Appendix 1

Adult Social Services

Summary of complaints received across service areas 2017-18

Older People Localities

21 complaints were received during the year, an increase compared to previous years.

X objected to being in a home and wished to return home. Clarity was also needed as to whether the Mental Capacity Act had been followed. We spoke with the Manager of the Discharge Support Nurse Team who confirmed a Mental Capacity Assessment and Best Interest decision was made and documented by the Discharge Support Nurse. Family were directed to Health if they had further issues about the process.

X complained we were acting against their father's views and wishes by not allowing him to come home from a residential home. We explained their father had capacity and an Advocate, and that he was seeking his own legal advice about his estate. As such, we would not take their complaint further, but they should seek their own legal advice.

X complained that her late husband was inappropriately placed in two placements we had identified for him, as well as the processes in the lead up these placements. We explained the reason for placing X's husband in a local residential home was in his best interests at the time, but it sadly didn't work out. We explained Health placed him in the hospital. We also explained the role of an Adult Mental Health Practitioner and reassured her that process was followed. The residential provider where X's husband spent his last few months responded with their observations about the cleanliness of his room and these will be taken forward by Wrexham's Contracts Monitoring Team.

X complained their mother's Social Worker was dismissive of their concerns around a planned return home on a trial basis. It was originally planned that she required permanent care but there had been a change of mind which concerned family. We met with family and advised that since the original decision was taken that X's mother required permanent care, her situation had improved somewhat and such a trail was worth a try. Family now understand this. There was an issue as to how the Social Worker communicated with family and this has been taken forward with them.

Older People Provider

7 complaints were received in the year, an increase upon previous years.

X complained carers had left their father's sling on causing him an accident and that they left a key code on full display in the window. Carers did indeed leave X's father arm sling on and this will be dealt with under a capability enquiry. The manual handling plan was amended and further assessment arranged. The key

code will be hidden away in future. We apologised for these oversights which family accepted.

X complained of a lack of communication and progress in terms of completing an assessment for their father to return from hospital to his residential home. We sought to reassure that X's father's wishes were always foremost in our minds. Father had been admitted to hospital and became quite poorly soon after. We were in regular contact with the hospital. Father was not mobile and was confused, and received a diagnosis of dementia. Instead of discharge back to the residential home where his room was unsuitable, arrangements were made for physiotherapy at Holywell hospital. We couldn't assess until his medication was completed. After a period of time to see how father would recover, it was decided his current home couldn't meet his needs. This was a decision not taken lightly.

X raised a concern as to what happened to their father on the day of his fall and why he was in a resus section when instructions were DNAR (Do Not Attempt Resuscitation). We explained that on the day itself, the sensors were triggered and staff found X's father on the floor. Staff checked him over and found no indicators of injury and he was not complaining of any pain. He was able to move and rotate his leg, indicators of a hip fracture. Staff checked on him a short while later and he complained of pain. Staff called paramedics who confirmed we had followed procedure as had they examined him initially and they too would have reached the same conclusion. Hospital staff subsequently put X's father in the Resus section due to his age rather than a busy A and E Department.

<u>Learning Disability Community Team</u>

8 complaints were received in the year.

X complained about our decision in turning them down for a carer's direct payment so they can have overnight respite away from the family home once a month. Advocates added this was against the spirit of the new Act. We reviewed our decision as further information was provided to support the family's case. The original decision was overturned. A carer's direct payment is now agreed to fund overnight respite for X.

X complained about a lack of action in exploring options about their son's placement as he is unhappy with one individual he lives with. We explained X has an Advocate whom he speaks with and he has told his Social Worker he does not want to leave his home, which we respect. All gentlemen living together have an equal right to remain living in their home. However, plans are underway to change the existing living arrangements but given the dynamics of the house, each individuals' needs and the relationship between the three means this is going to take time to resolve. In the meantime, no incidences have been reported by staff and a senior support worker has been recruited to further improve the living environment there.

X complained their daughter had been removed from the accommodation waiting list without their knowledge. We apologised for any distress this matter may have caused. We had reviewed the list earlier in the year as there were people who had been on it for some time, they were not immediately looking for a property and scored low on the criteria. There was an administrative oversight on our behalf. X's daughter's name has since been reinstated and the procedure revised.

Learning Disability Provider

10 complaints were received during the year.

X complained about the length of time it was taking (several months) to resolve the out of hours support at their sister's home, which she shared with three other people. We resolved the out of hours cover for the home via our own in-house Learning Disability Provider Service. Their telephone number will be registered with Telecare as the main responder. We apologised for the length of time it had taken to resolve this situation.

X complained about personal possessions going missing, family not having calls returned and their son eating out a few times a week as carers can't cook/prepare food. We apologised for personal possessions going missing and arranged for items that hadn't been recovered to be replaced. The inventory process has been revamped so staff now take ownership if items go missing and maintain regular contact with the family. In terms of eating out, Sunday dinners are to be provided at the respite home, takeaways restricted to once with anymore needing agreement from family. Service users can eat out if on a trip out.

Some parents of service users at Estuary Crafts had expressed their dissatisfaction in the lead up to the transfer of learning disability day services and work opportunities services to Hft. After the transfer had taken place, we met with them to listen to their views. After an open discussion in which we answered some outstanding questions, some actions were identified which will be taken forward with Hft and NEWCIS.

Mental Health and Substance Misuse

7 complaints were made during the year, an increase in previous years.

X complained about the conduct of a Social Worker following a home visit during a stressful situation prior to their son being taken to hospital by an ambulance and the Police. We apologised if the Social Worker appeared unprofessional. They did have to leave the property twice to take calls in an attempt to secure a hospital bed for X's son and speak in private with their Doctor, who was also present at the home.

