Northern Ireland
Public Services
Ombudsman

Investigation of a complaint against the Belfast Health & Social Care Trust

Report Reference: 201914447

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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, and 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.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

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.

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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201914447
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about how the Belfast Health and Social Care Trust (the Trust) handled requests the complainant made to it for a determination of her (now late) husband's eligibility for continuing healthcare (CHC). The complainant's husband is referred to in this report as 'the Resident'. The complaint was also about the Trust's handling of concerns the complainant, and later, a whistleblower, raised about the Resident's care in his nursing home, and its handling of a related complaint the complainant made to it in September 2019.

The complainant informed me that the Resident was admitted to the Ulster Hospital[1] in early October 2017. At the end of that month, when hospital staff advised that the Resident was fit for discharge, and it was suggested he move into a nursing home, his family asked the (Belfast) Trust to determine his eligibility for CHC. They asked the Trust about this again in early December 2017. On both occasions, the Trust indicated there was no provision for CHC in Northern Ireland. Later, after the Resident's discharge from the Ulster Hospital to a nursing home ('the Nursing Home') in early July 2018, the complainant made further representations to the Trust about the determination of his eligibility for CHC. In response, the Trust maintained the position that the Resident was not eligible for CHC because he did not have a primary healthcare need. When she complained to my Office, the complainant said she was dissatisfied with how the Trust had dealt with her requests for a determination of the Resident's CHC eligibility.

The complainant also said the Trust did not deal appropriately with concerns she raised with it in September 2018 about how the Resident's condition was deteriorating in the Nursing Home, in particular, in relation to the weight he had lost since his admission. In addition, the complainant complained that the Trust did not deal properly with allegations a whistleblower made in October 2018 about the Resident's care in the Nursing Home. The complainant was also dissatisfied that the

[1] The Ulster Hospital is within the South Eastern Health and Social Care Trust. Its actions do not form part of the complaint the complainant submitted to me.

Trust did not inform her of the whistleblower allegations as soon as they were reported, and said she considered the Trust did not deal appropriately with the complaint she made to it in September 2019 about its handling of the allegations.

In relation to the Trust's handling of the complainant's requests for the determination of the Resident's eligibility for CHC, my investigation found that numerous assessments of the Resident's needs were completed during his admission to the Ulster Hospital, from 7 October 2017 to 2 July 2018, and following his admission to the Nursing Home on 2 July 2018. I was satisfied these assessments were appropriate and sufficient to inform the Trust's further consideration of a determination of the nature of the Resident's primary care need. However, I found that despite having completed those assessments, the Trust did not then take the necessary steps to determine whether the Resident had a primary healthcare need or a primary social care need. Consequently, it did not determine his eligibility for CHC, in accordance with the Department of Health's policy direction and guidance.

I also found the Trust provided inaccurate information to the complainant about CHC arrangements in Northern Ireland when she and other members of the Resident's family raised the matter at meetings on 31 October and 5 December 2017.

In relation to the Trust's handling of the complainant's and the whistleblower's concerns about the Resident, I was satisfied the Trust took appropriate and reasonable action to respond to those concerns. However, I found the Trust failed to keep an appropriate record of how it responded to the whistleblower allegations. I also found the Trust failed to inform the complainant about the whistle blower allegations as early as ought to have been the case.

In addition, I found a number of instances of maladministration in the Trust's handling of the complaint the complainant made about how the Trust had dealt with the whistleblower allegations concerning the Resident. This maladministration included unreasonable delay in responding to the complaint; failure to keep the complainant updated about that delay and the anticipated timescale for the complaint response; failure to provide full responses to the matters the complainant had raised in her complaint; and providing inaccurate information in the final complaint response.

I recommended the Trust provide a written apology to the complainant and that it implement a number of service improvements. I also recommended that the Trust make a retrospective determination of the Resident's CHC eligibility.

The Trust informed me it was content that my findings and recommendations are reasonable.

