's record documenting her deterioration yet despite her being at risk of malnutrition and aspiration it was a number of weeks before she was referred for a SALT assessment. Again in the days leading to Mrs X's death there was evidence in the Care Home's record documenting the deterioration in her condition, yet despite Mrs X's complaints about her chest and the signs of acute deterioration in her condition she was denied medical attention until she was transferred to the hospital in the early hours of the following morning.

69. Through the NHS continuing healthcare assessment process, the LHB recognised that Mrs X had complex needs. By placing Mrs X at the Care Home it was understood by Mrs X and her family that those needs could be met by the LHB in this way. However this was not the case. Ms A purchased specialist equipment for Mrs X because the Care Home did not have the equipment available. Furthermore, on 12 January 2010 Mrs X was denied the chance to return to the Care Home to die in the comfort of her own bed in familiar surroundings, because the LHB did not have a district nurse

available who was appropriately trained in the administration of IV or subcutaneous therapy.

70. Mrs X said that Ms A had expressed a wish to die in her own bed with familiar surroundings and the people she cared for close by, and not be admitted to hospital. Ms A communicated this wish to the Care Home Manager. However Mrs X's end of life care wishes were not documented. This a serious failing, which resulted in the Night Staff Nurse and OOH GP not being able to take them into account when making the decision to transfer Mrs X to the hospital. Had the appropriate documentation been available Mrs X's end of life wishes could have been granted.

71. The LHB contracted with the Care Home that it would undertake a form of contract monitoring, which resulted in a reported annual inspection. In my view the monitoring undertaken at the Care Home was ineffective. The format of the reports often changed and there was little correlation between the Contract and the reports. This made meaningful comparisons difficult. Furthermore, whilst I accept that CSSIW were responsible for checking that the requirements it had made in its reports were complied with, there is little evidence in the contract monitoring reports of any regard given to the content of the CSSIW reports.

72. I am surprised that the LHB has stated that it did not have the authority to approve the Care Home's policies and procedures (see paragraph 37). In my view this is incorrect. The NHS Guide to Handling Complaints in Wales[18] states that local health boards should specify in their contracts with independent providers that they must "set up, publicise and run Local Resolution as far as possible identical to the Local resolution procedure."

[18] Paragraph 1.13 Improving Health in Wales; Complaints in the NHS, a Guide to Handling Complaints in Wales. April 2003 – applicable at the time of the events giving rise to this complaint.

73. The Contract placed an obligation on the Care Home to have a "clear and accessible" complaints process in place. I have not been provided with a copy of the relevant complaints process, however it is evident from the Care Home's response to Ms A's complaint that even if its complaints process was as far as possible identical to the NHS Local Resolution Procedure[19], it was not adhered to as it should have been. There was no evidence in the response letters of Ms A being informed of the next stage of the process or her options to take her complaint to either the Independent Complaint Secretariat or this office. Ms A's complaint could have been escalated quicker had she been made aware of these options at that stage.

74. With respect to the LHB's response to Ms A's complaint, the information provided shows that there was some attempt to respond to the complaints. I accept that Ms A was not wholly satisfied with the responses received and that these often prompted more questions. However, it is clear that the LHB did attempt to engage with Ms A and met with her on several occasions to try and resolve the complaints. Unfortunately it appears that despite this, the relationship between both parties had deteriorated and it would be unlikely that a satisfactory outcome for either party could be achieved.

75. In view of the shortcomings identified above I uphold the complaint against the LHB.

76. Ms A also complained that CSSIW had failed to undertake any enforcement action against the Care Home despite its failure to remedy the requirements outlined in its inspection report dated 13 August 2010. The Care Home Manager submitted his response to the requirements outlined in the inspection report to the CSSIW Inspector who was satisfied that they had been met and no further enforcement action would be necessary. In view of this information I do not uphold this element of Ms A's complaint.

[19] Ibid

77. I do however have some concern about the investigation and compliance process undertaken by CSSIW. During the course of the investigation the CSSIW inspector had focussed her investigation of Ms A's complaint so narrowly it resulted in her overlooking the serious failings relating to dignity, poor care and neglect identified by my Adviser. These were matters that at the time may have affected Mrs X and other residents in the Care Home and may have been appropriately considered for a POVA referral or referred as an escalated concern.

78. With respect to the CSSIW compliance process, I was surprised to see that the CSSIW Inspector had accepted the Care Home Manager's response to the requirements as satisfactory given that the work he said he had undertaken to resolve the issues was said to have been undertaken not only before the inspection, but before the complaint occurred. Given the above it is my view that the CSSIW compliance process was not robust enough in this case to ensure the service users basic needs were being adequately met and in consequence I invite CSSIW to consider how it could maintain an evidence based approach to compliance.

