Local Government &
Social Care
OMBUDSMAN

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Report by the Local Government and Social Care Ombudsman

Investigation into a complaint against Surrey County Council (reference number: 19 020 697)

10 February 2021

The Ombudsman's role

For more than 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.

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

Mrs X	The complainant
Mrs Y	Her late mother

Report summary

Adult care services

Mrs X complained about her late mother's (Mrs Y's) care on the day she died. Surrey County Council (the Council) arranged and funded Mrs Y's care in Puttenham Hill Care Home (the Care Home). Mrs X complained the care home:

- delayed in calling emergency services;
- did not have appropriate staff; and
- did not protect Mrs Y's dignity when she was dying, provide appropriate care or communicate with the family adequately.

Mrs X says this caused her avoidable distress. She found her mother's body unexpectedly, causing her significant shock at the time and alarm that such a situation could have occurred.

Finding

Fault causing injustice and recommendations made.

Recommendations

The care home no longer uses the member of agency staff and it has discussed the events of this complaint with current staff at meetings and apologised to Mrs X for the fault. This is a partial remedy.

To remedy the distress to Mrs X and minimise the risk of future injustice to others, the Council will, within one month of the date of this report:

- work with the Care Home through regular quality monitoring visits, to ensure the Care Home is regularly assessing staffing capacity and requirements so there are enough appropriately qualified staff at the care home;
- apologise to Mrs X for the fault identified and for her avoidable distress; and
- make Mrs X a symbolic payment of £500.

Within three months of the date of this report, the Council should ensure all care staff (nurses and care assistants) at the Care Home receive training in communication skills around bereavement.

The complaint

1. Mrs X complained about her late mother's (Mrs Y's) care on the day she died. Surrey County Council (the Council) arranged and funded Mrs Y's care. Mrs X said Puttenham Hill Care Home (the Care Home), owned by BUPA (the Care Provider):

- delayed in calling emergency services;
- did not have appropriate staff; and
- did not protect Mrs Y's dignity when she was dying, provide appropriate care or communicate with the family adequately.

2. This caused Mrs X avoidable distress. She found her mother's body unexpectedly, causing her significant shock at the time and alarm that such a situation could have occurred.

Legal and administrative background

The Ombudsman's role and powers

3. We investigate complaints about councils and certain other bodies. Where an individual, organisation or private company is providing services on behalf of a council, we can investigate complaints about the actions of these providers. ***(Local Government Act 1974, section 25(7), as amended)***

4. We investigate 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), as amended)***

5. We normally name care homes in our decision statements and reports. However, we will not do so if we think someone could be identified from the name of the care home. ***(Local Government Act 1974, section 34H(8), as amended)***

The law, policy and guidance

6. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) set out the requirements for safety and quality in care provision. The Care Quality Commission (CQC) issued guidance in March 2015 on meeting the 2014 Regulations (the Fundamental Standards). We consider the 2014 Regulations and the Fundamental Standards, as well as a provider's policies and procedures, when determining complaints about poor standards of care. The following regulations are relevant to this complaint.

- Regulation 10. This requires a care provider to treat people with dignity and respect. Guidance explains people must be treated in a caring and compassionate way.
- Regulation 12(i). This requires care providers to provide care and treatment in a safe way, including by working with health professionals to ensure the health and welfare of residents.
- Regulation 17. This requires a care provider to keep accurate, complete and contemporaneous records of care and treatment.

- Regulation 18. This requires a care provider to have sufficient qualified, competent, skilled and experienced staff who have received appropriate support and training to enable them to carry out their duties.

7. The Care Provider has a policy for staff dealing with expected and unexpected deaths. In the case of an unexpected death:
   - staff must immediately contact emergency services to attend and must inform the service manager in charge;
   - staff should not make any assumption about life being extinct until verified by the emergency responders. Staff must leave everything as they find it until the emergency services and senior manager have reviewed the area;
   - staff must keep accurate contemporaneous records of an unexpected death including the time the resident was found;
   - staff must inform the police immediately of an unexpected death and must also contact the GP as soon as possible;
   - family will be informed as soon as possible;
   - after death, staff must ensure the person receives dignity, privacy and respect in the care they receive; and
   - staff need to have the relevant skills and knowledge to provide bereavement care. Appropriate communication skills are required at the time and after a death in order to have sensitive conversations.

