The City of Edinburgh Council

10am Thursday 29 June 2017

Recommendations of the Social Work Complaints Review Committee of 28 April 2017

Item number	8.14(a)
Report number	
Wards	All

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Report

Recommendations of the Social Work Complaints Review Committee of 28 April 2017

Summary

To refer to the City of Edinburgh Council, recommendations of the Social Work Complaints Review Committee on consideration of a complaint against the social work service within Health and Social Care.

For decision/action

The Social Work Complaints Review Committee has referred its recommendations on complaints against the social work service within Health and Social Care to the Council for consideration.

Main report

1 Complaints Review Committees (CRCs) are established under the Social Work (Representations) Procedures (Scotland) Directions 1996 as the final stage of a comprehensive Client Complaints system. They are required to be objective and independent in their review of responses to complaints.

2 The CRC met in private on 27 April 2017 to consider a complaint against the social work service within Health and Social Care. The complainants and the service representatives attended throughout.

3 The complainant remained dissatisfied with the Council's response to her complaint regarding a fall experienced by her mother on 10 September 2015 and the Councils response thereafter.

4. The complainant outlined her complaints as follows:

   i) the complainant remained dissatisfied that the complaint response letter did not address a report by the Care Inspectorate, nor did it reference the findings of an independent healthcare consultant.

   ii) the complainant sought clarification as to why a wheelchair lap belt was not used when her mother was left unattended within the Care Home.

   iii) the Councils explanation of events leading to the complainant's mother sustaining facial injuries was not consistent with the injuries she sustained.

   iv) the complainant stated that the Care Home was understaffed when the incident occurred and queried why a member of staff was allowed to leave the building.

v) the complainant stated that she had received conflicting reports from staff.

vi) the complainant was unhappy that she had to request that Care Home staff photograph her mother's injuries.

5. The complainant explained that her mother had sustained head injuries following an unobserved fall from her wheelchair at a time when she had been left unattended. The injuries that had been sustained suggested that she had not been strapped into her wheelchair using a lap belt.

6. The complainant reported that nobody had accepted responsibility for the incident and that the Council's explanation that another resident may have caused her mother to fall was unacceptable.

7. Members of the Committee were then given the opportunity to ask questions of the complainant.

8 The Investigating Officer, confirmed that her role was to try and establish the facts concerning the complaint received, which had involved multiple agencies and individuals.

9. She confirmed that on 10 September 2015, the complainant's mother was assisted out of bed by two staff and transferred into her wheelchair to go through to the dining area for her evening meal. Staff made the decision to leave her in her wheelchair to have her meal as she was attending a birthday party soon after.

10. At approximately 6pm, one of the three services users within the lounge/dining room asked to use the toilet. The member of staff within the immediate vicinity of the dining area calculated that it would be safe to take the service user to the toilet leaving the other two services users, one of which was the complainant's mother, alone.

11. On returning to the lounge/dining room the carer reported that the complainant's mother was on her left side on the floor, she was still in her constricted seated position in the wheelchair. The other service user was on her feet nearby. She was then taken to the Royal Infirmary of Edinburgh Hospital by ambulance accompanied by a staff member and next of kin notified.

12 As the incident was un-witnessed the Investigating Officer could only speculate as to what had occurred in the two-three minute that the service users were left alone.

13. The Investigating Officer reported that her investigation was inconclusive due primarily to lack of an eye witness and poor recording keeping within the unit. She stressed that the number of staff within the unit at the time of the incident was within Care Inspectorate guidelines.

14. She confirmed that the complaint investigation had generated the following service improvements:

- Any staff member who accompanied a service user to hospital would be the person responsible for recording the outcome of the visit and any

assessment which took place. These would no longer be passed verbally to the team leader or key holder to record.

- Care home managers and staff had been reminded of the availability of slings and hoists within the Accident and Emergency Department at the Royal Infirmary of Edinburgh.
- A single family member would be identified for care home staff to communicate directly with regarding concerns, issues and updates.
- The seating areas within the unit concerned were no longer left unattended and all staff had been instructed to consider residents safety at all times. If a lone member of staff was required to leave the area for any reason, they had been instructed to call for the assistance of a colleague prior to leaving.

15 Members of the Committee were then given the opportunity to ask questions of the Investigating Officer.

16 Following this, the complainants and the Investigating Officer withdrew from the meeting to allow the Committee to deliberate in private.

Recommendations

After full consideration of the complaints the Committee reached the following decisions/recommendations:

1) The Committee **upheld** the complaint detailed at Paragraph 4(i) above, without qualification**.**

2) The Committee noted that the Social Work Complaints Review Committee was unable to provide any clarification as to why a wheelchair lap belt was not used when the complainant's mother was left unattended within the Care Home (paragraph 4(ii) above).

3) The Committee, on the evidence presented, did **not uphold** the complaint detailed at Paragraph 4(iii) above**.**

4) The Committee **upheld** the complaint detailed at Paragraph 4(iv) above

The Committee considered that the risk assessment undertaken by a member of staff to take a resident to the toilet, leaving two other service users (including the complainant's late mother) alone in the lounge/dining room to have been inadequate.

5) The Committee **upheld t**he complaint detailed at Paragraph 4(v) above, without qualification**.**

6) The Committee did **not uphold** the complaint detailed at Paragraph4(vi) above**.**

The Committee considered that for staff to have photographed the injuries would have been a breach of professional practise.

Background reading/external references

Agenda, confidential papers and minute of the Complaints Review Committee of 27 April 2017.

Links

Coalition pledges		
Council outcomes		
Single Outcome Agreement	SO2	Edinburgh's citizens experience improved health and wellbeing, with reduced inequalities in health
Appendices	None.	