Local Government
OMBUDSMAN

Report by the Local Government Ombudsman

Investigation into complaints against

Oxfordshire County Council

(reference number: 15 007 968)

Caring Homes Healthcare Group Limited

(reference number: 15 006 620)

20 June 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 15 007 968 against Oxfordshire County Council and complaint number 15 006 620 against Caring Homes Healthcare Group Limited

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

Mr X - the complainant

Mrs X - the complainant's wife (now deceased)

Report summary

Adult care services – safeguarding

Mr X's complaint relates to the quality of care provided to his late wife, Mrs X. Mrs X had a week's respite stay at Huntercombe Hall Care Home. The care home is owned and operated by Caring Homes Healthcare Group Limited.

The complaint also relates to the process of a safeguarding investigation undertaken by the Council into the care Mrs X received at Huntercombe Hall Care Home.

Finding

Fault found causing injustice and recommendations made.

Recommendations

The care provider should:

- provide Mr X with a full written apology for its failure to provide adequate care to his wife;
- apologise for its failure to deal with Mr X's complaint properly; and
- waive the full fee for Mrs X's stay at the care home.

The Council should pay Mr X:

- £250 for his time and trouble pursuing this complaint; and
- £500 for his distress.

During this investigation the Council has voluntarily implemented robust and extensive improvements to its policies and procedures (see paragraphs 79, 80 & 81). This action is welcomed.

The Council has also written to Mr X to provide him with a full written apology for its failings and set out the action it has taken as a result.

Introduction

1. This complaint has two elements which require consideration. The first relates to the quality of care Mrs X received at Huntercombe Hall Care Home. Mrs X had one weeks respite stay at the home which she paid for privately. This part of the complaint will be considered under Part 3a of the Local Government Act 1974.

2. The second element of the complaint is about how the Council conducted a safeguarding investigation into the care Mrs X received at the above care home. This part of the complaint will be considered under Part 3 of the Local Government Act 1974.

Legal and administrative background

3. The Local Government Act 1974 sets out the Ombudsman's powers and under which jurisdiction complaints are considered.

The Ombudsman's role and powers under Part 3 of the Local Government Act 1974

4. 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))***

The Ombudsman's role and powers under Part 3a of the Local government Act 1974

5. The Ombudsman investigates complaints about adult social care providers. We decide whether their actions have had an adverse impact on the person making the complaint. In this statement we refer to this as injustice. ***(Local Government Act 1974, sections 34B and 34C)***

6. If an adult social care provider's actions have caused an injustice, the Ombudsman may suggest a remedy. ***(Local Government Act 1974, sections 34H(4))***

7. Huntercombe Hall Care Home is privately owned and managed by Caring Homes Healthcare Group Limited. It is registered with the Care Quality Commission and provides nursing and residential care, personal care, and practical assistance to its residents. Therefore the actions of Huntercombe Hall fall within the Part 3a of the Local Government Act 1974 (amended October 2010) and may be investigated by the Ombudsman.

The law and guidance relevant to the complaint

8. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, was the basis for the Care Quality Commission's regulatory framework *Guidance about Compliance 'Essential Standards of quality and safety'.* This guidance was used by care providers of health and adult social care, to help them comply with the regulations. This guidance came into force in April 2010.

9. From 1 April 2015, the Care Quality Commission revised the guidance about compliance**.** For the purposes of this investigation, we refer to the **'***Essential standards of quality and safety***,** which was in force at the time the events complained about took place.

10. This guidance sets out the quality of care and safety that people who use care services have a right to expect. This includes both community care services and residential / nursing services.

