21 February 2023

Complaint reference:
22 001 037

Complaint against:
Nottinghamshire County Council
Dementia Outreach Service
Church Farm Care Home

Local Government & Social Care OMBUDSMAN

Parliamentary and Health Service Ombudsman

The Ombudsmen's decision

Summary: Miss C has complained about a Home, Council and a Dementia Outreach Service about the care of her late mother, Mrs D. We found fault with the Home with oral care and nutrition and the Council in Mrs D's move to a new care home. We did not find fault with Dementia Outreach.

The complaint

1. Miss C complains about the care and treatment of her mother, Mrs D, by Church Farm Care Home (the Home), Nottingham County Council (the Council) and the Dementia Outreach Service (Dementia Outreach) run by Nottinghamshire Healthcare NHS Foundation Trust (the Trust) in late 2021 and early 2022. She is also unhappy about how these organisations decided to move her mother to a new care home (the New Home).
2. Specifically, Miss C complains about:
   - a lack of oral care for her mother,
   - a lack of nutrition for her mother leading to weight loss,
   - diazepam management by the Home and Dementia Outreach,
   - the decision to move her mother to a different home,
   - unexplained bruises,
   - the coldness of her mother's room,
   - infection control,
   - Christmas dinner being cold,
   - lost property,
   - rudeness of staff and;
   - her mother was left in a wheelchair without its brakes on
3. Miss C says the alleged failings in care led to distress and pain for her mother. She also says the move to the New Home may have hastened her mother's death. Because of the events of this complaint Miss C has said she was off work with stress and was prescribed antidepressants.
4. Miss C wants some financial compensation to help pay for her mother's funeral costs. She also wants an apology and an admission her mother should not have been moved.

What I have and have not investigated

5. I have investigated:
   - a lack of oral care for Mrs D,
   - a lack of nutrition for Mrs D leading to weight loss,
   - diazepam management by the Home and Dementia Outreach and;
   - the decision to move Mrs D to a different home.

I have not investigated:
- unexplained bruises,
- the coldness of Mrs D's room,
- infection control,
- Christmas dinner being cold,
- lost property,
- rudeness of staff and;
- Mrs D was left in a wheelchair without its brakes on.

6. With the unexplained bruises an investigation would not find the cause of these bruises. The Home has responded appropriately by telling Miss C what action it took, that it gave her mother painkillers and apologising for not keeping Miss C informed.
7. On the coldness of Mrs D's room, we cannot investigate at this later stage what temperature the room was, and the Home has given an explanation which we could not investigate further.
8. There was a fault as the Home has admitted not checking the COVID-19 test results of visitors. However we could not find that this was the direct cause of Mrs D catching COVID-19 as other factors could have led to her infection. The Home has also apologised and it changed its practice so we would not add anything to this response.
9. It would not be a proportionate use of our resources to investigate the issue of Miss C and her mother's Christmas dinner being cold and the Home has already apologised.
10. Also, we will not be investigating the issue of lost property as we would not find out what happened to the missing property after this amount of time has passed. Further, the Home has responded appropriately to this complaint.
11. The Home has responded to the complaint about rudeness of staff and we could not prove whether staff were rude or not and so we will not be exploring this issue.
12. The Home has responded to the issue with the wheelchair brakes. An investigation by the Ombudsmen would not shed any further light on this issue as there would be no written record of whether Mrs D's wheelchair brakes were on or off.

The Ombudsmen's role and powers

13. The Ombudsmen investigate complaints about 'maladministration' and 'service failure'. We use the word 'fault' to refer to these. If there has been fault, the Ombudsmen consider whether it has caused injustice or hardship ***(Health Service***

Commissioners Act 1993, section 3(1) and Local Government Act 1974, sections 26(1) and 26A(1), as amended).

