Local Government & Social Care OMBUDSMAN

Report by the Local Government Ombudsman

Investigation into a complaint against Wokingham Borough Council (reference number: 14 000 933)

29 November 2016

The Ombudsman's role

For 40 years the Ombudsman has independently and impartially investigated complaints. We effectively resolve disputes about councils and other bodies in our jurisdiction by recommending redress which is proportionate, appropriate and reasonable based on all the facts of the complaint. Our service is free of charge.

Each case which comes to the Ombudsman is different and we take the individual needs and circumstances of the person complaining to us into account when we make recommendations to remedy injustice caused by fault.

We have no legal power to force councils to follow our recommendations, but they almost always do. Some of the things we might ask a council to do are:

- apologise
- pay a financial remedy
- improve its procedures so similar problems don't happen again.

Investigation into complaint number 14 000 933 against Wokingham Borough Council

Contents

Section 30 of the 1974 Local Government Act says that a report should not normally name or identify any person. The people involved in this complaint are referred to by a letter or job role.

Key to names used

Mrs A the complainant

Mrs X the complainant's mother

Report summary

Adult care services – residential care

Mrs A complains for her mother Mrs X about failings in care at a council funded residential placement, Murdoch House.

Finding

Fault found causing injustice and recommendations made.

Recommendations

To remedy the injustice caused by poor care planning and delivery, the Council should within one month of the date of this report:

- pay Mrs X £3,500 and Mrs A £500;
- ensure its future contract monitoring visits to Murdoch House include checks of:
  - nutrition care plans, food and fluid charts and weight charts;
  - falls monitoring, falls risk assessments and falls/mobility care plans; and
  - care plans for activities and records of activities on offer.

Introduction

1. Mrs A complains for her mother Mrs X about Wokingham Borough Council (the Council). The Council arranged and funded Mrs X's care in Murdoch House (the Care Home). The Care Home is currently owned and managed by Four Seasons Healthcare Ltd (the Care Provider).

2. Mrs A complains:
   - there were no activities and Mrs X was under stimulated;
   - Mrs X lost weight and became malnourished; and
   - Mrs X was not safe to walk unaided but was left with her walking frame and fell, breaking her hip.

Legal and administrative background

3. The Ombudsman investigates 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))***

4. The Ombudsman cannot investigate late complaints unless we decide there are good reasons. Late complaints are when someone takes more than 12 months to complain to the Ombudsman about something a council has done. ***(Local Government Act 1974, sections 26B and 34D)***

5. We exercised discretion to investigate Mrs A's complaint from 2010 until 2013 although some of this period is late. This is because examination of the records for the latter part of Mrs X's stay in the Care Home revealed fault and injustice.

6. The Ombudsman investigates complaints about councils and certain other bodies. Where an individual, organisation or private company provides services on behalf of a council, the Ombudsman can investigate complaints about the action of these providers. ***(Local Government Act 1974, section 25(7))***

7. The law has changed since the events of this complaint. The legislation, guidance and practices described in paragraphs 8 to 14 below were relevant then but may not apply now.

8. Once a community care assessment concludes a person needs residential or nursing home care, a council has a duty to make arrangements for such accommodation for people over 18, who by reason of age, disability, or illness or any other circumstances are in need of care and attention not otherwise available to them than by providing accommodation with care. ***(National Assistance Act 1948, section 21)***

9. If a council decides to provide or arrange care services to meet a person's needs, both should agree a written record of the care and support. Statutory guidance sets out what

the written record should include, such as a note of the eligible needs identified during assessment, agreed outcomes and how support will be organised to meet those outcomes. ***(Prioritising Need in the Context of Putting People First)***

10. Councils should review a care plan when providing community care services. Government guidance requires the frequency of review to be '*proportionate to the circumstances of the individua*l'. It is good practice for a council to carry out a review within four to six weeks after the service starts, and after that at least yearly. There should be a written record of the review to share with the service user. ***(Prioritising Need in the Context of Putting People First)***

11. A case in the High Court said when placing a person in a care home run by a third party, a council has a continuing responsibility to ensure the arrangements in the care home meet the person's needs as identified in any assessment(s). ***(R v Servite Houses and London Borough of Wandsworth ex p Goldsmith and Chatting [2000] 3 CCLR 325)***

12. National guidance, *Nutrition in Adults*, defines adults as malnourished if they have:

- a body mass index (BMI) of less than 18.5 kg/m^2;
- unintentional weight loss greater than 10% within the last 3–6 months; and
- a BMI of less than 20 kg/m^2 and unintentional weight loss greater than 5% within the last 3–6 months.

