Investigation Report

Investigation of a complaint against Somerton Private Nursing Home

NIPSO Reference: 17159

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities. She may also investigate and report on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS PAGE

EXECUTIVE SUMMARY

1. I received a complaint relating to the care and treatment provided to the complainant's late father, who was a resident in Somerton Nursing Home, Belfast in October 2014.

Background

2. The resident was 82 at the time of the complaint. He had a history of numerous recurrent falls, vascular dementia, a previous stroke and ischaemic heart disease.

3. He had been in hospital a number of times throughout 2014 and was a patient in Belfast City Hospital in September 2014 following a fall at home and delirium. He was unable to return home after discharge from hospital and was admitted to the Home in October 2014. He suffered a fall at the Home sustaining a bump to the left hand side of his forehead measuring approximately 2 inches in diameter. The night nurse on duty contacted the out of hours doctor (Beldoc) who advised that he be monitored. He stayed in the nursing home day room where he was observed and remained there until 05.00 when he went to bed.

4. The following morning, day staff were concerned regarding the resident's condition and noted the bump now measured 9cm by 4cm. They contacted Beldoc again and the doctor requested that an ambulance be called. A non-emergency ambulance arrived at 13.00 to take him to hospital.

5. He was admitted through A&E and had a CT scan. This revealed a 'tiny amount of traumatic subarachnoid haemorrhage', however 24 hour neurological observations were normal and he was due to be discharged. Unfortunately in November 2014 he aspirated vomit and commenced antibiotic treatment. He was discharged to a new nursing home in December 2014. From here he was again admitted to hospital with abdominal pain and aspiration pneumonia later in the month. His condition deteriorated and he died in early January 2015.

Findings and Conclusion

6. The investigation of the complaint identified a failure in the care and treatment received in respect of:

1. A failure to document observations following a fall in October 2014 (Paragraph 36)
2. A failure to request an ambulance immediately following the fall (Paragraph 39)

7. I am satisfied that these failures caused the resident the injustice of a failure to have observations recorded and to have his head injury assessed fully in hospital at an earlier time. I also consider the failures identified to have caused the complainant the injustice of upset, distress and uncertainty regarding the consequences to her father of the care and treatment which he received at the Home.

Recommendation

8. I recommend that the Home provide the complainant with an apology for the failures in care and treatment which I have identified.

THE COMPLAINT

9. The issue of complaint which I accepted for investigation was:

- Was the care and treatment provided to the resident following his admission to the Home appropriate and reasonable?

INVESTIGATION METHODOLOGY

10. As part of the investigation into the complaint the Investigating Officer obtained from the Home all relevant documentation, including the resident's medical records. The Investigating Officer also obtained medical records from the Belfast Health and Social Care Trust (the Trust) relating to telephone calls to Beldoc and inpatient stays and treatment at Belfast City Hospital and the Royal Victoria Hospital, Belfast.

11. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings. The complainant and the nursing home were both given the opportunity to see and comment on a draft of this report before the final version was issued.

Independent Professional Advice Sought

12. After consideration of the issues I obtained advice from two Independent Professional Advisors (IPAs) - a Consultant Nurse for Older People and a Consultant Neurosurgeon.

13. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs provided me with 'advice', however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

14. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

The general standards are the Ombudsman's Principles:

- The Principles of Good Administration[1]

These can be found in full in the Appendix to this report.

The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional judgment of those organisations and individuals whose actions are the subject of this complaint.

15. The specific standards and references relevant to the issues in the complaint are:

- Electronic Medicines Compendium (EMC)
- National Patient Safety Agency (NPSA) 2007, Slips Trips and Falls in Hospital
- NICE 2013 Falls in Older People CG161/CG21 June 2013
- NICE 2003 Triage Assessment Investigation and early management of Head Injury

[1] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

MY INVESTIGATION

Complaint

16. The complainant states that there was a lack of care provided by the Home following her father's fall in October 2014. She contends that an ambulance should have been called for her father immediately after he suffered the fall and sustained a head injury.