14. If it has, they may suggest a remedy. Our recommendations might include asking the organisation to apologise or to pay a financial remedy, for example, for inconvenience or worry caused. We might also recommend the organisation takes action to stop the same mistakes happening again.
15. If the Ombudsmen are satisfied with the actions or proposed actions of the bodies that are the subject of the complaint, they can complete their investigation and issue a decision statement. ***(Health Service Commissioners Act 1993, section 18ZA and Local Government Act 1974, section 30(1B) and 34H(i), as amended)***

How I considered this complaint

16. During this investigation I have considered evidence from Miss C and from the Council, the Home and Dementia Outreach. I have also considered the relevant guidance and legislation. I am sharing this draft decision with Miss C and the organisations to give them the opportunity to comment on it before I make my final decision.

What I found

Background

17. Mrs D had dementia and entered the Home in early December 2021. She had previously lived in her own home. In January 2022 Mrs D was assessed as ineligible for Continuing Healthcare funding. This is funding from the NHS for someone’s care when they meet the criteria of having a primary health need. This decision meant the NHS was no longer solely paying for Mrs D’s stay at the Home.
18. From this point the NHS provided funding for nursing care and the Council was responsible for the rest of the Home’s fees. At this point it emerged the Home charged an extra ‘top up fee’ for its services. A care home top-up fee is an extra payment that makes up the difference between what the Council will pay and the full cost of a care home.
19. The top-up is usually paid by a relative, friend or another third party. It is sometimes called a third-party top-up fee.
20. As the Council would not fund, and the family could not fund the third party fees, the Council took the decision to move Mrs D to the New Home. Mrs D moved to the New Home in February 2022. She died of heart failure in February 2022 shortly after the move.
21. Miss C complained about her mother’s care and the move to the New Home. The Council and the Home investigated these complaints and responded to Miss C before she approached the Ombudsmen with her complaint which then also included Dementia Outreach. Dementia Outreach responded to Mrs D’s complaints during our investigation.
22. Dementia Outreach offers specialist support to care homes having difficulty managing behaviours related to an individual’s dementia. Following assessment, Dementia Outreach provides guidance and support to the care home in such matters as medication and care plans.

Oral care

23. Miss C said that when her mother moved to the New Home, carers said her mother's dentures were black and had not been cleaned for a while. Also, her gums looked unhealthy. Miss C thought this may also have explained why her mother was not eating properly.

24. The Home said Mrs D got anxious and distressed and sometimes refused oral care. The Home said it would not have been right to give oral care at these times, but that staff should have recorded why they did not carry out this task. The Home said it was working on improving staff recording in this area, especially with agency staff, and there had been some improvement.

25. The Home said since this complaint all staff had extra oral care training in 2022. The Home also checks oral care during daily staff tours of the Home.

Analysis

26. Mrs D's care plan at the Home said staff should check Mrs D's oral hygiene daily, checking lips, tongue, gums, roof of mouth for any sore areas or redness.

27. The Home's records do not show evidence of staff carrying out oral care and hygiene daily. There are some instances of Mrs D being unsettled and refusing oral care.

28. However, there are several other occasions when it is not recorded and no reason recorded such as that Mrs D refused oral care.

29. There was fault in the record keeping and this has left Miss C unsure if the Home properly carried out her mother's oral care.

30. The Home has taken enough action on a systemic level to prevent this arising again, but Miss A is left with uncertainty caused by this issue.

Nutrition

31. Miss C said the Home did not manage her mother's nutrition which meant she lost weight and this affected her health.

32. The Home outlined the weights it recorded for Mrs D during her time at the Home:

- 10/12/21 – 70.05kg
- 29/12/21 – 66.45kg
- 01/01/22 – 70.25kg
- 04/01/22 – 68.8kg
- 21/01/22 – 65.3kg
- 01/02/22 – 63.65kg

33. The Home went on to say that on 19 January 2022 staff spoke to Mrs D's GP about poor nutrition and fluid intake. The GP said to continue to record her weight and offer food and drinks throughout the day while providing choices according to her likes and dislikes.