79. Finally, Ms A complained that the CSSIW January 2011 report had referred to her complaint as "resolved". Ms A said that the report was misleading because she had not found any resolution. Having considered the information made available to me I partly uphold this element of the complaint. The reason for this decision is that CSSIW had recognised that at the time of the investigation and publication of the investigation report, Ms A had been distressed at the findings. CSSIW also accepted that whilst its own complaint process had ended and its compliance requirements had been satisfied the matter was not concluded from Ms A's point of view (see paragraph 45). It is my opinion that given that CSSIW was aware of Ms A's feelings on the matter, it seemed somewhat disingenuous to use the term "resolved" when describing her complaint particularly when a more appropriate term reflecting Ms A's ongoing concerns could have been

used or it could have been clearer that the complaint was resolved from a regulatory point of view.

80. The complex issues outlined in this report arise in the context of an individual complaint, however they are likely to have implications across Wales. Where a Health Board commissions care from an independent provider, such as a care home it needs to satisfy itself that appropriate quality standards are in place and covered in the contract. The Health Board should ensure that provisions are included in the contracts which specify how complaints will be dealt with and these provisions must mirror the arrangements for raising and responding to complaints about the NHS in Wales ("PTR")[20]. Patients must be informed of their right to complain under PTR and I am not satisfied that this is the case at present. I am therefore concerned that Health Boards across Wales are missing opportunities to learn from the experience of patients who receive care from independent providers and therefore missing information which would be very useful in the context of contract monitoring and help to alert the LHB to any problems arising, especially where these suggested a pattern of concern. In view of these concerns I propose to meet with the Welsh Government and the Chief Executive Officers of Health Boards in Wales to ensure that contracts with independent providers are revised to include these provisions.

81. I am also mindful that as Health Boards in Wales become more reliant upon independent providers to provide care to patients with continuing health care needs there will be an impact on the roles of both CSSIW and the Healthcare Inspectorate for Wales. I am therefore proposing to meet with NHS Wales and the Regulators in order to identify the outstanding issues and the appropriate way forward.

[20] Putting Things Right - The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 which came into force on 1 April 2011.

Recommendations

82. I recommend that the LHB and CSSIW ensure that the issues raised in this report have been properly addressed by the Care Home.

83. I recommend that within one month the LHB provide Ms A with a written apology reflecting the failings identified in this report.

84. I recommend that within one month the LHB pay Ms A the sum of £500 in recognition of her time and trouble in pursuing this complaint.

85. I recommend that within one month the LHB reimburse Ms A for the specialist chair and cushion she had to purchase to meet Mrs X's planned safety needs.

86. I recommend that the LHB ensure that it has processes in place to identify poor standards of care and that any action points to be taken under contractual arrangements are properly followed up with compliance being achieved.

87. I recommend that the LHB ensure that the policies and procedures, particularly the complaints procedure, is adequate, appropriate and compliant with the requirement of "Putting Things Right".

88. I recommend that prior to placing a patient in an independent sector care home the LHB ensures that the care home can adequately meet the needs of the patient, and reviews the Care Home's capacity to meet any changing needs presented by the patient.

89. I recommend that the LHB ensure that the appropriate support systems are available to the Care Home, such as District Nurses and

Palliative Care Nurses, so that it may continue to meet the needs of its residents.

90. It is clear from the evidence that the LHB has undertaken a program of work with the Care Home in order to encourage and assist with improvements. I recommend that the LHB report ongoing process to my office for the next 12 months.

91. I recommend that within one month CSSIW provide Ms A with a written apology reflecting the failings identified in this report.

92. I recommend that within one month CSSIW pay Ms A the sum of £250 in recognition of her time and trouble in pursuing this complaint.

93. I recommend that CSSIW ensure that it has processes in place to pick up on shortcomings in standards of care and key concerns during the inspection process.

94. I recommend that CSSIW ensures that it has proper processes in place to fully satisfy itself that any requirements and compliance orders made are fully addressed by the providers of care.

95. I am pleased to note that in commenting on the draft of this report the LHB and CSSIW have agreed to implement these recommendations. CSSIW has also stated that as part of its modernisation programme it has reviewed its response to non compliance with regulations. It added that there is now a robust pathway in place to ensure that where required enforcement action is taken.

Peter Tyndall 14 December 2012
Ombudsman