11. Outcome 4: of the Guidance: *Care and Welfare of people who use services:*

- *"Staff will quickly recognise when a person who uses services becomes seriously ill, physically and / or mentally, and requires treatment, and immediately respond to meet their needs".*

12. Outcome 5: of the Guidance: *Meeting nutritional needs:*

- *"Staff identify where the person who uses services is at risk of poor nutrition, dehydration or has swallowing difficulties, when they first begin to use the service and as their needs change".*

- *"They have their food and drink intake monitored when they are at risk of poor nutrition or dehydration and action is taken as necessary".*

13. Outcome 12: of the Guidance: *Requirement relating to workers:*

- *"Have relevant qualifications, knowledge, skills and experience to carry out their role".*

- *"Can identify and respond to the changing needs of people who use the service".*

- *"Are aware of the services' policies, procedures, legislation and standards".*

14. Outcome 21: of the Guidance: *Records:*

- *"The service has clear procedures that are followed in practice, monitored and reviewed to ensure personalised records and medical records are kept and maintained for each person who uses services".*

- *"Records about care, treatment and support of people who use services are updated as soon as practical".*

- *"Records about care, treatment and support are clear, factual and accurate…".*

How safeguarding worked in Oxfordshire when the events took place

15. In 2014 Oxfordshire Safeguarding Adults policy was based on 'No Secrets' (Department of Health, 2000), the statutory guidance on safeguarding adults.

16. The Guidance says the objective of an adult protection investigation will be to:

- *establish facts;*
- *assess the needs of the vulnerable adult for protection, support and redress; and,*
- *make decisions with regard to what follow-up action should be taken with regard to the perpetrator and the service or its management if they have been culpable, ineffective or negligent.*

17. No Secrets also considers when a Council should appropriately intervene in relation to the seriousness or extensiveness of abuse. It states that the following factors should be considered: the vulnerability of the individual, the nature and extent of the abuse, the length of time it has been occurring, the impact on the individual, and the risk of repeated or increasingly serious acts involving the vulnerable adult or other vulnerable adults.

18. The Council's policy says that following a safeguarding referral it will ask the appropriate department to investigate. It says each investigation is led by a trained Safeguarding Adults Officer.

19. An assessment of risk determines the action the Council takes. If further action is required then a strategy meeting takes place. This is chaired by a Safeguarding Adults Manager.

20. The outcome of the strategy meeting clarifies any protection plan for the adult at risk and identifies who is to carry out the investigation. Further meetings take place to confirm the outcome of the investigation and to review the protection plan. The person and their carer/family are supported to be involved as much as possible.

How we considered this complaint

21. This report has been produced following the examination of relevant files and documents provided by the complainant and the Council.

Investigation

22. Mr X cared for his wife, Mrs X at home. Mrs X had dementia, which Mr X described as advanced. Mrs X required full assistance in all areas of daily living, including eating and drinking. Mrs X was unable to express if she was hungry or thirsty.

23. Mrs X had difficulty with swallowing and needed a thickening agent added to drinks. Mr X spoon fed the liquid to his wife, giving her a mug full of fluid approximately four times a day. Mr X says he was mindful his wife was vulnerable to dehydration and urinary tract infections. Whilst at home he experienced no difficulty with ensuring his wife had adequate fluid intake.

24. Mrs X had respite stays on numerous occasions at what Mr X calls 'their usual care home'. Mr X says there had been no problems during these stays.

25. On this particular occasion the usual care home where Mrs X stayed was full. Mr X decided that Huntercombe Hall would be suitable for his wife. One week's respite care was booked.

26. On 27 March 2014, the day before Mrs X was due to be admitted to the care home, a manager from the home visited Mr & Mrs X at home to undertake a pre-admission assessment. We have been given a copy of the assessment. The assessment is detailed and gives an overall picture of Mrs X's care needs, including her nutritional and hydration needs. It describes Mrs X's need to have fluids thickened and spoon fed to her, it also documents her risk of choking and that she is prone to urinary infections.

27. Mrs X went to stay at the care home on 28 March 2014 for a week. On admission care staff completed an admission form and a care plan. Over the following two days further assessments were completed, a manual handling assessment, including a waterlow pressure area risk assessment, a dependency assessment, a continence assessment and a falls assessment.