8. The Care Provider has a procedure in place for staff when dealing with 'last offices' or 'laying out'. This covers procedures for preparing the deceased (by washing and dressing them) before taking them to a funeral home. The aim is to enhance the way the body appears to relatives who wish to pay their last respects in the care home, providing dignity and respect. The guidance to staff says:
   - unexpected deaths must be confirmed by a doctor;
   - in cases of unexpected death, do not complete last offices until this has been discussed with the doctor;
   - refer to care planning documents to see what the person's wishes were and adhere to those wishes where it is possible;
   - explain all procedures to relatives with sensitivity; and
   - ensure the room is tidy, make the bed and ensure the floor is clean and free of clutter.

9. If a council has reasonable cause to suspect abuse of an adult who needs care and support, it must make whatever enquiries it thinks is necessary to decide whether any action should be taken to protect the adult. ***(Care Act 2014, section 42)***

10. The Human Rights Act 1998 brought the rights in the European Convention on Human Rights into UK law. Public bodies, including councils, must act in a way to respect and protect human rights. It is unlawful for a public body to act in a way which is incompatible with a human right. 'Act' includes a failure to act. ***(Human Rights Act 1998, section 6)***

11. Care providers regulated by the Care Quality Commission are public bodies for the purposes of the Human Rights Act, if care is arranged and provided under a council's statutory duties in the Care Act 2014. ***(Care Act 2014, section 73)***

12. It is not our role to decide whether a person's human rights have been breached. That is for the courts. We decide whether there has been fault causing injustice. Where relevant, we consider whether a council has acted in line with legal obligations in section 6 of the Human Rights Act 1998. We may find fault where a council cannot evidence it had regard to a person's human rights or if it cannot justify an interference with a qualified right.

13. Article 8 of the European Convention on Human Rights says everyone has a right to respect for their private and family life, home and correspondence. This right is qualified which means it may need to be balanced against other people's rights or those of the wider public. A qualified right can be interfered with only if the interference is designed to pursue a legitimate aim, is a proportionate interference and is necessary. Legitimate aims include:

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- the protection of other people's rights;
- national security;
- public safety;
- the prevention of crime; and
- the protection of health.

How we considered this complaint

14. We considered:

- the complaint to us;
- the Care Provider's response to the complaint; and
- documents from the Council and Care Provider described later in this report.

15. We discussed the complaint with Mrs X.

16. Mrs X, the Care Provider and the Council received a draft of this report. We considered their comments before issuing the final report.

What we found

What happened

Background

17. Mrs Y had a lung condition which caused breathlessness. She moved into the Care Home in 2018 after living with Mrs X for many years. Mrs Y used oxygen all the time. She needed help from one carer to move around and used a walking frame to walk short distances. Mrs Y did not have an end of life care plan. She had a 'do not attempt resuscitation' notice in place, which she had signed. This meant Mrs Y was not to receive resuscitation if her heart stopped.

18. Mrs Y died in August 2019, suddenly, of a brain haemorrhage, confirmed by the coroner. The coroner's officer said '*it would be difficult for staff to predict this type of event unless they are routinely monitoring the person's blood pressure and pulse and even then it can be spontaneous and catastrophic. When the event starts to happen if it starts to present as a headache and feeling a bit wobbly, it is not automatic to think the person is having a brain haemorrhage. It could be a cold or a virus.*'

19. Mrs Y's death was not suspicious, but it was unexpected. Mrs X's complaint is about the nurse in charge on the day Mrs Y died, the way the nurse cared for her mother and about how the nurse communicated with her, with Mrs Y and with other staff. The nurse was employed by an agency.

20. Our role is not to adjudicate on the competence of professionals, but we do consider the actions of staff to assess whether a body in our remit is at fault. Our findings are against the Council, which was responsible for commissioning Mrs Y's care and not against the individual members of staff mentioned in this report.

