Appendix 1

Adult Social Care

Summary of complaints by theme (2022-23)

Complaints relating to dignity

X complained about the care his mother (Y) received in the last few weeks of her life. Y was not given fluids by staff in her care home following advice from District Nurses.

The home advised Y came to the home on 'Nil by Mouth' but on the nursing assessment it also stated she was able to have fluids. Y was having small amounts of fluids when she first came back to the home. This was then withdrawn due to the District Nurses coming in to see Y daily and informing the home not to offer fluids and diet as she is not able to swallow and it not being safe to do so. Mouth care was then given to Y on regular intervals where her mouth was moistened as per palliative care guidance.

Complaints relating to communication

X complained we had ceased using a convene with her father (Y) after several years without communicating this to her and we still hadn't identified a provider to help her as a carer.

We explained we were now experiencing difficulties with the convene, so specialist training was arranged to help resolve. District Nurses advised in the meantime not to use the convene given the difficulties. We trialled not using the convene for a week whilst alternatives were explored and we involved Y in these discussions. In terms of sourcing a package of care we are working hard to identify a provider at the time.

X complained to her provider she was not able to communicate with her case worker via British Sign Language (B.S.L.) at her normal speed and they sometimes don't understand her. The provider is slow to react to important situations. The provider wouldn't translate on daughter's behalf with her employer.

The provider requires a minimum of B.S.L. Level 2 and the caseworker is qualified to Level 6 which exceeds the provider's requirement for the role. People whose first language is B.S.L. are able to contact the provider in a number of ways, email and text local being two options. The provider explained they are not an emergency service. Public bodies as part of the Disability Act should provide qualified interpreters to support their service users. If an additional family member requires support the provider would communicate directly with this family member to complete an individual referral on their behalf.

Complaints relating to timeliness of our decisions or actions

X complained she and family had waited over 5 months for a referral to be actioned on behalf of her father (Y).

We explained the initial referral was followed up in a timely manner but Y was able to complete a large number of tasks himself, so alternative reablement options were discussed instead. Since this time Y's condition has deteriorated so a Social Worker was allocated.

X complained of a 4 week gap between their brother (Y) being discharged from hospital and our making contact about a package of care to support Y at home

Y was referred to the Service and allocated a Social Worker a month later. The delay was unfortunately due to lack of capacity within the Service for which we apologised for. We visited Y once the case was allocated and X was also present during the visit (which was planned before the complaint was made) and the case has moved positively forward.

Complaints relating to disagreements with our decisions or actions

Parents disagreed with our view that we were trying to engage with them but we weren't listening to their or their son's (Y) views his needs.

A review meeting was held and a number of actions proposed. However, parents disengaged and asked to withdraw Y from our Services, which has concerned all professionals involved with the family as they were doing so with her agencies. Parents have since re-engaged and everyone involved are promoting Y's independence.

X complained about being 'badly supported' and our making threats about involving the Safeguarding Team. X no longer wanted the involvement of services and asked that her adult son Y be transferred to another social work team.

X had displayed unprofessional behaviour during a recent meeting and Y had also asked her to be quiet so he could share his views. X has been critical of ourselves but she has not given us the opportunity to work productively or support Y in any way without placing a barrier to this. With regard to the 'threat' of involving the Safeguarding Team, this was in the context of X not allowing us to support Y with the Pain Management Service and it was suggested the matter could be a safeguarding issue as X was preventing Y from accessing the correct support.

Complaints relating to charges applied or financial issues

X complained their adult son (Y) was being financially disadvantaged and we weren't providing the necessary advice or support to him.

X had no consent to act on Y's behalf. This has been a difficult case to manage over recent years. However, we met with Y and his Advocate, assessed his ability to manage his own finances, and advised the D.W.P. we were relinquishing our role as Y's Appointee as he could manage his own finances.

X complained her adult son Y had been removed from her care for his safety, yet Y still has to pay for his care and support costs.

We reminded Y is in a placement ordered by the Court of Protection. Y is supported by ourselves to meet with X and family as often as they would like. Further Court Hearings are planned. Charges are in accordance with the Charging Policy, and they are applied consistently to every person supported. The amount being charged is accurate and calculated using the accepted formula.