28. The assessments are detailed and highlight Mrs X's vulnerability to choking and her need for maximum assistance with eating and drinking. The admission diary notes are detailed and record *"she needs a lot of encouragement to eat and drink". "She requires a lot of fluid to reduce risk of urine infections".*

29. The care plan *'aim of care'* says *"To ensure [Mrs X] does not choke and to reduce risk of malnutrition by providing adequate nutritional intake and risk of UTI".*

30. The records indicate the need to record Mrs X's food and fluid intake. It also records *"Please report to nurse if urine smells or changes colour".*

31. On 29 March 2014 the care home began recording Mrs X's food and fluid intake. We have been given copies of the food and fluid monitoring charts for the whole of Mrs X's stay at the care home.

32. The first entry in the fluid intake chart, the day after Mrs X's admission, is at 10am. There are further five entries, the last being at 7pm. It was recorded in the daily care records on 29 March 2014 that, *"she didn't eat and drink well. She needs a lot of encouragement to eat and drink".*

33. On 1 April 2014 there are four recorded entries on the fluid chart, beginning at 10am, saying Mrs X had received small amounts of fluid. On 2 April 2014 there are five entries, beginning at 10am.

34. On 3 April 2014 there are entries at 3am and 6am. There is not another entry for eight hours, (2pm) that Mrs X had received fluid.

35. On 4 April 2014 there are three entries that Mrs X had received fluid, the first being 9am the last 12 midday. There are no further entries for that day.

36. The records show Mrs X often returned to bed as she was tired.

37. There are no records to suggest care staff had any concern for Mrs X's general well being or that she appeared unwell. There are no records to show that care staff had difficulty getting Mrs X to accept food or fluid.

38. On 4 April 2014 Mr X telephoned the care home to say he would be collecting his wife in the afternoon. The care records show he was advised Mrs X had eaten very little for breakfast and lunch that day, and that she had a small skin tear and blister on her elbow.

39. Mr X says when he arrived at the care home and saw his wife he realised she was not her usual self and appeared unwell. He says there was a marked deterioration in her condition from admission. He says she was less responsive and limp and when he attempted to transfer her to a wheelchair she was unable to weight bare, as she had been able to on admission. He also noticed her mouth had a coating of white spots.

Mrs X's discharge from the care home

40. Mr X took his wife home and immediately telephoned the care home to express his concern and dissatisfaction with his wife's condition. The manager of the home advised Mr X to contact the care home's usual GP. Mr X says the manager told him the white coating in his wife's mouth could be the fish she had eaten for lunch.

41. Mr X contacted the care home's usual GP immediately. The GP visited Mrs X shortly after her discharge from the care home, and concluded she was dehydrated and required admission to hospital. Mrs X was transported to hospital the same afternoon by ambulance. During the journey to paramedics administered intravenous fluids via a drip.

Mrs X's admission to hospital

42. On admission to hospital Mrs X was given further intravenous fluids via a drip. The white coating in her mouth was diagnosed as oral thrush. Mrs X remained in hospital for three weeks. The records show Mrs X was *"admitted with dehydration, problems with her kidneys due to dehydration".*

43. On 1 May 2014 Mrs X was discharged from hospital to her usual care home for palliative care. She passed away nine days later on 9 May 2014.

The Care home's response to Mr X's complaint

44. Mr X complained to the care home about the quality of care his wife received during her stay. He believed the care home had not given sufficient attention to his wife's fluid intake. He also believed the care home appeared to have no awareness that his wife was dehydrated and that her condition had deteriorated.

45. Mr X received a response to his complaint from the care home saying that fluid intake charts had been completed but his wife had been reluctant to take fluids and care staff could not force feed her.

46. Mr X wrote to the care provider on 27 February 2015 and again on 17 July 2015 to ask for copies of the food / fluid charts. Mr X did not receive this information.

47. Mr X approached his usual GP. The GP contacted the care home to ask for copies of the food / fluid charts and to ask the manager to meet with Mr X. Mr X says this request was also refused.