Evidence considered

17. I have considered extracts from the resident's medical records relating to his medical history prior to the fall as follows:

Royal Victoria Hospital (RVH) - Admitted January 2014 to February 2014 with one week history of lower abdominal pain. TIA[2] in May 2014.
Admitted July 2014 after collapse episode at home and had a further fall as inpatient, then transfer to -
Belfast City Hospital (BCH) – Admitted July 2014 to July 2014 with nausea, dizziness and vomiting. Headache and collapse episode. MRI scan in July 2014 noted 'generalized cerebral atrophy' and areas of the head with ischaemia/infarction[3]
TIA/Stroke clinic in September 2014 noted that his general condition had worsened with significant new cognitive impairment. At this time he disclosed that he had fallen twice in the previous week.
BCH – admitted early September 2014 on transfer from RVH following fall at home. Also admitted late September 2014 to mid-October 2014 following fall. An Occupational Therapy Care Management Assessment was carried out prior to discharge.

As part of my investigation I have examined the Daily evaluation/Progress notes

[2] Transient ischaemic attack – a brief interruption of blood supply to a part of the brain, sometimes described as a mini stroke without tissue death
[3] Ischaemia – insufficient blood supply to an organ or tissue. Infarction – Death of an area of tissue due to ischaemia

from the Home. The relevant extracts are set out below:

18. **Day of admission to Home** - '*Very aggressive on admission at 12.45….' 1.20 'Resident was attempting to leave by front door which was locked when zimmer frame was used to smash window*….'

Day 2 – *6.00pm - 'Reported that he had bumped his head on the bed. He was very confused and was walking while falling on to the bed and radiator cover. Small bump was noted on r head. Cold compress applied. Crash mat on both sides of the bed provided……..he was found lying on the crash mat 2 times already…..'*
14.10 – Demanding an ambulance and shouting very loudly in the lounge. Very unpredictable and invading the space of staff who feel vulnerable…
18.40 - 'Very unpredictable in the evening….

Day 4 – *after 8.00pm 'Starting to shout which frightened the other residents. Medication given and assisted to bed about 12 midnight. About 3.35am he managed to walk from his bedroom to the hallway where a thud was heard. When checked he was on the floor with a duvet and a bump on his L forehead about 2 inches in diameter. Cold compress applied and vital signs taken BP=190/96 P=80 R 21/m level of consciousness – alert and both pupils equally reactive to light.*
Out of hours contacted right away and doctor phoned back. Had informed about the fall and was given the result of the vital signs taken, and the bump on his forehead. Doctor advised to continue to monitor and if any deterioration to contact out of hours again.
Assisted to bed about 5.00am and has slept since. Daughter tried to be contacted about 7.40am, phone was ringing but no answer. No answering machine to leave message. Please try again if possible.'
10.00am – 'Very big bump on his left side of his head and surrounding area is swollen. Confused restless and agitated. Sleepy and drowsy. (Bump on the head measured again at 10.00 am. It's about 9cm by 4cm…Not c/o any pain or discomfort). Informed to the Beldoc. Doctor advised to send him to the hospital. Arrange ambulance. 13.00 Ambulance arrived 13.00 and take him to RVH. Family informed re transfer.'

19. The relevant extracts from Beldoc record of out of hours calls state as follows.

Day 6 - *Call received at 03.22, replied at 03.39. 'Pt has fallen, large bump on head. Note meds. Recent admission to emi. Wandering has a hx of falling bp diat 94 and pulse at 80 large 2 inch bump to forehead I note no warfarin is on Plavix. Advice to nurse re obs no localising signs observe tonight every hour or 2 and if any deterioration can call and will arrange a+e assessment. Vascular dementia…. Call back if concerned.'*

Call received at 11.00, replied at 11.14.
'Fell earlier sleepy drowsy, bump on head. Sustained head injury overnight much more drowsy this morning large bump on left temple 9cm by 4cm BP 100/70 intermittent confusion more pronounced today h/o cognitive impairment Refer to A+E'

20. The relevant extracts from the Royal Victoria Hospital medical records state as follows:

Day of fall - *'CT scan reported as tiny amount of traumatic subarachnoid Haemorrhage[4] (SAH)…no fracture seen…..discussed with neurosurgical reg on call, not for neurosurgical intervention.'*
Nursing assessment and Plan of Care – 'seen by surgical reg in A+E, for conservative treatment and observation.'
Following day – *'Admitted for observation' 'discussed case with neurological reg (registrar) …he reviewed CT's and can see no trace of SAH'*
Day 2 - *Clinical notes – remains medically fit for d/c (Discharge)*