34. The Home said it sought a medication review from Dementia Outreach as it felt an increase in mood could help with her food intake.

35. On the daily records, the Home said they showed dietary intake changed depending on Mrs D's mood and anxiety. The Home offered her a fortified diet with milk and cream in food and cakes and chocolates offered outside mealtimes to encourage her to eat.

Analysis

36. From the evidence provided by the Home there is a weight loss of 7.4kg during Mrs D's stay which was about seven weeks. This represents a significant weight loss for a short period. I also noted that at the start of January 2022 Mrs D's weight had gone up to 70.25kg. It then went down to 63.65kg so there was a significant weight loss which happened in the space of a month.
37. Mrs D's care plan review in January 2022 stated she had poor cognition when it came to diet, and she would need prompting and assistance.
38. It states all staff should follow the care plan, offer her choices, weigh her each month and update the care plan as necessary. It also required staff to liaise with Miss C and Mrs D's GP if there were any concerns about her weight. The plan also said to involve a Speech and Language Therapy Team (SALT) and her GP if Mrs D constantly refused food. Speech and language therapists provide treatment, support and care for people who have difficulties, eating, drinking and swallowing.
39. The records state Mrs D could eat independently but that she was often distressed and refused food.
40. There is evidence that in January staff were staying with Mrs D to encourage her to eat. It was also correct they involved the GP on 19 January and were updating Mrs D's care plan to reflect her changing eating and drinking habits.
41. There is sufficient evidence in the records to show that despite these actions, Mrs D was still losing weight.
42. Also, there was a week to ten days at the start of January 2022 when Mrs D was consistently declining her main meals and her weight started to go down rapidly.
43. According to the care plan, the GP and the SALT Team should have been involved at this stage. I find it was fault the Home did not seek help from the GP and SALT at this point as it had been an issue for a number of days.
44. We cannot decide whether the Home involving the GP and SALT earlier would have improved Mrs D's nutrition as there were other factors such as her mood and dementia which can affect someone's food intake. However, Miss C is left with frustration from not knowing if more could have been done to improve her mother's nutrition earlier. Also, the Home has not taken any action to prevent this happening to other residents in the future.

Diazepam

45. Miss C said the Home ran out of diazepam for her mother. Also, she felt the Home was not controlling her mother's hallucinations before she was moved to the New Home. Miss C said the head nurse at the Home told her the diazepam was not working. Miss C said that Dementia Outreach was supposed to be changing her mother's medication to help with her mood and improve her appetite. This improvement did not happen, and her mother was moved while still suffering hallucinations.
46. Diazepam is a drug used to treat anxiety. It has in the past been used to treat hallucinations which can be a symptom of dementia.
47. The Home said the only occasion where it ran out of diazepam was in early January and this was for a total of 12 hours. Home staff chased this and obtained more. It said the prescription of the medication was managed by Dementia Outreach and Mrs D's GP.

48. Dementia Outreach said it gave advice over the phone in December 2021 before a Community Psychiatric Nurse (CPN) from its service visited Mrs D two days later. Along with advice about giving diazepam more regularly the CPN told staff to record the effects of this to see if it was working.

49. Dementia Outreach said it followed up one week later when the Home said the diazepam was not having much effect, so it planned to discuss this at its Multi-Disciplinary Team meeting. Dementia Outreach stated that in the initial weeks after moving to a new home its approach would be to watch and wait as the resident gets used to their new environment.

50. Dementia Outreach said that in January 2021 Mrs D's GP asked it to review her again as she was not responding well to diazepam. The CPN reviewed Mrs D a week later and carried out a medication review.

51. Dementia Outreach said it discussed possible medication options with the Home and family and also discussed it with a Consultant Psychiatrist who suggested mirtazapine. Mirtazapine is an antidepressant and can be used to treat anxiety.

52. The Consultant Psychiatrist started Mrs D on mirtazapine but when the CPN contacted the Home a week later to follow up, Mrs D had already moved to the New Home.