THE COMPLAINT

1. I received a complaint about the actions of the Belfast Health and Social Care Trust (the Trust). The complainant made the complaint on behalf of her (now late) husband, who is referred to in this report as 'the Resident'. The complaint relates to the Trust's handling of requests the complainant made to it for a determination of the Resident's eligibility for continuing healthcare (CHC).[2] The complaint is also about the Trust's handling of concerns the complainant, and subsequently, a whistleblower, raised about Resident's care in his nursing home, and its handling of a related complaint the complainant made to it in September 2019.

Background

2. The Resident was diagnosed with Parkinson's disease more than 30 years ago. Until August 2017, he lived at home with his wife, the complainant, receiving support through a package of domiciliary care. On 3 August 2017, the Resident began a temporary placement at a local nursing home for period of emergency respite care. This was because the complainant had been admitted to hospital following an accident and could not help care for the Resident at home.

3. On 8 October 2017, the Resident was admitted to the Ulster Hospital, within the South Eastern Health and Social Care Trust (SEHSCT). (The actions of the SEHSCT were not examined in my investigation of this complaint.) The complainant, the Resident and the Resident's son attended a meeting with Ulster Hospital staff and (Belfast) Trust social work staff on 31 October 2017. Ulster Hospital clinical staff advised that the Resident was medically fit for

[2] At the time these requests were made to the Trust, 'Continuing Healthcare' (CHC) was the term used in Northern Ireland to describe the practice of the health service meeting the cost of any social need which was driven primarily by a health need. Essentially, this meant that if an individual's primary need was for healthcare, rather than for social care (which is also known as personal social services), they did not have to pay for the care they received, irrespective of where that care was provided. The Department of Health introduced a new policy for determining eligibility for CHC in Northern Ireland in February 2021. This new 2021 policy has since been quashed by the High Court ([2023] NIKB 72) on the basis that in adopting it, the Department of Health did not have due regard to the need to promote equality of opportunity between persons of different age under, section 75 of the Northern Ireland Act 1998.

discharge. The Resident's son requested a determination of the Resident's eligibility for CHC. The Trust informed the family there was no provision for CHC in Northern Ireland.

4. The Trust had a further meeting with the Resident's family on 5 December 2017 to discuss the Resident's care needs and options for his discharge from the Ulster Hospital. The Resident's family again raised the matter of the Resident's eligibility for CHC. The Trust informed the Resident's family that there were *'no structures in place at present in relation to [CHC].'*

5. On 5 January 2018, the Trust wrote to the complainant, acknowledging the Resident's family's request for the determination of his eligibility for CHC. The Trust stated it considered *'this level of care [was] not required for [the Resident]'* but that it was *'agreeable to, and … currently in the process of reassessing [the Resident] for eligibility for same'.*

6. The Trust wrote again to the complainant on 22 January 2018. It advised that at the time the Resident was deemed fit for discharge from the Ulster Hospital, it *'carried out the necessary multidisciplinary assessments to allow his discharge from an acute medical bed'.* The Trust stated these multidisciplinary team (MDT) assessments *'confirmed at the time that [the Resident] did not have a primary healthcare need and that a placement in a nursing home was entirely appropriate'.*

7. The complainant telephoned the Trust on 1 February 2018 to complain about its handling of her requests for a determination of the Resident's eligibility for CHC. She stated she was dissatisfied that the Resident's family had not been aware of the MDT assessments the Trust had conducted, nor had the family had any input to those assessments. The complainant also expressed her dissatisfaction that the MDT assessments had not had any input from the Resident's Consultant Neurologist.

8. Subsequently, the complainant wrote to the Trust on 22 February 2018. She stated the Resident's family were *'once again formally requesting that [the*

Trust] begin the process of assessing [the Resident] for eligibility for NHS Continuing Healthcare.'

9. There was a further meeting between Ulster Hospital staff, Trust social work staff, the complainant, the Resident, and the Resident's son and daughter on 27 February 2018. During the meeting, in addition to discussion of options for the Resident's discharge from hospital, the Trust made the Resident's family aware that it had initiated legal proceedings (declaratory judgement proceedings) relating to the determination of the Resident's place of residence, given he no longer had a clinical need to remain in hospital.