21. I have examined the relevant policies, in particular those relating to head injury. The relevant extracts state:

[4] A type of brain haemorrhage in which a blood vessel ruptures into the cerebrospinal fluid surrounding the brain and spinal cord. It may occur as a result of head injury or spontaneously

Protocol for Managing Head Injury at Somerton

'Residents who sustain a head injury should be checked out at A and E. Our residents may be unable to tell us their symptoms so it is necessary for the nurse to seek medical attention immediately especially to someone who is being treated with warfarin or other blood thinning medication. Signs of injury may include some of the following – unconsciousness either briefly or for a longer period, Drowsiness, Slurred speech, General weakness, Balance problems, Vomiting, Irritability, Bruising, Swelling to an area of the head……In the event of a suspected head injury – the nurse should seek immediate medical attention by dialing 999 and requesting immediate assistance…'

Somerton Out of Hours Policy

' …*In the event of an emergency, for example – sudden chest pain, fall resulting in possible fracture, suspected CVA and head injury, you may dial 999 immediately and request emergency assistance, without contacting Beldoc…*

22. As part of my investigation the Home stated that nursing staff made an assessment based on their observations. The Home confirmed that other than a bump to the head the resident was not displaying any obvious signs of head injury, his vital signs were normal, he was alert and conscious and his pupils were equally reactive to light. It stated that three registered nurses examined him from the time of the fall until the arrival of an ambulance and at no time did they suspect that he had a serious head injury. The Home further stated that staff had contacted Beldoc following the fall and the advice received had been not to call an ambulance.

The IPA advice

23. As part of my investigation I asked the Nurse IPA to provide me with advice on two issues:

a. The adequacy of the falls risk assessments carried out in the Home
b. Should an ambulance have been called for immediately following the fall?

24. The Nurse IPA advised me that the NICE Clinical guideline, 'Falls in Older People', provides guidance that older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial risk assessment. The IPA stated that the resident was appropriately assessed at the care home using a proforma that covered key areas of assessment as recommended by the NICE guideline. These are

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review

The Home also assessed the appropriateness of the use of bed rails, correctly identifying that he would be at high risk of falling from a bed.

25. The Nurse IPA advised that following the multifactorial assessment, the Home correctly recorded the outcome that the resident was at high risk of falling. Its plan specified that he should be provided with the use of a Zimmer frame and assistance of 1or 2 carers. Further he should be provided with an explanation before all transfers to avoid confusion, the main lounge area was to be used during the day where possible, he was to have hourly checks during the night whilst in bed, the bed was to be at its lowest height and a mat was placed at side of his bed. The IPA stated that this was an appropriate level of support and supervision. However, while the plan was appropriate to the level of risk, the IPA considered it would not eliminate all risks as he would be at risk of falling during periods when he was

unsupervised (that is in between checks), or even during periods when he was supervised, as a person can fall even whilst a carer is in the room. Overall the IPA stated that the plan was reasonable and there were no evidence based interventions that were overlooked.

26. The Nurse IPA also commented on the level of risk of a fall which the resident would have presented given his history, medical condition and age at the time of the incident. The Nurse IPA stated that he had risk factors which were identified on the nursing home assessment. They related to his previous history of falls. The Nurse IPA noted he was taking more than four medications and noted his medical history (stroke) and unsteady gait. Following the NICE guidelines, he was also at risk due to cognitive impairment. The care home assessment includes an assessment of whether the person can rise from a chair unaided, which is a relevant assessment in an institution where many residents may be chair bound but still at risk of falling out of the chair (the resident was however able to rise from the chair and walk independently). On transfer to the home his behaviour was recorded as confused and agitated. Therefore, the Nurse IPA advised this increased the likelihood of him attempting to mobilise unassisted and would be likely to lead to increased falls risk further. In view of these multiple risk factors, the Nurse IPA rated the resident's level of risk of falling as very high (my emphasis).

27. With regard to the events on the night in question, the Nurse IPA stated that when he fell at 03:35, his blood pressure, pulse, and respiratory rate were checked by staff in the Home. His level of consciousness was assessed together with pupil reaction and a cold compress was applied. However no further observations were recorded until 08.30 as he was reported to be fully awake but uncooperative and aggressive.