13. The Care Quality Commission ('CQC') is the independent registration body and regulator of health and adult social care services in England. CQC issued guidance in March 2010, *Essential Standards of Quality and Safety,* to help registered care providers comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ('the 2010 Regulations'). When investigating complaints about standards of care in a care or nursing home placement which a council has arranged and funded, we consider the 2010 Regulations and whether the essential standards set out in CQC guidance (the Guidance) have been met. If they have not, we consider whether any identified faults have resulted in injustice to the person affected.

14. The 2010 Regulations relevant to this complaint are:

- *Regulation 14*: A care provider should protect residents from the risks of inadequate nutrition and hydration by providing suitable food and drink in enough quantities to meet their needs. Residents should have support, where necessary, to enable them to eat and drink sufficient amounts for their needs. The Guidance explains in more detail that staff should identify and take suitable action where a person is at risk of poor nutrition or dehydration when they first come into the home or as their needs change. Staff should also record food and drink intake when residents are at risk of poor nutrition and dehydration.
- *Regulation 9:* A care provider should plan and deliver care to meet a resident's individual needs including promotion of their wellbeing. This includes stimulation and day time activity.
- *Regulation 10c*: A care provider should make changes to a resident's care plan where information identifies a risk of inappropriate or unsafe care.

- *Regulation 24*: A care provider must make suitable arrangements to protect the health, welfare and safety of service users by:
    - supporting people to obtain suitable healthcare; and
    - working together to ensure appropriate care planning where responsibility for care is transferred to others.
- *Regulation 20:* There should be an appropriate record of each person's care and treatment.

How we considered this complaint

15. This report has been produced following the examination of relevant files and documents and discussions with the complainant. The complainant, the Council and the Care Provider were given a confidential draft of this report and invited to comment. The comments received were taken into account before the report was finalised.

Investigation

Background

16. Mrs X lived in the Care Home between 2010 and December 2013 when she went into hospital and then to a different care home. Southern Cross Healthcare Ltd operated the Care Home until September 2012 when it was sold to the Care Provider. The Care Home's current manager was also in post during Southern Cross's operation. She told us Southern Cross removed computers and some documents and that no computerised records were available before September 2012. There are no Southern Cross policies or procedures available. Southern Cross is no longer registered with the CQC.

The Council's assessment of need and care plan

17. Mrs X is in her nineties and has aphasia (problems with speech after a stroke). She has arthritis and osteoporosis. The Council carried out an assessment of Mrs X's needs in April 2010, which was updated in August 2010. She came out of hospital following a stroke and went to live with Mrs A and her family with a package of care at home. Mrs A had health problems of her own and could not continue caring for her mother. Mrs X went into the Care Home in August 2010 for respite care and she later agreed to stay there permanently. The Council's care plan for Mrs X dated August 2010 said she needed:

- supervision with mobility and transfers;
- assistance with personal care;
- assistance to take medication;
- help to have adequate food and drink; and
- encouragement to interact as she was low in mood.

The Council's records after Mrs X moved into the Care Home

18. In January 2012, Mrs A contacted the Council to say the lift had broken and Mrs X had been in her room for several days. Mrs A also said, when she visited, her mother's dirty washing was strewn all over her bathroom floor. And Mrs X needed help with personal care, but was not getting this despite requests. The Council treated Mrs A's contact as a safeguarding issue. A social worker contacted the Care Home; by then the lift was working again. The plan was for a social worker to review the case the following week.