10. At a court hearing on 29 June 2018 in relation to the declaratory judgement proceedings, an interim court order was granted, allowing the Trust to place the Resident in a local nursing home ('the Nursing Home') on his discharge from the Ulster Hospital. The Resident was discharged from hospital on 2 July 2018 and began a placement in the Nursing Home.

11. The Trust wrote to the complainant on 11 September 2018, advising that the Court would consider the Resident's eligibility for CHC as part of the ongoing declaratory judgement proceedings.

12. On 25 September 2018, the complainant sent an email to the Resident's key worker ('the Resident's Key Worker') alerting him to what she described as the Resident's *'rapidly deteriorating situation'*. She raised concerns about the Resident's *'condition [and] his state of mind'* and about the weight he had lost since his admission to the Nursing Home on 2 July 2018.

13. On 17 October 2018, the Trust prepared an affidavit in relation to the declaratory judgement proceedings it had initiated some months previously. The Trust shared the affidavit with the complainant's solicitor. Within the affidavit was a Trust report detailing its consideration of the Resident's eligibility for CHC. This report stated that recently completed assessments of the Resident's needs had concluded he did not have a primary healthcare need.

14. The Trust's affidavit of 17 October 2018 also referred to allegations a whistleblower had made to the Regulatory and Quality Improvement Authority

(RQIA) on 4 October 2018 about the care the Nursing Home was providing to a number of its residents, including the Resident. The complainant's solicitor made her aware on 19 October 2018 of the affidavit's reference to the whistleblower allegations.

15. The Trust prepared a further affidavit on 5 December 2018 in relation to the declaratory judgement proceedings. This affidavit included information about the action the Trust had taken in response to the whistleblower allegations about the Resident's care in the Nursing Home. Following a hearing on 11 December 2018, the Court granted a full court order, confirming that the Resident should remain in the Nursing Home. The court order made no reference to consideration of the Resident's eligibility for CHC.

16. The complainant contacted the Patient and Client Council (PCC) on 17 April 2019, seeking its assistance in relation to a number of complaints she had by then submitted to the Trust, including her complaint of 1 February 2018 about the determination of the Resident's eligibility for CHC. She also sought PCC's assistance in obtaining information from the Trust about its handling of the whistleblower allegations about the Resident's care in the Nursing Home.

17. On 10 May 2019, the complainant wrote to the Trust asking it to again consider her request for a determination of the Resident's eligibility for CHC, given that the Court had not addressed the matter as part of the declaratory judgement proceedings, which had concluded on 11 December 2018.

18. The complainant wrote again to the Trust on 11 September 2019 to complain about how it had responded to the whistleblower allegations about the Resident's care in the Nursing Home. The complainant referred to the Trust not having informed her of the whistleblower allegations. She also highlighted difficulties she had encountered in seeking to obtain full and accurate information about the action the Trust had taken in response to those allegations. The complainant found it necessary to write again to the Trust, on 19 November 2019, when she did not receive a response to her complaint of 11 September 2019.

19. The Trust wrote to the complainant on 10 April 2020 about a number of matters she had raised with it, including her complaint of 11 September 2019 about the Trust's handling of the whistleblower allegations. The Trust provided some information about action it had taken in response to the allegations. It also apologised that it had not informed the complainant immediately about the whistleblower allegations.

20. The complainant wrote again to the Trust, on 2 December 2020, about a number of matters. These included her dissatisfaction with the Trust's lack of response to her complaint regarding its handling of her requests for the determination of the Resident's eligibility for CHC and about the Trust's handling of the whistleblower allegations concerning the Resident's care in the Nursing Home.

21. The Trust responded to the complainant's letter on 8 April 2021. In relation to the Resident's eligibility for CHC, the Trust informed the complainant that the MDT assessments completed while the Resident was a patient in the Ulster Hospital (from 8 October 2017 to 2 July 2018) had confirmed that he did not have a primary healthcare need. The Trust also advised the complainant that it had since reviewed this decision and that the outcome of this review was set out in the Trust's affidavit of 17 October 2018.