28. The Nurse IPA stated that the Home's initial assessment and recording of vital signs immediately after the fall was discovered was appropriate. However the IPA stated that, given the circumstances, it was not acceptable that further observations were not recorded for 4 hours. The Nurse IPA explained that, from the description of a swelling on the head which gradually increased in size, a risk of more serious injury should have been suspected and an ongoing assessment and observation of

vital signs would therefore be indicated. The Nurse IPA noted that he was recorded as being uncooperative, in which case it may have been difficult to take pulse and blood pressure, and observe pupil size, but she advised that there is insufficient detail in the nursing home records to evaluate whether they had made reasonable attempts to overcome this. The Nurse IPA stated that she would have expected there to be more evidence of attempts to take vital signs, and also to infer from his physical signs whether there was further reason for concern e.g. increased swelling, agitation.

29. The complainant was concerned that her father was receiving blood thinning medication (Plavex). She believes that as he was receiving this drug and had a head injury, he should have been taken to hospital sooner. In response to this the Nurse IPA stated that Plavix is a treatment that prevents blood platelets sticking together. It is used to prevent blood clots in people that are at risk of conditions such as stroke. The Nurse IPA stated that the most common side effect that is cited by the Electronic Medicines Compendium (EMC) for this medication is bleeding, which includes the risk of bleeding in the head, although this is uncommonly reported. There are special warnings and precautions for use in people who have bleeding and hematological disorders, but this did not apply to the resident. The Nurse IPA's opinion was that due to the fact that he had fallen and hit his head, and had an increasing swelling and was treated with Plavix, it would be reasonable to consider hospital treatment at an early stage.

30. The Nurse IPA stated that the Home's policy for managing a head injury would suggest that an ambulance should be called for all suspected head injuries. In this case the out of hours doctor was called. The doctor was informed of the medication the resident was receiving (Plavix) and advised that he be observed for the time being. The Home's protocol states that 'in the event of a suspected head injury the nurse should seek immediate medical attention by dialing 999'. Therefore in this instance the most appropriate action would have been to call an ambulance. However, the Nurse IPA noted that the Northern Ireland Ambulance Service (NIAS) 'when to call 999' guidance does not specifically list suspected head injury as a medical emergency requiring a 999 call. The Nurse IPA stated that this guidance is

not fully consistent with the Home guidelines. This may have caused a conflict but as a nurse is professionally accountable for his/her actions and should make an independent judgement according to the situation, it was ultimately the nurse's responsibility to exercise judgement to decide whether the circumstances of the head injury indicated a 999 call.

31. When asked if is accepted practice for a nurse to rely upon and accept the advice of a doctor, I was informed that were a nurse concerned about a patient he/she should call an ambulance even against the advice of the doctor. A nurse is not bound to follow the advice of the out of hours doctor if their assessment of the situation is that a 999 call is required. The Nurse IPA stated that it would be the professional duty of the nurse to call an ambulance if he/she felt the situation was potentially life threatening/emergency. The Nurse IPA advised that a head injury that might cause bleeding into the brain would fit into that category.

32. Overall the Nurse IPA advised that there is no single falls risk assessment tool that is completely valid and reliable. Therefore risk assessment scores are only a guide. The professional must make a judgement about the implications of the assessment for safety and management planning. The guidance on head injury and 999 calls require the practitioner to make a professional judgement on the action to be taken in any case.

Analysis and findings

33. It is evident from an examination of the resident's medical history that he had significant mobility and balance problems throughout 2014 and before. These had resulted in numerous falls both at home and while in hospital, necessitating stays in both the Royal Victoria Hospital and Belfast City Hospital throughout the year. Occupational Therapy and nursing assessments carried out prior to his discharge from Belfast City Hospital noted his poor balance and poor compliance with safety advice. He was noted to be able to sit in a chair but it was noted that he would attempt to stand unaided. Further he was deemed not to have capacity. The occupational therapy care management assessment carried out in October 2014

concluded by stating '*The patient's care needs can no longer be met at home. He requires PNH (Private Nursing Home) accommodation which can manage his verbal aggression and behavioural outbursts. His rehab potential is limited by his cognitative impairment…'*

34. The complainant has raised concerns over the effects of falls on her father's condition while in the Home, and in particular the fall the day before he was admitted to hospital. I note that he had also fallen at the Home two days previously when at that time a small bump was noted on the right hand side of his head. This appears to have been a relatively minor fall and he was appropriately observed following it. In the record of this incident it was noted that the resident had been '*found lying on the crash mat 2 times already*...' I therefore asked the Nurse IPA if the falls risk assessments conducted by the Home had been appropriately carried out and whether the Home gave adequate consideration to the factors which contributed to his falls.