19. The Council's records include a note of a phone call between Mrs A and a social worker in February 2012. Mrs A told the social worker Mrs X had a fall and was taken to hospital but had no injuries. She was not eating and her weight had dropped to less than 7 stone (44 kg). She had been moved to a room downstairs which opened onto the garden and seemed happier. The social worker said she would ask the Care Home if the move was permanent and if so, there would be no further action.

20. A note by the Care Home's manager, on the Council's files as a response to an earlier complaint by Mrs A, says the lift was fixed as soon as possible and all residents had risk assessments. Mrs X moved to the ground floor when a room became available. Mrs X wanted to stay in her room but staff checked on her. She did have help with personal care but sometimes got dressed on her own before staff could help her. Staff did not see any clothes on her floor but would have picked them up if they had done.

21. There was no further action under safeguarding procedures.

The Care Home's records

22. The Care Home's pre-admission assessment of Mrs X completed in August 2010 said she had a fall two weeks earlier and listed her health problems. The moving and handling assessment scored her as low risk at eight. The pre-admission form said Mrs X weighed between 52 and 64 kg. The nutritional assessment said she had a normal appetite and ate independently. Her nutritional score was five which meant she was at low risk of malnutrition. (Scores of eight and above were to have an individual care plan.)

Activities

23. The activities care plan of March 2012 described Mrs X as happy with her own company. She was able to choose when she wanted to join in with activities. Staff were to tell her about activities and encourage her to join in. She went to the stroke club with Mrs A once a week. She was to have one to one time in her room if she did not want to join in with activities.

24. The Care Home sent us activities timetables for 2013. There was a weekly film club and other activities including coffee mornings, Italian cooking, a summer BBQ and a visit from the Mayor. The Care Home sent us some photos of Mrs X taking part in activities. There is a general record of Mrs X's daily living, but some of this describes personal care and activities Mrs A arranged for her mother, rather than those provided by the Care Home.

Nutrition

25. The Care Home kept weight charts for Mrs X. Her weight shortly after admission in September 2010 was 61.9 kg with a BMI of 22. This is within the healthy range of 18 to 25. Mrs X was weighed monthly and her weight remained stable until February 2011. There was no entry for March, but in April it had dropped to 55.6kg, giving a BMI of 20. A note on the chart next to this entry reads 'back from hospital'. The Care Home started to weigh Mrs X every week from July 2011. From August 2011, her BMI was 18 and declining gradually. By the end of 2011 she weighed 45.9 kg with a BMI of 16. In the first half of 2012, Mrs X's weight remained at around 45kg. The Care Home recorded monthly weights from May 2012. There was a downward trend until Mrs X left the Care Home at the end of November 2013, weighing 41.4 kg with a BMI of 15.

26. The eating and drinking care plan of December 2011 noted Mrs X's allergies but not that she was vegetarian. She was to be encouraged to eat more and to have a high calorie diet with cream added to meals and to be offered milky drinks. In January 2012, she was placed on supplements. The care plan said she should be on a food chart. But the Care Provider did not disclose any food charts to us for the whole of Mrs X's residence. The records for Southern Cross Healthcare Ltd are not available. But there are also no food charts from September 2012 onwards (the date when the current Care Provider took over) either.

27. The eating and drinking care plan of March 2012 said Mrs X could eat independently but needed encouragement to eat more. Cream was to be added to soup and desserts and she was to have milky drinks and snacks. She could choose what she wanted to eat. This care plan said *'Mrs X was vegetarian but now chooses to eat meat'.*

28. A later nutrition care plan noted Mrs X ate and drank independently, had her own teeth and needed a normal diet. She had a small appetite.

29. The Care Home completed malnutrition screening assessments for part of Mrs X's stay and reviewed these. Mrs X scored two, so she was at high risk of malnutrition. The standard instruction on the malnutrition assessment for those scoring two was '*implement food chart, encourage energy dense food, fortified drinks and snacks 1 to 2 times a day, encourage snacks and milky drinks, refer to dietician'.* Mrs X's nutrition care plan said she had 'low' nutritional need. It said she did not need recording of food and drink intake and staff were to add extra cream and butter to her food.

30. In June 2013, a note on the care plan says the GP thought Mrs X had lost weight, but on checking, she had put on a small amount. The GP was not concerned.