22. In relation to the Trust's handling of the whistleblower allegations, the Trust apologised it had not made the complainant aware of the concerns as soon as it had learned of them. The Trust also stated it was satisfied that staff had followed relevant guidance in responding to the whistleblower allegations.

23. Being dissatisfied with the Trust's response regarding its handling of her requests for a determination of the Resident's eligibility for CHC and its handling of the whistleblower concerns, the complainant complained to my Office.

Issues of complaint

24. I accepted the following two issues of complaint for investigation:

    Issue One:
    Whether the Trust considered appropriately the complainant's requests for the determination of the Resident's eligibility for continuing healthcare, in accordance with relevant policies, procedures and guidelines.

    Issue Two:
    Whether the Trust responded appropriately to concerns raised in 2018 about the Resident's care in the Nursing Home, in accordance with relevant policies, procedures and guidelines, in particular:

    (i) whether the Trust dealt appropriately with the concerns the Resident's family raised in September 2018 and with the concerns a whistleblower raised in October 2018; and

    (ii) whether the Trust responded appropriately to the complaint the complainant made in September 2019 about its handling of reported concerns regarding the Resident's care in the Nursing Home.

INVESTIGATION METHODOLOGY

25. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation and records, together with the Trust's comments on the issues the complainant had raised. The Investigating Officer also obtained the Resident's records and notes from the Nursing Home, his GP records and records relating to several hospital admissions during the period my investigation considered. In addition, the Investigating Officer obtained records from PCC relating to the support and assistance it provided to the complainant in raising her concerns with the Trust.

Independent Professional Advice

26. After further consideration of the issues raised in this complaint, I obtained independent professional advice from the following independent professional advisor (IPA):

- a Registered Nurse with 40 years' experience, including 20 years' experience within NHS Continuing Healthcare.

27. The IPA provided me with 'advice'. How I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

28. 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. I also refer to relevant regulatory, professional and statutory guidance.

29. The general standards are the Ombudsman's Principles:[3]
    (i) The Principles of Good Administration; and
    (ii) The Principles of Good Complaint Handling.

    These Principles are reproduced in Appendix One and Appendix Two to this report.

30. The specific standards are those which applied at the time the events complained of occurred. These governed the exercise of the administrative functions of the organisation and professional judgement of the individuals whose actions are the subject of this complaint.

31. The specific standards relevant to this complaint are:

    (i) The Health and Personal Social Services (NI) Order 1972 ('the 1972 Order');

    (ii) Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance, issued by the (then) Department of Health, Social Services and Public Safety on 11 March 2010 ('the 2010 Circular');

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

(iii) Circular ECCU1/2006, HPSS Payments for Nursing Care in Nursing Homes, issued by the (then) Department of Health, Social Services and Public Safety on 10 March 2006 ('the 2006 Circular');

(iv) Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system, issued by the Department of Health on 12 May 2021 ('the 2021 Circular');

(v) Safeguarding Vulnerable Adults, Regional Adult Protection Policy and Procedural Guidance, September 2006 ('the 2006 Safeguarding Vulnerable Adults Regional Policy and Procedural Guidance');

(vi) Northern Ireland Adult Safeguarding Partnership Adult Safeguarding Operational Procedures, September 2016 ('the 2016 NIASP Adult Safeguarding Operational Procedures');

(vii) Belfast Health and Social Care Trust Quality Monitoring Reporting Process ('the Trust's Quality Monitoring Reporting Process');

(viii) Whistleblowing the Public Sector, A Good Practice Guide for Workers and Employers, November 2014 ('the 2014 Whistleblowing Good Practice Guide'); and

(ix) Guidance in Relation to the Health and Social Care Complaints Procedure, issued by the Department of Health on 1 April 2019 ('the 2019 HSC Complaints Procedure Guidance').

32. I did not include in this report all the information I obtained in the course of the investigation. However, I am satisfied that in reaching my findings, I took into account everything I consider relevant and important.

33. I shared a draft of this report with the complainant and with the Trust to allow them to comment on its factual accuracy and the reasonableness of my findings and recommendations. The complainant and the Trust both provided comments in response. I gave careful consideration to all the comments I received before finalising this report.