<u>Complaints relating to hospital discharges</u>

X complained about the advice he received outside of office hours in terms of supporting his parents, which included him needing to step in and support them. X wasn't coping with the present situation and nobody was helping.

We advised we had spent a great deal of time supporting X's parents during this period. It is not uncommon for us in emergency situations to kindly request family in the short term to assist in supervising an elderly family member, in conjunction with liaising with carers. At the time the complaint was made N.H.S. Wales called on family members to assist in getting loved ones home from hospital as there was currently an unprecedented demand across the whole health and care system in North Wales.

<u>Complaints relating to the quality of care from a home or carer</u>

X complained about a number of things including: weight loss, inadequate meals, mixed messages re. father's (Y) infection and Y going missing from the home for an hour and a half without X being told.

The home agreed Y had lost weight which they were monitoring and could also be put down to Y being unsettled since admission, as well as a chest infection. Staff sit with Y at mealtimes to prompt him to eat and a referral had already been sent re. a Dietician. The home disagreed about X's views about their food and they have observed Y likes a little but often. The absconding incident had been subject to a safeguarding investigation and safeguards had been implemented to ensure there is no repeat.

X complained on the day their mother (Y) was admitted to hospital following an accident. X wasn't informed of Y's admission to hospital by the home concerned. Y wasn't taken to hospital by staff and they instead called a family member. No one from the home travelled with Y to hospital and the home didn't realise mum had also hurt her back believing it was just a wrist injury.

The home explained Y suffered an unwitnessed fall. She had banged her head and her hand was hurting but she did not want to go to hospital. X has capacity to make her own decisions and therefore the home had to respect and support her with that decision. The home continued to monitor Y and later called 111 with their concerns and were advised to take her to hospital for an x-ray. It was Y who called another family member and they agreed to take her to hospital. The home advised Y to contact them if she required any support when she arrived at hospital. All staff in the home who were on duty were informed of Y's admission to hospital, but the home apologised if whoever answered X's call did not communicate this to her at the time.

Complaints relating to a lack of support

X complained her daughter's (Y) 1:2:1 care and support was being cut short or cancelled at short notice, meaning she had to cover the staff member not able to cover.

The provider had reported to ourselves they were experiencing staffing problems as a rival provider was poaching staff and packages of care. The provider advised a new member of staff has been recruited that should hopefully alleviate recent experiences which Y was satisfied with as both X and Y want to continue with the provider. Problems did persist for a short while afterwards but have since been resolved.

X raised concerns about the lack of services and support their adult son (Y) was receiving.

In terms of support from the North Wales Integrated Autism Service, Y would not be eligible for a service from them as he has complex mental health needs that need an appropriate response on a therapeutic level, which the Service are unable to support. Instead the Community Mental Health Team CMHT have become involved and explained to Y when he is ready to engage again with services, Y can be referred back for assessment if he wishes so. This applies to pursuing any social opportunities he may wish to take up with the Social Links Team.

Complaints relating to process issues

X was under the impression following conversations with ourselves that he would be included in any reports regarding his sister (Y) produced by the R.P.R. (Relevant Person's Representative), which is a key reason why he chose not to be R.P.R. for his sister in the Deprivation of Liberty Safeguards (D.o.L.S.) process.

Our records indicated we had spoken at length with X about the D.o.L.S. process and the role of R.P.R., and we suggested a paid R.P.R. purely due to his X's geographical location as he felt unable to commit to monthly visits due to his work (X lived some distance away). X had agreed to see how this arrangement progressed and review again in 12 months. At no point did we say he would receive the R.P.R. report as it remains independent as the person's voice so there must have been a misunderstanding. We offered to meet with him to go through how he could act as R.P.R. in future.

X complained she had been accused of 'getting random people off the street' to care for her adult son (Y) and that it wasn't her job to recruit people via the direct payment.

We reminded X of our role in terms of supporting people with direct payments. During a home visit concerns were raised about a recent P.A. who was recruited by X without support from the Direct Payments Team. This P.A. had been recruited without necessary checks, did not possess a current D.B.S. certificate and had not been issued with a contract of employment. Concerns have been raised over a period of time around X's understanding of responsibilities and her ability to act as a responsible employer, even with support. During the visit these concerns were again highlighted to X and we continue to monitor the arrangement.