Scottish Parliament Region: North East Scotland

Case 200503379: The Scottish Commission for the Regulation of Care

Summary of Investigation

Category

Scottish Executive and Devolved Administration: Scottish Commission for the Regulation of Care, Complaints handling

Overview

The complainant (Mr C) was unhappy with an investigation undertaken by the Scottish Commission for the Regulation of Care (the Commission) into his complaint that his mother (Mrs D) had been prevented from leaving the Care Home (the Home) where she was resident.

Specific complaint and conclusion

The complaint which has been investigated is that the initial report and subsequent review of Mr C's complaint about the Home were flawed. In particular, that all the evidence was not taken into account and the initial report focussed on the social work department and not on the complaint actually made (*not upheld*).

Redress and recommendation

The Ombudsman makes no recommendations.

Main Investigation Report

Introduction

1. The Ombudsman received a complaint from a man referred to in this report as Mr C. Mr C's mother (Mrs D) had become resident in the Home on 10 November 2004 following an assessment by a psychogeriatric consultant (the Consultant) that, because of Mrs D's vascular dementia, she was unable to look after herself in the community.

2. Social work review meetings were held on 6 and 20 December 2004. Mr C was present at the second meeting and expressed his wish to take Mrs D home. The meeting concluded that Mrs D should remain in the Home. On 24 May 2005 Mr C visited his mother at the Home and requested to take her out. He signed a document to say he would bring her back. Mr C returned later that day to say Mrs D would be staying with him and asked for her clothes.

3. Mr C complained to the Scottish Commission for the Regulation of Care (the Commission) about the Home saying the social work department had told the owner of the Home (the Owner) his mother was free to leave and that he should not have been made to sign any document. He was also concerned about how her medication was handled. The Commission investigated Mr C's complaint and in a letter to him dated 25 November 2005 did not uphold his complaints. Mr C asked for a review of this decision. He said that evidence supplied by the Home and the social work department to the Commission was wrong. In particular, he claimed the social workers who had signed the notes of a meeting of 6 December 2004 had knowingly signed a false document and only one of the social workers was present. He said that Mrs D was always a voluntary patient, had had no initial assessment and there was evidence the Owner had been informed of the true legal position by the social work department. He claimed the actions of the Owner were illegal.

4. A review was held by the Commission and on 15 February 2006 Mr C was informed by the Commission that there was no evidence to support his concerns they had been supplied false information, that the original investigation was based on the available evidence and was reasonable.

5. The complaint from Mr C which I have investigated is that the Commission's initial report and subsequent review of Mr C's complaint about the Home were flawed. In particular, that all the evidence was not taken into

account and the initial report focussed on the social work department rather than on the complaint actually made.

Investigation

6. In investigating this complaint, I have obtained all the relevant documentation and complaint file from the Commission including notes of an unannounced visit to the Home. I have also considered documentation produced by Mr C. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Commission were given an opportunity to comment on a draft of this report. A summary of abbreviations used is contained in Annex 1. A glossary of medical terms is contained in Annex 2.

Complaint: The initial report and subsequent review of Mr C's complaint about the Home were flawed. In particular, that all the evidence was not taken into account and the initial report focussed on the social work department rather than on the complaint actually made

7. Mr C's letter of complaint to the Commission was dated 28 August 2005. This was acknowledged, with an apology for the delay in acknowledging the letter due to staff absence, on 14 September 2005. On the same day the Commission advised him that a complaints investigation officer (Officer 1) would be responsible for this investigation. Officer 1 wrote to Mr C on 10 October 2005 asking him to contact her and spoke to him about his complaint by telephone on 28 October 2005. She visited the Home, interviewed the Owner and depute manager and reviewed documentation relating to Mrs D's care. This included details of social work involvement.

8. On 25 November 2005 the Commission wrote to Mr C to say that his complaints were not upheld. They noted that the decision of the social work review on 20 December 2004 was that it was in Mrs D's best interest that she remain at the Home and that she had indicated she wished to do so. They also said that a note indicated that Mrs D had told a senior social worker that she wished to stay at the Home in April 2005. It was accepted that Mrs D did leave the Home on three occasions but that this was consistent with her tendency to wander and she had settled quickly when returned. The letter stated there was no written evidence to suggest that the social work department advised the Owner that Mrs D was free to leave to return to her own home. The letter further said that the document Mr C had been given to sign on 24 May 2005

was not binding but that it had been reasonable of the Owner to record his intentions as it formalised the arrangement.

