Appendix 1

Adult Social Care

Summary of complaints by theme (2018-19)

Complaints relating to dignity (2 complaints)

1. X complained about the standard of care provided by the home in terms of dignity and how they treated residents there.

The home interviewed carers on duty at the described times and all were shocked at the comments allegedly made. They insisted they were discreet and treat residents with dignity and respect. The home assured staff do engage with residents, do short bursts of activities and these are reflected in diary notes. There were no concerns from ourselves.

2. X complained their partner was not attended to one night despite X pressing the alarm meaning they slept in a wet bed. Staff did not change the bed the following morning and instead placed a blanket over him.

The home apologised for any upset and anxiety caused. They explained a bottle had overflowed and the Nurse went quickly once the alarm bell was pressed. No evidence was provided by the home as to the response time that night, so the timeliness of responding to alarm calls was featured in the next visit by a Contracts Monitoring Officer.

Complaints relating to communication (14 complaints)

3. X complained they had booked time off work to attend a family member's review meeting but the Officer left earlier than the time agreed.

We apologised for our actions and leaving the venue early without checking to see if a family member was on their way. The Officer had already spoken with staff and met with the individual concerned before the agreed review time which is not acceptable. Officers in future will ensure they have the contact details of those invited so if changes are to be made, invitees can be contacted.

4. X complained we had visited mother without a family member being present or without them being informed so we could assess the safety of bed rails that had been installed by family. Mother becomes anxious with new faces visiting and no family member being present. We removed the bed rails which X believes left mother at risk of falling out of bed.

We apologised for visiting without advising family, but we explained why we had to undertake a prompt visit to check upon the handrails given our understanding that family had left mother to attend a wedding over the weekend. An O.T. will complete another visit and go through in detail our concerns about the handrails and suggest alternative solutions.

5. X complained they had not been informed of their rights in terms of contact with their son, who is sectioned some distance away. X believes we have washed our hands of their son now that he is locked up and we aren't exploring placements nearer to home.

We reminded X their rights were explained to them by the Approved Mental Health Professional and their son's G.P. at the time son was sectioned and placed. We assured X we had not washed our hands of her son but Health were now responsible for their son's care co-ordination, though we had identified a placement closer to the area.

Complaints relating to timeliness of our decisions or actions (10 complaints)

6. Family complained that we were not following the recommendations made by the Multi-Disciplinary Team. We were not enabling X to return home and instead keeping them in hospital and hampering their recovery.

We reassured family it was never our intention to have X stay in hospital and apologised if our communication came across this way. Their care provider is now in a position to able to support her return home and a planning meeting has been convened to facilitate this soon.

7. X complained about our timeliness of agreeing a package of care for their mother who was moving from England to Flintshire.

We explained the cross-border referral process to X and the difficulties we had faced in engaging with the Local Authority of origin. We had also found it difficult to engage with family about the matter. As a package of care cannot be sourced at this time, we offered short term care in a residential setting here.

Complaints relating to disagreements with our decisions or actions (10 complaints)

8. X challenged Panel's decision to reduce their respite care nights. X's daughter's needs haven't changed and X remains an 'elderly' sole carer.

We reviewed our decision and found X's allocation had been calculated correctly. However, given the impact a 6 night reduction may have upon them we agreed to reduce by 3 nights this year and implement the full 6 night reduction next year.

9. X complained about Panel's decision not to award her a direct payment because of historical mismanagement of funding. Panel instead agreed to a package of care.

We reviewed our decision and agreed a direct payment given X's circumstances. However, our decision came with a number of caveats for X to adhere to given their previous mismanagement of funds.

10. X complained of our decision to return their mother home, a home that has been empty for 15 months after family emptied its furniture and contents. X believed their mother wouldn't be returning home as she lacked capacity and she would continue living in the residential home where she currently resides.

We explained we had twice completed a mental capacity assessment several months apart, which confirmed X's mother had capacity. The DoLS process was also followed. Family were communicated with during this time. Mother wants to return home and we are respecting her wishes by supporting a phased return home.

Complaints relating to charges applied or financial issues (4 complaints)

11. X complained about Panel's decision not to financially support their mother's move to a privately registered home. X also needed some financial help until their mother's home was sold to fund the placement.

We explained our assessment of mother meant she could be supported at home with a care package but this option was declined by her. Mother decided however that she wanted to go into a home privately which she has every right to do. Family can approach the home and negotiate an arrangement until X's property is sold.

12. X complained about the safeguarding concerns made against them re. alleged financial abuse and on whose authority did we re-direct their son's benefits and set ourselves up as Appointees?

We explained a referral was received earlier this year regarding a lack of funds being provided by X for their son. Requests for funds had previously been requested on many occasions but none were forthcoming causing X's son financial hardship and impacting on his personal and social opportunities etc. We contacted the Department for Work and Pensions who stopped son's benefits to X and we took over their Appointeeship.

13. X complained he had started to receive bills in relation to their friend's residential fees. X's friend had transferred their property to X in the 1980s but has no documentation to evidence this.