35. The Nurse IPA advised me that the resident was appropriately assessed by the Home covering the key areas relating to his falls and that it had correctly recorded the outcome that he was at high risk of falling. I was also advised that the care plan put in place was appropriate to the level of risk presented by the resident. However the Nurse IPA also explained that it is impossible to prevent all falls and given his history, medical condition, age and level of cognitive impairment, he was always at a very high risk of falling.

36. I acknowledge that there is a high incidence of falls in hospital and nursing home settings with ill, elderly patients experiencing proportionately more falls than other age groups. I also accept that not all falls can be prevented and that patients can and do fall, even at times when a carer is present. I note NICE guidance CG161/CG21 which quotes the risk of falling as: 'People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year'. I am satisfied that this was recognised and the appropriate manual handling and falls risk assessments were completed by the Home. The Nurse IPA has confirmed that the risk assessments were carried out in line with current practice and that steps were taken to minimise the resident's risk of

falling but despite this he did experience two falls.

37. Having considered all the circumstances relating to this case I have come to the conclusion that the falls experienced by the resident in October 2014 were unfortunate incidents for which I am unable to attribute a single cause. I accept that it is impossible to prevent with absolute certainty every fall in a nursing home and it is probable that his physical condition and cognitive impairment were significant factors in reducing his recognition of risk.

Finding: I accept the opinion of the Nurse IPA that reasonable precautions and assessments were taken by the Home to minimise the risk of the complainants' father falling. I hope that she is reassured by this.

38. The central aspect of the complaint is that an ambulance ought to have been called following the residents' fall on the night in question. In considering this aspect of the complaint, I also assessed the adequacy of the observations carried out by the Home before his transportation to hospital.

39. The resident fell at approximately 03.35 and was discovered with a bump on his left forehead measuring about 2 inches in diameter. I note that the first telephone call to Beldoc was made at 03.22 while he is recorded in the Home's Evaluation Sheet as falling at 03.35. In considering this discrepancy, I accept that the key priority for the staff involved in times of clinical necessity must be that immediate clinical care is provided to the patient. In such circumstances I fully accept that notes, because of clinical priorities, will require to be written, often some time after the event has occurred and as a consequence timings may therefore be estimated and approximate. I do not consider there to be anything sinister in this slight discrepancy in the timings recorded. I note that a cold compress was applied to the resident's head and his vital signs were taken, that his blood pressure, pulse rate and level of consciousness were noted. The Nurse IPA has stated, and I accept, that this initial assessment and recording of his vital signs following the fall was appropriate.

40. However it is of concern that following the return telephone call from Beldoc at 03.39 no further observations were recorded until 08.30. Further observations were then recorded at 9.30 and 11.00. The Home has stated that he remained in the

lounge area for approximately 90 minutes before going to bed during which time he was monitored by staff. The Home have stated that observations were not physically recorded as he was aggressive and uncooperative during this time.

41. I have considered this matter carefully and having taken the Nurse IPA advice into account, I am of the opinion that the failure to record further observations before 08.30, a period of over four hours, represents a significant failure in the care and treatment afforded to the resident. Following the fall a decision was taken not to immediately call an ambulance and instead the advice of Beldoc was sought. That advice was quite clear - '*observe tonight every hour or 2 and if any deterioration can call and will arrange a+e assessment'*. I acknowledge from the notes and records that the resident could be at times difficult and aggressive. This tendency had been well documented during in his short stay in the Home. However as advised by the Nurse IPA any attempts (and failures) to obtain vital signs ought to have been documented by the Home. Also it is evident from the description and measurement of the bruising on his head taken at 10.00 (9cm) compared to that at 03.39 (2 inches or 5cm) that a physical change had occurred in his bruise but that this or other visual indicators had not been noted in the intervening period. I therefore consider that day staff, who would have taken over from the night staff by 10.00, would have had no reference points upon which to assess the resident, in particular whether he was presenting with a changing condition as time progressed.