48. A Director of the company that owns and manages the care home, Caring Homes Healthcare Group Limited, wrote to Mr X in January 2015 with a formal response to his complaint. The author explains he had studied the notes relating to Mrs X's stay at the home. He says food and fluid intake charts were completed during Mrs X's stay at the home but at times she was reluctant to take food or drink in reasonable quantities and staff were reluctant to force feed her. He also said *"During her stay there was no deterioration in her condition. Staff did not note any signs of dehydration but did note that your wife could be reluctant to take appropriate diet and fluids... Food and fluid charts in your wife's file do show that food and fluid were offered regularly and that staff were monitoring intake".*

49. The author makes reference to the Council's safeguarding investigation. He acknowledges the care home *"put into place actions as a result..."* . He said this action was as a result of the safeguarding investigation not because "*staff believed there was any neglect of [Mrs X]"* but "*because all investigations should be a learning curve and if matters may be improved upon...".*

50. The author concluded *"I do not concur that there were serious shortfalls in the process at Huntercombe Hall at the time of your wife's stay or at the present time".*

Safeguarding referral and the Council's response

51. Hospital staff made a safeguarding referral to the Oxfordshire County Council on 7 April 2014.

52. We have seen a copy of the Council's alert/referral form confirming the referral was received by the Council on 7 April 2014. It gives a brief overview of the concerns and the care home involved.

53. The notes on the alert/referral form show the action taken by the Safeguarding Manager the following day, 8 April 2014. The officer telephoned the hospital to gather further information about the concerns and Mrs X's condition.

54. The officer also telephoned the manager of the care home. The notes of this conversation detail the care home manager's response to the concerns, she said care staff had difficulty feeding Mrs X the thickened fluids and were reluctant to force-feed her. She further says that on the day Mrs X was discharged "*she had not had a lot of fluids at lunchtime".*

55. The Safeguarding Manager told the care home manager she would *"require a report".* The officer followed this up with an email to the care home manager, dated 9 April 2014, confirming the request that the manager investigate the concerns raised and provide the Council with a report. The Council said the report should be submitted by 16 April 2014.

56. The Council did not contact Mr X to discuss the referral.

57. The alert/referral form was completed and dated 9 April 2014.

58. The council then forwarded the referral for further action, described as '*initial assessment and investigation'.*

59. The Council records *'Outcome of initial assessment'* show the actions and decisions taken by the Council between April 2014 and August 2014.

60. There are no records of a strategy meeting or discussion taking place. The assessment and investigation paperwork is incomplete.

61. The care home did not submit a report to the Council's safeguarding manager by 16 April 2014, the deadline given. The Council did not chase the care home for a response until 2 May 2014. Again the care home failed to respond to this request.

62. The Council sent a further email to the care home manager on 28 July 2014 asking the care home to submit its report. The Council added *"Please note that if we do not receive this report in the next couple of days, we will have no option but to close the referral with the allegation substantiated".*

63. The care home responded to the Council the same day by email stating it had already provided the report to the Council. It did not say when it had done this. It asked for confirmation the Council had received it.

64. The Council confirmed it received the report from the care home, along with the care home's assessment plans of Mrs X and the food/fluid recording charts.

65. We have seen a copy of the report the care home submitted to the Council. The report is undated. It re-iterates the point that Mrs X was reluctant to take food or fluid, and that *"During her stay there was no deterioration in her condition".* It further said Mrs X had not shown any signs of being dehydrated during her stay.

66. The report went onto highlight the action it had taken as a result of its investigation. This included:

    - assessment of the suitability of potential residents with problems with eating and drinking;
    - improved training for all care staff in the prevention and recognition of dehydration;
    - ensuring fluid was readily available to all residents in communal areas;
    - improved handover procedures;
        - an activity programme that included drinking.

67. The next recorded action by the Council is 28 August 2014 when a telephone discussion took place between the safeguarding manager and the care home's usual GP. This was

the GP who examined Mrs X on the day she left the care home and admitted her to hospital.