The nurse's daily notes on the day Mrs Y died

21. The nurse made the following notes in Mrs Y's care record.

- *"15:30: Mrs* [Y] *took her due medication at 09:00. Continued with oxygen. Fluid tolerated. Checked, appeared breathless though on oxygen.*
- *16:10: Was called to check Mrs* [Y]*… care staff was worried with her breathing….I took the BP* [blood pressure] *machine*. [The nurse recorded the readings of Mrs Y's blood pressure, temperature, and oxygen levels.]
- *16:20: Checked again then went to get her paracetamol as she was complaining of a headache. I asked her to try and transfer to bed so I could check her observations while she was in bed. She stood up then lost her balance then she slid on to the floor she then scratched the side of her face sustained a small skin tear. Raised the emergency alarm, staff responded then she was assisted to bed.*
- *16:30: While she was in her bed she took paracetamol and had her inhaler.* [The nurse recorded the readings of Mrs Y's blood pressure, temperature, and oxygen levels again and for a third time at 16:45.]
- *16:50: Called the out of hours doctor about Mrs* [Y's] *breathing and chest.*
- *17:10: Daughter informed of Mrs* [Y's] *critical condition which appeared to be deteriorating.*
- *17:20: Mrs* [Y] *appeared not to be responding to verbal stimuli. Called the paramedics and informed them Mrs* [Y] *was not breathing. When the relatives came they said she had a pulse.*
- *17:45: Called the paramedics as the relatives asked me to call them again. While I was on the phone the paramedics arrived. Went to Mrs* [Y] *and applied the leads and monitors……..*
- *18:50: Informed the home manager.*
- *18:50: Out of hours doctor called.*
- *19:10: Had an interview with the police"*

22. The nurse also gave a written statement to the agency which employed her. This is similar to the record set out above, with some extra details.

23. Mrs X told us there were some differences between what the nurse put in Mrs Y's care records and what the nurse told her on the day. Mrs X told us on her arrival at the Care Home, she was left in reception, there were care assistants running around and the nurse ignored her. Mrs X also told us:

- the nurse did not say on the phone that Mrs Y's condition was critical, only that she had a headache and breathing difficulties;

- the nurse said she had accidentally scratched Mrs Y's face during the fall;
- she did not ask the nurse to call the paramedics; and
- the home manager told her she only found out Mrs Y had died after receiving an email from Mrs X the following day.

Mrs X's complaint to the Care Provider

24. Mrs X emailed the Care Provider and the Council the day after Mrs Y's death saying:

- the nurse called her at 17.11 saying she had put Mrs Y to bed as she was having breathing difficulties;
- she (Mrs X) arrived at the Care Home at 17.30. One carer told her to wait in reception. Another carer said he could not say what was happening. The nurse came, she appeared agitated and was unclear. The nurse said Mrs Y's breathing was not good and she had a headache. She talked about not having enough time. She said Mrs Y had taken paracetamol and she had called 111;
- she (Mrs X) went to Mrs Y's room after 15 minutes. Mrs Y was alone, lying on the bed and there was dried blood on the floor and oxygen pipes to her nose. It was apparent Mrs Y had died. Nobody prepared her for this. Two other carers came into the room;
- the paramedics arrived and said Mrs Y had died. The paramedics told her they received two calls at 17.32 and 17.46 and this was in their report;
- the nurse told the paramedics what had happened; and
- the nurse went past her a few times and did not speak to her or offer her any support or empathy.

The Care Provider's investigation report

25. Senior staff at the Care Provider carried out an investigation. This concluded:

- the nurse followed the correct procedure by contacting 111 first. Then Mrs Y's breathing worsened and so the nurse called 999. This action was also correct;
- the manager checked all agency nurses' profiles before hiring them. The nurse completed an induction before starting work and would have had a full handover;
- the cause of death was a brain haemorrhage which is difficult to spot. The nurse correctly gave pain relief for a headache, assisted Mrs Y by trying to support her to lie down and rest. Mrs Y lost her balance and fell, causing a small cut to her face. The nurse's actions were all appropriate and did not suggest concerns about her competence or knowledge;
- the care assistants were familiar with Mrs Y and so it was appropriate for the nurse to pay some attention to their advice, while also relying on her nursing assessment of Mrs Y and clinical judgement;
- all agency nurses should be reminded of BUPA's internal procedures including contacting the on-call manager in the event of an emergency;
- all agency nurses who cover shifts in the home on a regular basis should continue to attend nurses' team meetings and to have access to the communication book and any internal communication; and

- the Care Home should continue to ensure agency staff profiles including their training and competency should be reviewed to ensure up to date detail is in place.