THE INVESTIGATION

Issue of Complaint One:

Whether the Trust considered appropriately the complainant's requests for the determination of the Resident's eligibility for continuing healthcare, in accordance with relevant policies, procedures and guidelines.

Detail of Complaint

34. The complainant expressed her dissatisfaction with how the Trust handled requests she, and other members of the Resident's family, made for a determination of the Resident's eligibility for CHC.

35. My investigation examined the Trust's actions during the period 31 October 2017 (the date on which the complainant (and/or other members of the Resident's family) first asked the Trust to determine the Resident's CHC eligibility) to 8 April 2021 (the date on which the Trust last notified the complainant of its position on her requests for a determination of the Resident's CHC eligibility).

Evidence Considered

Legislation, Policies and Guidance

36. I considered the following legislation, policies and guidance:
    - The 1972 Order;
    - The 2010 Circular;
    - The 2006 Circular; and
    - The 2021 Circular.

37. Relevant extracts of the legislation, policies and guidance I considered are at Appendix Three to this report.

The Trust's response to investigation enquiries

38. I made written enquiries of the Trust about the issues the complainant raised. Relevant extracts of the Trust's response to my enquiries are at Appendix Four to this report.

Documentation and records examined

39. I completed a review of the copy documentation the Trust provided in response to my investigation enquiries; the documentation the complainant provided in support of her complaint; the Resident's Nursing Home and GP records; and records relating to the Resident's hospital admissions during the period my investigation considered. Relevant extracts of the documentation I reviewed are at Appendix Five to this report.

40. Based on my review of the documentation, I compiled a chronology of key events relating to the Trust's handling of complainant's requests for a determination of the Resident's CHC eligibility. This chronology is at Appendix Six to this report.

Independent Professional Advice

41. I considered the advice I obtained from the IPA. This advice related to the Trust's assessment of the Resident's care needs and its actions in relation to the determination of his eligibility for CHC.

42. The IPA's full advice report is at Appendix Seven to this report.

Analysis and Findings

43. Before I set out my findings on this complaint, I should highlight that in February 2021, the Department of Health published the outcome of a public consultation it launched in June 2017 on future arrangements for CHC in Northern Ireland. Later, in May 2021, the Department of Health issued details[4] of a new policy for determining CHC eligibility on the basis of applying a single eligibility criterion. The new CHC eligibility criterion was whether an individual's care needs can be properly met in any setting other than a hospital. The new policy was that if the answer to this question was 'yes', then the individual would not be eligible for CHC and would be subject to the relevant charging policy for the care they receive.

[4] Circular HSC (ECCU) 1/2021 – Continuing Healthcare in Northern Ireland: Introducing a fair and transparent system ('the 2021 Circular')

44. The new single eligibility criterion policy came into effect on 11 February 2021, and applied to new applications for CHC made since that date.[5] Consequently, the new CHC policy was not in operation at the times the complainant asked the Trust to determine the Resident's CHC eligibility. It is not, therefore, applicable to my investigation of this first issue of complaint. The relevant policy is the previous CHC eligibility policy, that is, the one set out in the 2010 Circular, as issued in March 2010. Therefore, in setting out my findings on this issue of complaint, I will refer to the 2010 Circular policy.

45. Given the particular circumstances of this case, primarily that the Resident was diagnosed with a long-term condition (Parkinson's disease) more than 30 years ago and that many of his care needs were related to that condition, it is also important that I emphasise a further matter concerning CHC eligibility. This is that eligibility for CHC in Northern Ireland is determined solely on the basis of an individual's assessed needs, that is, a determination of whether their primary need is for healthcare or for social care; CHC eligibility is not determined on the basis of the individual having any particular disease, diagnosis or condition.