31. The Care Home's diary entry for November 2013 said the GP had referred Mrs X to a dietician. This is not recorded in Mrs X's care plan.

Falls and mobility

32. The Care Home kept monthly falls risk assessments for Mrs X from August 2010 to March 2012. The outcome each month was that she had a high risk of falls. The risk assessment indicates Mrs X did not fall between August 2010 and March 2012. But she was deemed at high risk of falling because of other factors such as an unsteady gait (way of walking),

taking lots of medication and poor vision/hearing. As Mrs X was at high risk of falling, the assessment said she should have a falls care plan.

33. The professionals' visit records indicate Mrs X saw her GP after a fall in November 2010. She had bruises. She may have had another fall the following week as the GP came again to check her arm - but this may have been the same fall. Mrs X also saw her GP in December 2011 as she had bumped her head (no mention of a fall) and for weight loss. She was prescribed a food supplement. In January 2012, the GP saw Mrs X for stomach cramps. The record noted she had started eating more. On 26 January, Mrs X fell to her bottom from standing and was taken to hospital by ambulance.

34. The relatives' communication record indicates staff told Mrs A about Mrs X falling in September 2010 (no injuries) and November 2010. Mrs A and staff met to speak about Mrs X in January 2012. Mrs A felt her mother was giving up on life, had no interest in activities and did not want to come downstairs for meals. After this meeting, Mrs X moved to a different room on the ground floor so staff could monitor her more closely. She had another fall, but no injuries. At the end of January 2012, the GP reviewed Mrs X; she was said to be eating more and the GP held off prescribing antidepressants.

35. Mrs X's mobility care plan of January 2012 said she walked slowly with a zimmer frame and used a wheelchair for longer distances. She liked wearing slippers which were too big and was to be encouraged to wear shoes outside.

36. The daily journal in July 2012 noted Mrs X was not well enough to go to the stroke club because of a fall.

37. Mrs X's mobility care plan of November 2013 said she transferred on her own using a frame. She had a fall previously, but not in the last year. Staff were to make sure her room was free of clutter. She dragged her left leg and was a slow walker. Mrs X had a chest infection in December 2013 and was more frail than usual. The care plan noted she had a fall on 11 December and was found on the floor. She went to hospital in an ambulance. She had broken her hip. There is a brief accident/incident report of this fall saying the manager checked Mrs X over and called an ambulance when she said she could not move her leg. There is also an account of the fall in an email from the manager to Mrs A:

    '[Mrs X] *was given a cup of tea as always and was told someone would be along to help her with a wash.* [Mrs X] *was seen just before 8 when they collected her cup and she was still in bed. After hand over,* [Carer A] *was walking the corridor and heard* [Mrs X] *call out she went in and* [Mrs X] *was at the foot of her bed this was around 8.20 am…. called paramedics…'*

38. Mrs X stayed in hospital until February 2014 when she moved to a different care home. A letter from a hospital dietician described her in February 2014 as severely underweight at 37.2 kg with a BMI of 14.5. She had food supplements in hospital.

Complaint responses from the Care Provider and Council

39. The Care Provider's response to Mrs A's complaint said:

- the Care Home had no personal activities leader (activities co-ordinator) since October 2013 and they were recruiting;
- Mrs X had a chest infection in December 2013, but could transfer with her frame. Bed rails were not suitable because they were for people at risk of falling out of bed. It was not good practice to use bed rails as a means of restraint (to stop someone from getting out of bed independently); and
- the weight loss for the last seven months of Mrs X's stay was not significant and the home manager was correct to say a GP would not have prescribed food supplements.

40. Mrs A complained to the Ombudsman in April 2014 as she was not happy with the Care Provider's response. We asked the Council to investigate and respond to her complaint first. The Council's response said:

- there was no support from the Council for the whole time Mrs X was in the Care Home. There should have been reviews of her care. These did not happen because of an administrative error in transferring her case to the long-term team. The Council did not advise Mrs A she could contact officers if she had concerns about her mother's care;
- Mrs X's weight was documented as of concern. There was a decline in her weight from 2010 but no action taken to address this. Her care plan was not updated to reflect her needs;
- there was no activities co-ordinator in place. The Care Provider accepted there were no regular activities for residents;
- the CQC inspection concluded record keeping was poor;
- Council officers would make an unannounced visit to the Care Home. Officers would meet residents and look at records to look for issues such as weight loss and action taken, quality of meals and whether there was an activities co-ordinator in post.