Analysis

53. The Home has not addressed whether it was managing Mrs D's hallucinations. Whilst Miss C has provided evidence which she states shows her mother hallucinating, there was no evidence of hallucinations in the Home's records.

54. From the Home's records there is evidence in December 2021, after Mrs D had been a resident at the Home for three weeks, staff sought help from Dementia Outreach.

55. The December 2021 records outline that the Home told Dementia Outreach Mrs D was anxious, crying most of the time and asking to go home. They discussed the medication, and the plan was to give regular diazepam and monitor its effectiveness. Also, Dementia Outreach advised that Mrs D had not long been in the home and she needed time to settle and build relationships with staff.

56. The Dementia Outreach record of the visit in December 2021 states that staff had contacted it as Mrs D was very anxious and disorientated.

57. The Dementia Outreach worker said Mrs D did not appear to be having hallucinations at this time.

58. According to this visit record, Dementia Outreach told staff to give Mrs D diazepam more regularly to see if this helped. They would then do a medication review to see if they could try Mrs D on another medication.

59. The daily records from the Home also portray the situation of Mrs D being very anxious and tearful from when she first entered the Home in early December.

60. Mrs D's mood did improve slightly in January 2022 and staff recorded her mood several times a day. The Home records outline a visit by Dementia Outreach a month later which states diazepam is helping and Mrs D's mood is more settled than before.

61. According to this note Dementia Outreach also said it would speak to Mrs D's GP about prescribing mirtazapine and then decrease diazepam. Mirtazapine usually takes about four to six weeks to start working.

62. There is sufficient evidence in the notes from the Home and Dementia Outreach that they were managing the diazepam effectively in upping the frequency of the dose at first and then looking at other options.

63. It was appropriate to have a period of waiting to see if Mrs D would settle down as she was a dementia patient who had just moved to a care home for the first time and there was likely to be a period of her being unsettled.

64. The Home sought advice when necessary and followed the instructions of Dementia Outreach in using the medication more frequently and noting its effects.

65. Dementia Outreach acted appropriately in visiting Mrs D twice at the request of the Home, following this up with calls and giving advice to the Home and Miss C in how to help manage Mrs D's anxiety. It also carried out a medication review and sought advice of the Consultant Psychiatrist to see if another medication would benefit Mrs D.

66. The records also illustrate there was an occasion in early January when the Home ran out of diazepam and there was a delay in obtaining some as the pharmacy was not answering their calls.

67. There is no evidence of deterioration in Mrs D's mood or an increase in anxiety during this time. Therefore, I have not found fault in the Home running out of diazepam or that it caused any harm to Mrs D.

68. Taking the above into consideration, I do not find fault in the Home or Dementia Outreach's management of Mrs D's diazepam.

69. In addition, I have not found sufficient evidence in the Home's or Dementia Outreach's records to show that Mrs D was suffering unmanaged hallucinations when she was moved to the New Home.

The move to the New Home

70. Miss C said she was unhappy with the speed of the move as her mother was still very anxious, had just started on mirtazapine and was not well enough to be moved. In addition, Miss C said she found a suitable home for her mother, but it had a waiting list. She said that no one was willing to wait the matter of weeks it would take before this home would accept her mother.

71. The Council said that Mrs D was assessed as ineligible for Continuing Healthcare funding from 10 January onwards. It went on to say the Home charges a third-party payment which is the responsibility for the family to pay.

72. Because of the family being unable to pay this third-party payment, the Council started looking at the option of moving Mrs D to another home, but it would make this payment in the meantime.

73. The Council said during this process is liaised with several professionals involved in Mrs D's care. The Council said it spoke to Dementia Outreach who said although Mrs D had recently changed medications, it did not think this would have a detrimental effect on any transfer arrangements to a new home.

74. The Council also said that Dementia Outreach, the Home and the Continuing Healthcare nurse who had assessed Mrs D did not have any concerns about her health and that she was stable.