9. In Mr C's letter to the Commission of 5 December 2005 asking that this be reviewed, he said there was no evidence that Mrs D required to be in a home and that she was free to leave. He said Mrs D asked him on 13 December 2004 that he take her home but the Owner had refused to allow this. He also said that at the meeting on 20 December 2004, Mrs D was not present and the decision was made by a sole social worker. He maintained that the Owner had made him sign the document on the basis of advice given to the Owner by the social work department. Mr C enclosed a number of documents. One contained information relating to the Consultant which said the Consultant had met with Mrs D in early August 2004 and she had been diagnosed with vascular dementia. It explained her condition deteriorated and she was admitted to hospital for assessment. Following this, it was felt 24 hour care was beneficial and the Consultant was said to have explained to Mrs D the concerns he had should she return to the community and that her care would be best met in a care home. The document states that the Consultant told Mrs D she had been admitted on a voluntary basis and that it had been confirmed she would be free to leave at any time. Mr C also enclosed case notes from the social work department, a list of Mrs D's medication and a letter which he said Mrs D authorised and signed dated 20 April 2005 asking that she be allowed to leave the Home with Mr C.

10. The review was undertaken by a team manager within the Commission. The team manager examined all the paperwork provided for the original investigation, examined additional correspondence provided by Mr C, and discussed the complaint with Officer 1. The letter to Mr C dated 15 February 2006 did not alter Officer 1's findings and said that there was no evidence to support Mr C's concern that information supplied by the social work service was 'erroneous'. It also confirmed that at the meeting on 20 December 2004 (paragraph 8) it was agreed Mrs D would remain at the Home and that Mr C had said he would take legal advice regarding Mrs D's care.

11. In reviewing the documentation I had sight of the notes of the social work review meetings dated 6 and 20 December 2004 and case notes produced by social workers on 13 December 2004 and 24 April 2005.

12. At the first review meeting on 6 December 2004 it is stated that it was difficult to ascertain Mrs D's views due to dementia and that Mrs D's family wanted Mrs D nearer them and had identified the Home as suitable.

13. The review of 20 December 2004 was set up to allow the family to discuss their concerns. Mr C and his wife (Mrs C) were present as were Mr C's brother (Mr A) and his wife (Mrs A). The summary of the meeting states:

> '[Mr A] agrees that his mother's care needs are best met within [the Home]. Mr C states that he would like to take his mother home to her own home and be a full time carer. This would prove very difficult as Mrs D is in need of 24 hour supervision as she is known to wander. There is obviously disagreement about the type of care and where her care is to take place. [Mrs D] has quite categorically stated that she does not wish to stay with either of her sons. She would like them to visit on a regular basis.

14. The social work case note of 24 April 2005 said that during a visit to the Home a social worker had 'explained the legal position regarding [Mrs D] leaving the home with her son and that she is free to go if that is her wish'. It said that the Owner had agreed to convey the information regarding the legal position to staff and would personally make an attempt to be available should Mr C want to take his mother out. The note also confirmed the social worker interviewed Mrs D and that Mrs D had said she did not want to live with either son and their family and would prefer to live on her own.

Conclusion

15. On the basis of the evidence of the paperwork obtained and the interview notes, I consider that the Commission have undertaken a thorough investigation and review into Mr C's complaint. In particular, there is nothing that suggests the investigation wrongly concentrated on the social work department or that all the evidence was not taken into account. The question of communication between the Home and the social work department was at issue and correctly investigated. It should also be noted that the evidence available for the review did not fully support Mr C's claim that Mrs D had been held against her will but rather indicated her preference to live alone which, because of her health, would have been impossible. Accordingly, I do not uphold this complaint.

Recommendation

16. The Ombudsman has no recommendations to make.

[laying date]

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Commission	The Scottish Commission for the Regulation of Care
Mrs D	The complainant's mother
The Home	Care Home in which Mrs D was resident
The Consultant	The psychogeriatric consultant who assessed Mrs D
The Owner	The owner of the Care Home
Officer 1	The officer from the Commission who undertook the initial investigation
Mrs C	The complaint's wife
Mr A	The complainant's brother
Mrs A	The complainant's sister-in-law

Annex 2

Glossary of terms

Psychogeriatric	A branch of psychiatry which specialises in the elderly
Vascular dementia	Vascular dementia is a type of dementia caused by problems in the supply of blood in the brain