41. To reflect the lack of reviews and distress caused, the Council offered a payment of £500. It also apologised for the failing in Mrs X's care.

Comments from Mrs A

42. Mrs A told us:

- her daughter wrote Mrs X's care plans at her key worker's request;
- she recalled Mrs X weighed about 70 kg on admission in 2010. She has also said Mrs X weighed 76.2kg in April 2010;
- the weight charts were forged; they were completed by the same person every month;
- Mrs X only stopped being vegetarian because meat was placed in front of her because it was more convenient for the Care Home. She had little speech and could not say she did not want to eat it;
- Mrs X fell five times during her stay at the Care Home. The last fall happened because she wanted to go to the toilet on her own and fell getting out of bed. The fall was preventable; and

- she organised activities for her mother and other residents because there was little going on.

Comments from the Care Home's manager:

43. The Care Home's manager told us:

- there were difficulties recruiting an activities co-ordinator. One person has been in the role part time continually since 2001. And a series of second part-time co-ordinators have been in post since 2010;
- Mrs X was reluctant to engage in activities arranged by the Care Home and preferred to do things with her daughter;
- she asked the GP to refer Mrs X to a dietician as well as discussing her weight with the GP in June 2013;
- Mrs X lost weight in hospital;
- Mrs X ate small meals and staff tried to encourage her to eat more; and
- the chef added cream and butter to drinks and meals for extra calories.

Comments from the Care Provider

44. The Care Provider told us:

- it cannot be responsible for lack of records or poor record keeping or any other matters while the Care Home was owned and run by the previous operator up to September 2012;
- it was the GP's responsibility to prescribe food supplements and the GP did not;
- Mrs A's daughter did not write Mrs X's care plans and there is no evidence to support this;
- the fall was neither predictable nor preventable; and
- there is no evidence Mrs X weighed 70 kg.

Comments from the Council

45. The Council told us it failed to complete annual reviews of Mrs X's placement because of an IT malfunction when switching to new software.

Conclusions

46. The Council contracted with the Care Provider under responsibilities in the National Assistance Act 1948. For this investigation, the Care Home and Care Provider acted for the Council. Any fault by the Care Home and/or Care Provider is fault by the Council.

There were no activities and Mrs X was under stimulated

47. The Care Provider kept some records of activities offered to Mrs X. Some of these activities Mrs A ran. But we do not consider these showed satisfactory daily activities were available throughout Mrs X's stay.

48. There is no personalised activities care plan before 2012 for Mrs X setting out her preferences and needs. Based on the general information provided, we do not consider the care to Mrs X was in line with Regulation 9 and this is fault.

Mrs X lost weight and became malnourished

49. We do not consider there is enough evidence to support Mrs A's view that weight charts were forged after the event. They are mainly completed by one member of staff. But this does not mean there was forgery. We also do not consider there is enough evidence to conclude Mrs X was forced to start eating meat. There is also no documentary evidence suggesting Mrs X weighed as much as 70kg, or more, on admission or that Mrs A's daughter wrote her care plans. But we are critical of Mrs X's nutritional care for reasons set out below.

50. According to records from the Care Home, Mrs X weighed 61.9 kg with a BMI within the healthy range (22) on admission in 2011. When Mrs X left in 2014, she was 41.4 kg with a BMI of 15 meaning she was malnourished by the definition in national guidelines applicable in health and social care settings. She lost a third of her body weight during her stay. This is a significant loss. We note Mrs X had a period in hospital in 2011 where it seems she lost about 5kg and for which the Council or the Care Provider which acted on its behalf cannot bear responsibility. Even so, we are not satisfied with the nutritional care because Mrs X's BMI was under 18 from August 2011 and little action was taken to try and address this.