X complained support was being changed without proper consultation or communication, which was causing them some anxiety. We explained our conversations with X were to gradually move their support to Social Links who were best placed to meet his needs. X does enjoy these drop in sessions. We also expressed our concern that X was becoming overly attached to his present support worker hence why they had been moved elsewhere.

Physical Disability and Sensory Impairment

4 complaints were made during the year.

X complained of a lack of support and empathy in relation to their circumstances and illness. We explained the role of the Promoting Independence Service (P.I.S.) and, given X's circumstances and their lack of engagement during the course of the year, the Team was not best placed to support her needs. Instead and with their permission, we referred them to the Mental Health Service (though X didn't engage with them either). X was offered to use the P.I.S again if they believe they can engage with us.

X complained their Social Worker does not liaise with other professionals so how can they meet their needs? X's Social Worker also told her she can afford the charge applied to her despite X not yet sharing financial information with the Waiver Panel. We reviewed our records and since the case was allocated to X's present Social Worker, there has been a review which both X and her agency support worker attended. Records also show a number of activity/actions from both the Social Worker and O.T., evidencing communication in terms of meeting her needs. The Social Worker is not a member of Waiver Panel and has no influence in their decision making.

Other (Business Support Services etc.)

Three complaints were received during the year.

X complained about a range of issues following our decision to cancel our contract with their privately registered home and move residents from there. In particular X complained how the moves were conducted and at such short notice. We reminded X of our concerns whilst their home was in escalating concerns. We gave a detailed background of events and staff involvement in the weeks leading up to moving residents out of their home.

X complained about the way in which we managed their mother's move from their existing privately registered home to their new registered home. We explained we did not close the home but did cancel the contract we had with them. This was because of our concerns and that no improvements had been made since the home was placed under escalating concerns. Issues regarding outstanding monies owed needed to be referred back to the home. There had been

communication with X's sister at the time of escalating concerns and prior to the day of the moves.

Safeguarding

3 complaints were received during the year, the same number as last year.

X complained that a referral made to the Safeguarding Unit by Health was not properly investigated. We reviewed whether our response was appropriate given that the referral made by Health was incomplete. The Safeguarding Manager believed due process had been followed and proper consideration given as to the information we had from Health. This was confirmed by an independent investigation at Stage 2.

X was dissatisfied with the outcome of a Safeguarding investigation and a lack of written information from the Team. Although X's family weren't invited to the safeguarding meeting, we had gone through the rationale behind the decision of "disproven" with the family. Reconvening a meeting would not change the outcome. We also shared a copy of the safeguarding meeting minutes and the investigation report with family.

X complained that we weren't listening to or acting upon their concerns about their adult son, whom X believed was being kept "prisoner" at home with their ex-wife. We explained that a Social Worker had been to visit X's son and met with him alone. Son has capacity and he confirmed he did not want to make any changes to his life. We sought to explain that X's son's view was paramount and he was not under any duress when spoken with.

Registered Provider (Residential)

10 complaints were received during the year, an increase upon previous years.

X complained about a range of issues following their mother's move from her existing registered home to her temporary registered home. Issues included the cleanliness of the room, problems with belongings and the professionalism of Managers at the new home. The home gave a differing account, adding that X's behaviour on the last visit had been deemed as threatening which has been reported separately. Neither the Service Manager nor Contracts Team Manager had anything further to add to the comprehensive response sent by the home complained about.

X complained about the state of their mother's feet (photographic evidence was provided) as well as issues about personal property. The home found X's mother had not been seen by a Chiropodist some few months prior. They apologised and immediately made arrangements for a Chiropodist to visit. They highlighted issues about the need for their own care staff to communicate with the Chiropodist rather than assuming a resident has been seen. This issue has been shared with Contracts Monitoring to inform future visits.

X complained about a range of issues relating to their mother's care whilst she was resident at the home. X also complained that we didn't act in her mother's best interests following her discharge from hospital back to the home where she had lived for a number of years to pass away peacefully. We reviewed meetings that took place and stood by our position that X's mother's best interests were respected. We and hospital staff believed it was in her best interests to pass away surrounded by her own personal items and with people she knew (she had lived in the home for a number of years). The home responded to the issues raised in some detail - we had no further observations to make about the standard of care and we believed she was well cared for by the home.

Registered Provider (Domiciliary)

7 complaints received during the year, down from previous years.

X complained that the registered provider had discharged their support provided to X's father whilst they were away on holiday. This was done without a satisfactory reason and leaving their father without support whilst they were away. The provider reassured X's father wasn't without support whilst they were away. The Homecare Team stepped in meaning the provider could withdraw. The provider communicated directly with X's father as to the reasons why their support was discontinued and this was a private matter between the provider and X's father.

X complained their provider had started turning up late for morning visits to administer medication for their mother and make her breakfast. The provider explained the carer was running late from an earlier call but accepted they should have called ahead to advise of the delay. The medication was administered and lunch made in preparation, albeit late. However, the provider was in breach of their contract for not informing mother/daughter and charges reimbursed.

X complained about the recent standard of care and the carer not disposing of waste appropriately. The agency failed to attend a mediation meeting we arranged. However we met with X who advised us the carer who didn't dispose of waste properly had now left. They also advised the standard of care had since improved. We shared the outcome with Contracts Monitoring to inform any future visit.

Complaints Relating to Dignity

4 complaints related to dignity. They related to older people and:

- The condition of their feet as X hadn't seen a chiropodist.
- Being hungry and wearing soiled nightwear in soiled bedding.
- Being turned away by a home when they arrived by ambulance to end their life there, but funding hadn't been agreed.

- Being left in an ambulance on a cold night whilst discussions took place about their admittance to the home.

In the above cases, an apology was made and each situation reviewed by the relevant team/provider to ensure nothing similar happened again.