The Council's safeguarding investigation

26. The Council carried out a safeguarding investigation under section 42 of the Care Act 2014 (see paragraph 9). The safeguarding officer obtained information from the Care Provider, the agency, statements from carers and the nurse and records from the ambulance service. The report of the safeguarding investigation concluded:
    - having only one nurse on duty was not sufficient;
    - the ambulance service confirmed the first call to them was at 17.32 and this was classified as life threatening. This call was then downgraded to urgent as the nurse told the operator Mrs Y had died and this was an expected death with a do not attempt resusitation notice in place. There was then a second call at 17.47 where the ambulance service recorded the nurse said Mrs Y had been taking irregular breaths, so the call was re-classified as life threatening;
    - it was unclear if the nurse called an ambulance soon enough or gave accurate information to the operator;
    - other staff and Mrs Y's family had to prompt the nurse to check on her and call 999 again;
    - the nurse didn't fully consider the opinions of other staff who knew Mrs Y better and whether they could have done more to support Mrs Y;
    - the nurse didn't fully communicate to other staff how she was managing the situation or how they could assist;
    - the nurse didn't contact the Care Home's manager soon enough;
    - Mrs Y likely died alone;
    - the Care Home's protocol for maintaining dignity at the end of life wasn't followed;
    - record-keeping of the incident was not adequate; and
    - the nurse did not conduct herself professionally towards the family.
27. Recommendations from the safeguarding investigation were: the Care Home should review staffing ratios and should consider how care assistants could raise concerns apart from to the nurse on duty.
28. The Council's safeguarding manager raised queries with the Care Home's manager in December 2019. The manager said the nurse did not follow the Care Provider's procedure after death because:
    - Mrs Y was still attached to oxygen which was switched on, the monitor was still attached to her finger, there was blood on the floor and her eyes were open; and
    - she left Mrs X with the paramedics and there should have been another member of staff present to offer support.

The Care Provider's response to the complaint

29. The Care Provider responded to Mrs X's complaint in March 2020. It apologised for the nurse's conduct and said:

- it was sorry for the delay in responding, but it needed to wait for the Council to finish the safeguarding investigation;
- it accepted the nurse did not consider care assistants' opinions and she did not manage the situation appropriately. She did not communicate with others how she was managing the situation or how they could assist. She should have contacted the Care Home's manager sooner;
- the nurse would no longer be used. The agency agreed the nurse should have contacted the manager;
- the manager tried to avoid using agency staff at the weekends or nights. Staff reflected on the incident in a staff meeting; and
- the nurse said in a statement that she rang 999 at 17.20. The paramedics automated system reported a call at 17.32. Mrs Y's emergency bell went off at 17.28. This supported a call to the emergency services after 17.28 (so at 17.32).

Comments from the Care Provider

30. The Care Provider told us:

- there were enough staff on duty: four carers and one nurse for 16 residents;
- there is always an on-call manager at weekends, either the Care Home's manager or the deputy. The managers always telephone the Care Home in the morning to check everything is ok and to remind the nurse on duty to call if they have any concerns. There is always a manager on call when there is not a manager present in the home, day or night. There is always a notice up in the nurses' station and in the front of the allocation folder, for all the staff to see who is on call and the correct contact number for them to call. On the day of the incident, the manager had called the care home in the morning as always and reminded the nurse to call her if she had any concerns; and
- the manager minimises the use of agency nurses at nights and weekends, but this is not always possible where staff are sick. The manager currently uses a regular agency nurse at night (he has worked there for two years) and he attends all nurses' meetings and staff training and is one of the team.

Was there fault?

31. When a council commissions another organisation to provide services on its behalf it remains responsible for those services and for the actions of the organisation providing them. So, any fault in the care Mrs Y received at the Care Home is fault by the Council. The Care Provider acted on the Council's behalf when providing services to Mrs Y.

There was a delay in calling emergency services

32. There is conflicting evidence about the timing of the nurse's calls to the emergency services. In Mrs Y's care records, the nurse noted she made two calls to 999: the first at 17.20 and the second at 17.45. This information is unlikely to be accurate because the NHS's automated system recorded the first call at 17.32 and a second call at 17.47. Regulation 17 of the 2014 Regulations requires care providers to keep accurate records. The record keeping fell below expected standards and this was fault.

33. We note the nurse also wrote in the care records that Mrs Y's condition was 'critical' at 17.10 so she called Mrs X. The nurse however did not call 999 at the same time as calling Mrs X. According to the care records she called 999 at

17.20, however, the NHS records indicate the first call was not until 17.32. As set out in the previous paragraph, we consider the NHS record is likely to be the accurate one as it is an automated system. This means there was probably a delay of 22 minutes in contacting 999 after the nurse decided Mrs Y was in a critical condition. Care to Mrs Y fell below expected standards: it was not in line with Regulation 12(i) of the 2014 Regulations. There was no effective way of working with the NHS to ensure Mrs Y received timely medical care from the paramedics.