Finding: I consider this serious failure in the Homes care and treatment relating to observations by staff to represent a loss of opportunity and thus an injustice to him. I also consider this failing to have caused the complainant the injustice of upset, distress and uncertainty regarding the level of the care and treatment which her father received.

42. A significant element of the complaint relates to concern that an ambulance should have been called immediately upon discovery that the resident had suffered a head injury. In this regard the Home's Protocol for Managing a Head Injury (dated 7 March 2013) is clear and states 'Residents who sustain a head injury should be checked out at A and E.' (Paragraph 21 refers). The protocol also states 'IN THE EVENT OF A SUSPECTED HEAD INJURY – the nurse should seek immediate

medical attention by dialing 999 and requesting immediate assistance…' The rationale for this is provided in the protocol as being the fact that elderly residents in a nursing home may not always be able to communicate their symptoms to nursing staff. I note also that the Home's out of hours policy states that with head injury cases an ambulance should be summoned without first contacting the out of hours service.

43. I note the Northern Ireland Ambulance Service leaflet 'When to Call 999' and Nice Clinical Guidance 176 (January 2014) is not as explicit in stating that an ambulance should be called. I acknowledge that any guidance on head injury and 999 calls will require the practitioner to exercise their professional judgement on appropriate action. I also acknowledge that a nurse in a situation such as this is professionally accountable for their actions and decisions and that on occasion very fine and balanced judgements must be made. I note that action was taken in that a nurse sought the advice of a doctor and in this case the advice received was to monitor and to call back if the situation deteriorated. However, given the Home's clear protocols for managing head injuries and the fact that the resident had suffered a head injury, I consider that the appropriate course of action should have been to call an ambulance to take him to hospital. A further relevant factor in this regard was the additional risk given that he was receiving the medication Plavex. This medication is not a blood thinning medication (such as warfarin), but the IPA has confirmed that a rare complication of taking this drug is a risk of bleeding.

44. **Finding: I consider the failure to call an ambulance to take the resident to hospital following his fall to represent a significant failure in his care and treatment by the Home. I consider it to have caused him the injustice of a loss of opportunity to have his injury fully assessed in hospital at an earlier time. I also consider it to have caused the complainant the injustice of distress and uncertainty regarding the consequences to her father of the care and treatment which he received at this time.**

45. The complainant remains concerned about the subsequent effect of the fall on her father's health. In considering this element of the complaint I obtained the advice of a Consultant Neurosurgeon. The Neurosurgeon IPA advised that the resident was

managed appropriately by the Royal Victoria Hospital when it was decided, following a CT scan of his head, that he required only 'conservative treatment and observation'. The Neurosurgeon IPA noted that, following observations he was deemed to be medically fit for discharge two days later and he agreed with this opinion. However this discharge did not take place until early December 2014 when he was placed in a new Private Nursing Home. The initial delay in discharge was not because of any medical problems relating to the fall being experienced but was due to a delay in sourcing the new Home as his family were reluctant for him to be returned to the previous Home. In early November 2014 he aspirated vomit and developed chest problems, which necessitated him staying in hospital for approximately 1 month. The Neurosurgeon IPA considered that this was wholly unconnected to the head injury experienced in October 2014.

46. He was readmitted to hospital in late December 2014 from the nursing Home with abdominal pain and vomiting. After examination it was decided that he was not a suitable candidate for intensive care or resuscitation should he have a cardio/respiratory arrest. I note over the next few days he developed worsening pneumonia and swallowing difficulties. His condition continued to deteriorate and sadly he died in early January 2015. The Neurosurgeon IPA advised that there is no indication in the medical records that his death was in any way related to or connected to his fall in the Home. I hope that the complainant is reassured by this advice.

CONCLUSION

47. I received a complaint about the actions of Somerton Nursing Home in relation to the care and treatment received by the complainant's late father in October 2014.

48. I have investigated the complaint and have found failures in his care and treatment in relation to the failure to record appropriate observations and a failure to call an ambulance at an earlier time (Paragraphs 41 and 44). I recommend that the

Home provides the complainant with an apology for the injustice of distress and uncertainty regarding the consequences to her father of the care and treatment which he received at this time.

MARIE ANDERSON
Ombudsman

March 2018

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.