68. The GP did not see Mrs X at any point during her stay at the care home.

69. He commented that it was not unusual for people with dementia to be disturbed by being in a new environment and not respond to new carers, especially with eating and drinking. However he felt the carers should have been more aware of the deterioration in Mrs X's condition and raised the alarm earlier. He also said carers should have picked up on the issues of poor eating and drinking and discussed this with him. He also commented that *"[the care home] were aware that their fluid/nutrition charts were not filled in very well".*

The outcome of the safeguarding investigation

70. The Council completed its initial assessment of the safeguarding investigation on 28 August 2014. It records no concern of institutional abuse. It describes institutional abuse as "*organisational failure to effectively safeguard service users for whom it is responsible thereby placing service users at risk of physical, emotional or psychological harm as a result of abuse or neglect".*

71. It records that no further action is required.

72. The following day, 29 August 2014 the Council completed a '*Safeguarding Adults-Closure form'.* This records a finding of '*Neglect – Partially substantiated*'. It records the following outcomes:

- no requirement for a protection plan to be developed or implemented;
- safeguards put in place by alleged perpetrator Counselling/Training/Treatment;
- Risk Level – Risk Removed.

The Council's response

73. Mr X contacted the Council on 29 July 2014 to complain he had heard nothing from the Council in relation to the safeguarding alert and that he believed his concerns had not been taken seriously.

74. The Council telephoned Mr X on 1 August 2014 to explain the safeguarding alert would be closed as fluid charts showed his wife did have fluids but staff found it difficult to encourage her to drink.

75. The Council sent an email to Mr X on 1 September 2014 attaching a letter dated 6 July 2014 informing him of its findings of the safeguarding investigation. The letter referred to the safeguarding alert having been received by the Council on 7 June 2014. The Council says both these dates were incorrect and this had been due to human error.

76. The Council sent a subsequent email to Mr X on 1 September 2014 attaching a copy of its findings letter dated 1 September 2014. The letter explained the outcome of the safeguarding investigation.

77. It said *"I have been unable to identify events that led to your wife's severe dehydration and admission to hospital as fluid charts show your wife had been given fluid by staff at regular intervals".* It explained the care home's report set out the actions it would take to prevent other concerns being raised about fluid intake.

78. The letter went on to say that in order for Mr X to receive copies of his wife's care plans and fluid charts *"you would need to formally lodge a complaint regarding your wife's care".*

79. During our investigation the Council took the following action. It has:

- written to Mr X to acknowledge and apologise for its failure to deal with the safeguarding investigation properly and set out the action it has taken as a result.
- introduced new best practice safeguarding procedures which emphasise the importance of involving people /and/or their relatives fully in the safeguarding process.
- introduced standards around response times and completion times for adult safeguarding enquiries.
- introduced monthly meetings between the Safeguarding, Complaints, Health and Safety and Quality and Contracts Team to review information arising from safeguarding alerts and concerns, complaints, recent Care Quality Commission inspections and health and safety issues. A serious concerns / standards of care framework has been developed to support this.
- strengthened the management arrangements of the safeguarding service to ensure better management oversight of cases and the timescales for undertaking and completing safeguarding work.
- introduced a clearer process for escalating issues and maintaining oversight of provider services.
- introduced systems whereby the Care Quality Commission and the Council's Quality and Contracts Team will always be notified of the outcomes and conclusions of safeguarding investigations as a matter of course.

80. To ensure the above learning points are implemented the Safeguarding Team managers will review these points during their monthly case audits of safeguarding investigations.

81. Additionally the Council recently introduced quarterly Care Governance meetings. A representative of the Care Quality Commission and the Clinical Commissioning Group attend these meetings.

Conclusions

The care home's actions

The care provided to Mrs X

82. The safeguarding investigation completed by the Council into the care Mrs X received during her stay at the home concluded 'partial neglect'.

83. A finding of neglect is a serious failing and one which only a Court or a safeguarding investigation can find.

84. We have considered the documentary evidence supplied by the Council as part of its safeguarding investigation. We are satisfied the Council considered all the relevant evidence as part of its safeguarding investigation.