75. The Council also said it worked with Miss C to help identify alternative homes and checked availability before it chose the New Home. It said that there were several lockdowns at the time due to COVID-19 and so even though Miss C did identify

an alternative home the wait was around six weeks and there was no guarantee it would accept Mrs D or not be subject to lockdown.

76. The Council said the move was made in Mrs D’s best interests.

77. Dementia Outreach said on the evidence available there were no discussions between it, the Council the Home or the family regarding the decision to move Mrs D. It said it was not its role to make decisions about moving residents and no one made it clear to Dementia Outreach why Mrs D was moved.

Analysis

78. The responsibility in cases such as Mrs D’s for moving residents lies with the Home and the Council.

79. The Council has a policy governing such moves - Care Home Placements Guidance (the Guidance). It states if a care home has a third party fee the Council should let the family know and the resident may need to be moved if the family or Council will not pay the fee.

80. The Guidance also states that the Council should consider if the resident’s needs can be met at alternative accommodation and if such a move poses a significant risk to the person’s care and wellbeing. To this end the Council should carry out a risk assessment which takes into account such factors as the length of stay at the original home, the opinions of professionals and the wishes and preferences of the resident and relevant people such as family.

81. The Council records show it discussed the proposed move with the family and the Home. Miss C was against the move until the mirtazapine took effect due to her mother’s anxious state.

82. The Council weighed this view with that of the nurses at the Home that Mrs D was stable enough to be moved.

83. Although there is a telephone record of a call between the Council and Dementia Outreach in which the move was discussed, Dementia Outreach has said it did not have any input into the move and the follow up email it sent after this conversation does not mention the move and whether it would be suitable for Mrs D. Therefore, I have insufficient evidence that the Council sought the views of Dementia Outreach about the move.

84. There is also no medical input into this decision from Mrs D’s GP or a written risk assessment of the move.

85. There was an assessment of the New Home done over the phone, but this is not properly documented.

86. Due to the lack of a risk assessment, there was fault in how the Council carried out the procedure to move Mrs D. She was suffering from dementia and had chronic anxiety as well as recently starting medication that takes four to six weeks to take effect.

87. There should have been a written full risk assessment to show Council had properly considered how the move could have affected Mrs D. It would also have been better if the Council had consulted properly with Dementia Outreach and contacted Mrs D’s GP. The Council did consult some professionals with clinical knowledge such as the nurses at the Home. Therefore, I cannot say the move would not have happened or that Mrs D was caused injustice because of the fault identified.

88. We also cannot link Mrs D’s death with the move as there are too many other factors that could have impacted on her deterioration and there is no medical evidence to show she was unfit to be moved. However, the faults in the process of the move have led to uncertainty for Miss C about whether the move was appropriate and whether the Council acted correctly.

Recommendations

89. Due to the frustration and uncertainty caused to Miss C by the faults of the Council and the Home, I have made the following recommendations:

90. By 24 March 2023:

The Home:

- should write to Miss C apologising for the frustration and uncertainty she experienced caused by its lack of adequate oral care record keeping and the lack of involvement of the SALT team,
- should pay Miss C £100 for this uncertainty and the frustration it caused her; and
- should remind its staff of the importance of following resident's nutrition care plans and when to involve other professionals. It should also consider whether any training is necessary for its staff.

The Council:

- should write to Miss C apologising for the uncertainty caused by the faults in its process of moving Mrs D to the New Home,
- should pay Miss C £100 for the uncertainty it caused her; and
- should remind its staff of the importance of completing written risk assessments when considering moving residents with dementia to a new care home. It should ensure all officers involved in moving residents are aware of what procedure to follow

91. The Home and the Council should provide us with evidence they have complied with the above actions.

Final decision

92. I find fault with the Home’s actions in relation to oral care and nutrition but not with its management of diazepam. I find fault with the Council in how it handled Mrs D’s move to the New Home. I do not find fault with Dementia Outreach.

Investigator’s decision on behalf of the Ombudsmen