51. The Care Home completed malnutrition assessments for the latter part of Mrs X's stay. These suggested she should have been on a food chart and referred to a dietician, because she was at high risk of malnutrition. Yet the care plan said a food chart was not needed and Mrs X was at low risk. But she had a nutritional assessment score of two for this period which indicates a high risk. We consider the assessments and care planning around nutrition are contradictory, confusing and incomplete. Mrs X's care was not in line with Regulations 9, 20, 10c or 24 because:

- there were no records of Mrs X's food intake, despite the nutrition assessment recommending this. This meant there was no way of showing whether Mrs X's diet was nutritionally adequate for her;
- there is no evidence in the records (such as food charts) that staff fortified her food or drink as stated in the care plan;
- Mrs X was malnourished, having lost a significant amount of weight since moving into the Care Home and having a BMI of below 18. Staff did not seek specialist dietician support either directly or through the GP in 2012 and only spoke to her GP twice in 2013 about her low weight. No-one reviewed the records from admission. If senior care staff had considered the admission weight and looked closely at the weight charts over time, it would have been apparent Mrs X had lost a significant amount of weight since 2010.

52. The Care Provider's response to Mrs A's complaint did not recognise Mrs X's continued low BMI should have been a cause for concern. This is also fault.

Mrs X was not safe to walk unaided but was left with her walking frame and fell, breaking her hip

53. Mrs X walked on her own with a zimmer frame until the fall leading to her hospital admission for a broken hip in December 2013. The Care Home did not have a systematic way of recording falls and information about Mrs X's falls history is contradictory. For example, four falls are noted in the relatives' communication records and in the records of GP visits between August 2010 and March 2012. Yet a risk assessment said there were no falls in the same period. And there was no falls chart and so no way for staff reviewing Mrs X's care to consider whether any preventative action was appropriate (such as pressure alarms).

54. Mrs X was unwell with a chest infection in December 2013 before she fell and broke her hip. She was much frailer. Mrs X's care plan should have been updated to reflect a change in her needs; this meant her care was not in line with Regulation 10c which requires changes to a care plan to address a risk of unsafe care. But the inadequacy of records and care planning did not cause the fall and we do not conclude that on a balance of probability that they would have prevented it.

55. We are satisfied with the Care Provider's explanation of why bed rails may not have been appropriate. There is no indication that Mrs X had fallen out of bed before.

The Council's role

56. The courts hold councils responsible for ensuring council-funded placements meet assessed needs. The Council accepted it was at fault because there was no review of Mrs X's placement. The Council should have reviewed Mrs X's assessment at least yearly. We consider a thorough review involving Mrs A would have likely identified the concerns about Mrs X's low weight and under stimulation. There was a lost opportunity to take action in early 2012 when Mrs A raised concerns. Unfortunately, the Council closed the safeguarding enquiry without ensuring a review of Mrs X's care was completed. A review would have led to improvements in Mrs X's care or to an earlier transfer to a different care provider which could have better met her needs.

Decision

57. Mrs X's nutritional care was inadequate and not in line with regulations or guidance for care providers. There were not enough activities to stimulate her or promote her wellbeing. Care planning and risk assessment around falls and mobility was also inadequate. There were no annual reviews of the placement by the Council. This is fault and caused Mrs X distress. She was under stimulated, suffered an avoidable loss of weight and her wellbeing was not promoted. Since moving to a different care home, Mrs X has regained weight and her weight is now within a healthy range. Mrs A also suffered distress because she saw her mother's health decline.

Recommendations

58. To remedy the injustice caused, we recommend, within one month of this report, the Council pays:

- Mrs X £3,500; and
- Mrs A £500.

59. During our investigation, the Council said it carried out quality visits to the Care Home since Mrs A's complaint. And between March and April 2014 it did not place anyone there because of a poor CQC inspection. To minimise recurrence, we recommend the Council's future contract monitoring includes specific checks of:

- nutrition care plans, food, fluid charts and weight charts;
- falls monitoring, falls risk assessments and falls/mobility care plans;
- care plans for activities and records of activities offered to people.

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