85. In light of the Council's findings we uphold Mr X's complaint about the quality of care provided to his wife at the care home.

How the care provider dealt with Mr X's complaint

86. The care home did not provide Mr X with a written response to his complaint until nine months after he had made his complaint. This falls short of effective complaint handling.

87. We have considered the comments contained within the care provider's written response to Mr X's complaint. The author makes reference to the completion of food/fluid records to support his findings. The records are incomplete and do not support the claims made by the author that food and fluid was offered but declined.

88. The author concluded there were no shortfalls in the care provided to Mrs X, when in fact there had been a finding of partial neglect. The author appears not to be aware of the outcome of the Council's safeguarding investigation.

89. The care provider has not explained why it refused to provide Mr X or his GP with Mrs X's care records, specifically the fluid/food records.

The Council's actions

90. There are a number of elements in this complaint which require consideration. Whether the Council responded appropriately to the safeguarding alert, if the process to investigate the concerns was timely and proportionate, and the action it took following the conclusion of the investigation.

91. The Council failed to engage with Mr X throughout the safeguarding investigation. This is fault.

92. When the Council received the safeguarding alert from the hospital it acted promptly. A safeguarding manager made relevant and timely enquiries of the hospital. Prompt contact was also made with the care home manager, to inform the manager of the allegations and

to ask that the manager investigate the matter and provide the Council with a report. There is no fault by the Council here.

93. The Council did not receive a report or any response from the care home by the deadline date, 16 April 2014. The Council took no action to chase the care home until 2 May 2014. This is not adequate. At this time the Council did not know the full extent of the events complained about and if there was a possible risk to other vulnerable residents at the care home.

94. The care home failed to respond to the Council's reminder. This should have given the Council cause for concern. It should have taken a proactive and firm approach in seeking a response from the care home. It failed to do this.

95. The Council took no further action until 28 July 2014, 14 weeks after it received the initial alert. Even then it did not act appropriately. It emailed the care home to say it would close the complaint and uphold the complaint if it did not receive the report. This is fault and is contrary to government guidance and the Council's policy.

96. This may have had grave consequences had other residents been at risk.

97. When the Council received the report from the care home it says it considered it alongside the supporting documents the care home provided, Mrs X's care records, including the food/fluid recording charts.

98. From this point on the Council's actions and decisions become contradictory and somewhat chaotic.

99. The Council appeared not to take any action whatsoever in response to the care home's report. It appears the matter never progressed beyond the initial investigation stage. Much of the paperwork is incomplete.

100. At this point in time there was conflicting information. The care home reported there was no deterioration in Mrs X's condition during her stay, yet she was admitted to hospital clearly unwell within a few hours of her discharge from the care home. The Council appeared to accept the care home's version of events without question.

101. The Council took no further action until Mr X contacted the Council on 29 July 2014 to ask about the progress of the investigation and express his concern.

102. The Council telephoned Mr X on 1 August 2014 to inform him the safeguarding alert would be closed as the charts showed his wife had been offered fluids but staff found it difficult to encourage her to drink.

103. It is difficult to know how the Council came to this decision if it had examined the fluid charts as it said it had. The charts did not support this finding. The Council was merely repeating the version of events given by the care home. The Council told Mr X it would discuss the fluid charts with the care home's GP when he returned from holiday.

104. On 28 August 2014, 18 weeks after the initial alert, a safeguarding manager had a telephone conversation with the care home's usual GP. The GP had not seen Mrs X throughout her stay. His opinion was that the actions of the care home were not adequate in this situation. He also commented that the food/fluid charts were no completed adequately. This contradicts the information the Council gave to Mr X on 1 August 2014.

105. This should have raised serious questions for the Council about the reliability of the report that had been produced. Also about the quality of care this home was providing to vulnerable residents who required support with diet and nutrition. The Council failed to identify the inconsistency in the records or give weight to the GP's comments. The Council failed to act on this information. This is fault.