We explained we had agreed X's friend for short term care funding support which runs for up to maximum of 8 weeks under Welsh Government rules. X has been offered a bungalow and the plan is for their friend to eventually move in with them. If however the friend remains in a home after the short term care runs out then "Temporary" care applies which means the friend's care charges will change and increase, and be applied to X.

Complaints relating to hospital discharges (2 complaints)

14. X complained about the length of time it was taking to assess their mother so she could be discharged from hospital and moved to supported living accommodation nearer to X.

We apologised for the delay in assessing X's mother though the hospital was not the right setting for a housing and social care assessment to be completed. A Social Worker was allocated to visit mother at home to advise and support her with her wish to move to Cheshire.

15. X complained their partner had been kept in hospital for three and a half months as we couldn't source carers for them to return home.

We explained we assessed X's husband and made a request to Brokerage for a new package of care that day. However, given the demand on care providers, one could not be found and X's partner stayed in hospital for a further two months. An I.C.F. bed was offered after a month but this was declined.

Complaints relating to the quality of care from a home or carer (23 complaints)

16. X complained that planned work to make their father's room safer was not taken forward. Father was found on his bedroom floor one morning soon afterwards and passed away soon after in hospital.

The home advised it was unsafe for father to mobilise without the Zimmer frame and that the use of pressure mats, with advice from O.T., would further increase his risk of trips and falls. We sought to reassure X his father was provided with excellent care and support at a time his overall health was deteriorating.

17. X complained their carer had made an unplanned visit to their home and acted strangely, possibly under the influence of alcohol. The provider themselves gave an unusual response that required a formal follow up.

The provider explained the carer had not long received some distressing news and had misunderstood a telephone message hence why she attended X's home unannounced. She was not under the influence of alcohol.

18. Daughters raised a number of concerns following their late father's stay and their mother's stay in separate homes, but under the same home management. Their concerns included: dental hygiene, inappropriate food, the home's general environment and staff interaction with residents.

We undertook an already planned contract monitoring visit to both homes and made general observations but no concerns were raised. We also read through all residents' reviews held this year in both homes and found no issues against the themes identified.

19. X complained a carer had not checked if their father had taken his medication on one occasion and that staff had been unprofessional with them when they questioned the matter.

The agency reviewed their records for the evening concerned. The evening carer went to give father his medication and noticed the pack had already been opened. Father could not remember taking the medication. Checks were made with earlier carers who both confirmed the medication was there. It is believed father took his own medication. The agency did try and explain this to X but they were continuously rude and abrupt, and X would not listen to the explanation.

20. X complained about the manner with which a home had managed their mother's move from the home to another home. The move was done with a lack of advice, support and empathy/understanding.

The home apologised for the service family received toward the end of mother's placement there and that information was not expressed in a clear manner to them. The former Manager involved in the move no longer works at the home. The home advised family the decision to move their mother was taken in her best interests given her increasing health needs.

21. X complained we were denying their mother some liberties by now dictating visiting times.

We explained mother had been returned as late as 1.30am on occasions which was affecting her health and wellbeing, and her medication. We reminded X it was important to return their mother at an acceptable time so her medication is taken on time. X is not reliable to oversee their mother's medication. Given our concerns about X's own health and wellbeing, and their admittance that their life had no structure or routine, with Legal advice X was instructed not to remove their mother from the home until we fully complete our assessments. X is welcome to visit their mother at the home and leave before the allotted time.

<u>Complaints relating to process issues (14 complaints)</u>

22. X complained about a number of issues with regard to their initial assessment including being recorded as a "known risk to lone workers" and being put under pressure to confirm an appointment or their assessment would be closed.

We acknowledged the "known risk" box should not have been ticked and was done so in error and we apologised for the misinformation recorded in the assessment which we have since put right. We explained the Social Worker had heard nothing from X for four weeks so sent a 14 day letter to clarify if she wished to continue with the referral or not as is our usual procedure.

23. X complained that their partner's C.H.C. funding had ended and they were now self-funding. X couldn't understand why.

We reminded X of the meeting when it was discussed X's partner no longer met the criteria for Continuing Healthcare Funding and the reasons why (which was followed up in writing by Health). The letter we sent was in relation to a means tested financial assessment that indicated X's wife was over the financial threshold to apply for financial assistance.

Complaints relating to staff (6 complaints)

24. X complained their working relationship with her Social Worker had broken down following her request for additional support.

We reminded X of her current package of support including a direct payment which provides a reasonably high level of supervision throughout the day. Many of the concerns X has are health related and we redirected them to Health where we will support their application for Continuing Health Care funding.

25. X complained about the way we had spoken with them about their grandmother.

We acknowledged that tensions have run high and conversations have been emotional for some. However, we sought to work with the family on behalf of grandmother, who has expressed a wish to return home which family members did not agree with.

26. X complained that their Social Worker 'intimidates and demoralises' her.

Although X withdrew their complaint and given the allegations made, we completed a comprehensive investigation that involved Health as well. No evidence was found to uphold X's allegations that her Social Worker was disrespectful or intimidated her.