34. The Council's safeguarding investigation concluded it was 'unclear' whether the nurse called 999 soon enough or gave accurate information to the emergency services because the call priority was downgraded then upgraded. There is not enough evidence to conclude the nurse's information to the 999 operator was inaccurate. We note the nurse is reported to have told the operator Mrs Y had stopped breathing and it was an expected death. While it later turned out that Mrs Y had a brain haemorrhage, the nurse could not have known this at the time and she may have reasonably believed Mrs Y had stopped breathing due to a deterioration in her pre-existing lung condition. We note comments from the coroner's officer that the haemorrhage was difficult to spot and could have been misidentified for various non-fatal medical conditions.

35. In any event, the outcome for Mrs Y would not have been any different had there not been a delay in summoning the paramedics because she had signed a 'do not attempt resuscitation' notice which the paramedics treating her respected.

The Care Home did not have appropriate staff

36. The Council's safeguarding enquiry concluded having only one nurse on duty was not sufficient. And the Council recommended the Care Home considered staffing ratios. The Care Provider told us four carers and one nurse on duty was sufficient. We cannot say whether one nurse for 16 residents is an appropriate ratio because it depends on the profile and needs of all the residents living in the Care Home at the time and we do not have this information. However, the Council, as commissioner of the placement, needed to be satisfied the service met the needs of those it placed there. The Council identified a lack of qualified staff. We are not satisfied the service to Mrs Y met the requirements of Regulation 18 of the 2014 Regulations and this was fault. Nor are we satisfied appropriate action has since been taken in response to an identified problem.

Staff did not protect Mrs Y's dignity when she was dying, provide appropriate care or communicate with the family adequately

37. The Council's safeguarding enquiry and the Care Provider's complaint response upheld Mrs X's concerns about the nurse's conduct including her communication with staff, with Mrs X and her lack of communication with the on-call manager, which was a breach of the Care Provider's procedures.

38. Communication and support was inadequate, especially with Mrs X. Mrs X should not have found her mother alone in her bedroom, with no forewarning of Mrs Y's presentation. Mrs Y should not have been alone when she died; she should have had staff present in the room with her to support her. Mrs X should also not have had to speak to the paramedics on her own without any support from staff at the Care Home.

39. The failings above were in breach of the Care Provider's procedures as we have described in paragraphs 7 and 8. And, Mrs Y's care in the final moments of life

did not meet the standards set out in Regulation 10 of the 2014 Regulations because it was neither compassionate nor dignified.

40. Mrs Y's care was arranged and funded by the Council and so by section 73 of the Care Act 2014, the Care Home acts as a public authority for the purposes of the Human Rights Act. We do not consider the Care Provider, which acted on behalf of the Council, provided services in a way which had regard to Mrs X or Mrs Y's right to respect for family and private life.

Did the fault cause injustice?

41. Because of the fault identified above, Mrs Y was alone in her final moments of life with no support from care staff or the nurse, potentially suffering avoidable distress. Mrs X also suffered avoidable distress because she was left in a waiting area, knowing only her mother was critically unwell, but not that she was dying or very close to death. Mrs X suffered further avoidable distress when entering Mrs Y's room because the body was unprepared. While it may have been necessary to preserve the body untouched as this was a sudden death, staff should have spoken to Mrs X before she entered the room so she would have been better mentally prepared and perhaps less shocked. Sadly, Mrs X also missed the opportunity to be with Mrs Y before she died. This is a further avoidable distress.

Agreed action

42. The Care Provider no longer uses the nurse and it has discussed the events of this complaint with staff at meetings and apologised to Mrs X for the fault. This is a partial remedy.

43. To remedy the distress to Mrs X and minimise the risk of future injustice to others, the Council will, within one month of the date of this report:

- work with the Care Provider through regular quality monitoring visits, to ensure the Care Home is regularly assessing staffing capacity and requirements so there are enough appropriately qualified staff at the Care Home;
- apologise to Mrs X for the fault identified and for her avoidable distress; and
- make Mrs X a symbolic payment of £500.

44. Within three months of the date of this report, the Council should ensure all care staff (nurses and care assistants) at the Care Home receive training in communication skills around bereavement.

45. The Council has accepted the above recommendations, which we welcome.

46. The Council must consider the report and confirm within three months the action it has taken or proposes to take. The Council should consider the report at its full Council, Cabinet or other appropriately delegated committee of elected members and we will require evidence of this. ***(Local Government Act 1974, section 31(2), as amended)***

Final decision

47. We uphold Mrs X's complaint about her late mother Mrs Y's care on the day she died. The Council will apologise and make a symbolic payment to recognise Mrs X's avoidable distress. The Council will also work with the Care Home to ensure the Care Home (1) has enough nurses and (2) provides training to all staff in communication around bereavement.