106. The Council then closed the initial assessment. It took no further action. It recorded no organisational failure, neglect or abuse by the care home. However it upheld a finding of partial neglect. This is inconsistent and a failure to follow safeguarding procedures.

107. It appears the Council accepted without question the care home's proposal to implement actions as a 'learning outcome' from the complaint.

108. It is not clear if the Council told the care home it had come to a finding of partial neglect. The Council has no records to show whether it shared this information with the care home.

109. The Council did not inform its contract monitoring department of its findings. Neither did it inform the Care Quality Commission. This is fault which may have placed other residents at risk.

110. During this investigation the Council has acknowledged it failed to inform the relevant bodies of its finding of partial neglect. It did this in January 2016.

111. In September 2015 the care home was inspected by the Care Quality Commission and found to be in breach of three regulations, relating to record keeping of food and fluid intake and the usage, recording and storage of thickening agents used for people with swallowing difficulties.

112. If the Council had notified the relevant bodies of its findings the care at the home could have been monitored and prevented the continuation of poor care in this area being provided to other residents.

The Council's response to Mr X

113. The Council wrote to Mr X on 1 September 2014 to say it had not been able to establish the cause of his wife's dehydration. This is inaccurate and contrary to its findings.

114. The Council told Mr X he could obtain his wife's care records only if he lodged a formal complaint about her care. Why the Council had this view is unclear given Mr X had complained to the care home and pursed the Council for a response to the safeguarding alert. This is fault and added to Mr X's frustration and distress.

115. The Council's actions have caused Mr X a significant injustice. It has denied him a truthful outcome to his complaint. He has also suffered the stress and anxiety of pursing this complaint which has impacted on his grief at losing his wife.

Care Quality Commission Inspection of the care home 2015

116. Huntercombe Hall is a care home which is registered to provide both nursing and residential care. Its website says it specialises in providing care for various conditions, including care for older adults with dementia.

117. In October 2015 the Care Quality Commission carried out an unannounced inspection of the home. This concluded the home provided a caring service, rated as good, but identified five areas of concern which required improvement.

118. Under '*Is the service safe'* the Care Quality Commission found "*Thickening agent is used to reduce the risk of choking or older people with swallowing difficulties. The thickening agent was not stored safely… The containers of thickening agent did not have the details of the person it was prescribed for or the consistency required".*

119. Under *'Is the service responsive?'* the Care Quality Commission found *"Records were not always accurate and legible...". "Monitoring forms were not always completed in a timely manner. For example, on one unit people's food and fluid charts contained no entries at 11:00am...".*

120. The Care Quality Commission Inspectors found three breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It made numerous recommendations for improvement.

Decision

The care home's actions

121. The care home is at fault for failing to provide Mrs X with adequate care during her stay, which has been found to amount to partial neglect.

122. The care home failed to respond to Mr X's complaint properly.

The Council's actions

123. The Council is at fault for failing to act in accordance with the law and relevant government guidance. It:

- did not adhere to the guidance as set out in the Department of Health statutory guidance (No Secrets) on safeguarding adults;
- failed to follow its policy and procedure relating to safeguarding investigations;
- failed to inform its monitoring department of its finding of partial neglect;

- failed to inform the Care Quality Commission of its finding of partial neglect

- failed to engage with Mr X throughout the safeguarding investigation and failed to inform him of its findings.

124. The Council's actions caused Mr X a significant injustice.

Recommendations

125. The care provider should:

- provide Mr X with a full written apology for its failure to provide adequate care to his wife;

- apologise for its failure to deal with Mr X's complaint properly; and

- waive the full fee for Mrs X's stay at the care home.

126. The Council should pay Mr X:

- £250 for his time and trouble pursuing this complaint; and

- £500 for his distress

127. During this investigation the Council has voluntarily implemented robust and extensive improvements to its policies and procedures (see paragraphs 80, 81 & 82). This action is welcomed.

128. The Council has also written to Mr X to provide him with a full written apology for its failings and set out the action it has taken as a result.