46. In considering this complaint, I am mindful that the 1972 Order (the main legislation governing the provision of health and social care services in Northern Ireland) does not provide an explicit statutory framework for the provision of CHC, nor does it expressly require that CHC be provided to people in Northern Ireland. Nevertheless, I am aware that the 2010 Circular, which sets out the Department of Health's guidance on charging for social care (which is also known as personal social services) provided in residential care homes and nursing homes, states at paragraph 63, *'[The 1972 Order] requires that a person is charged for personal social services provided in residential or nursing home accommodation arranged by a [Health and Social Care] Trust.* ***There is no such requirement, or authority, to charge for healthcare provided in the community, either in the service user's own home or in a residential care or nursing home'*** (the 2010 Circular's emphasis). There is, therefore, a clear and important difference between healthcare and social care, in terms of

[5] The new 2021 CHC eligibility policy has since been quashed by the Northern Ireland High Court ([2023] NIKB 72)

whether a HSC Trust has the legal authority to charge for care provided to an individual who has moved into a residential care or nursing home.

47. I note this distinction was reinforced by the (then) Minister of Health when he responded in September 2013 to an Northern Ireland Assembly Question[6] about CHC. The Minister stated, *'… an individual's primary need can either be for health care – which is provided free – or for social care for which a means tested contribution may be required.'*

48. I note too that the difference between charging for healthcare and social care was highlighted in the Department of Health's June 2017 public consultation document on future arrangements for CHC in Northern Ireland. The consultation document stated that where an assessment of an individual's needs *'indicate[s] a primary need for healthcare, [the relevant HSC Trust] is responsible for funding the complete package of care in whatever setting. This is what is known as continuing healthcare in the local context. Alternatively a primary need for social care may be identified and where such a need is met in a residential care or nursing home setting, legislation requires the HSC Trust to levy a means-tested charge'.*

49. Given the significance of the distinction between healthcare and social care, in relation to a HSC Trust's authority to apply charges for the care an individual receives, I should highlight the advice I obtained from the IPA regarding the difference between the two.

50. The IPA advised that healthcare in the community is provided free of charge and is delivered through services such as GP practices, therapy services and specialist health teams, such as mental health. The IPA advised that an individual's identified health needs are normally met either directly by, or under the supervision of, registered nurses, therapists, dieticians, audiologists etc., depending on the specialism required to meet the identified healthcare need.

51. The IPA highlighted that a definition of personal care (or social care) is provided in Annex D to the 2010 Circular. She pointed out this states that personal care

[6] Assembly Question AQW 25318/11-15

'includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity; disablement; past or present dependence on alcohol or drugs; or past or present mental disorder …'. The IPA advised that a further definition of personal care is provided in the Department of Health's 2006 publication, 'Payments for Nursing Care'. The IPA highlighted this states that personal care is *'care you need to help you in the activities of daily living; for example, help with toileting and other personal needs like bathing, dressing and undressing, getting in and out of bed, moving around and help with feeding. It might also cover advice, encouragement and supervision in these activities. Care assistants rather than registered nurses will usually see to your personal care needs'.*

52. For the sake of clarity, I should also highlight the difference between personal care (or social care) and nursing care. This difference is important because the 2006 Circular (paragraph 2) explains that HSC Trusts are responsible *'for paying the cost of nursing care of residents who otherwise pay the full cost of their nursing home care.'* The IPA pointed out that the Department of Health's publication, 'Payments for Nursing Care', describes nursing care as follows: *'Nursing care means care by a registered nurse in providing, planning and supervising your care in a care home providing nursing care. It does not include any time spent by any other staff, such as care assistants, who may also be involved in your care. However, it would include the time spent by a nurse in supervising the care you get from others and in monitoring any aspects of your care delegated to other staff. It is different from personal care … It might also cover advice, encouragement and supervision with these [personal care] activities …'.*

53. I now return to my findings on the Trust's handling of the complainant's requests for a determination of the Resident's eligibility for CHC. I established that during the period my investigation considered, the complainant (and/or other members of the Resident's family) made several specific requests to the Trust for a determination of the Resident's eligibility for CHC.

54. I found that the complainant, the Resident and the Resident's son met with Ulster Hospital staff and Trust social work staff on 31 October2017, approximately three weeks after the Resident's admission to hospital on 8 October 2017. The Ulster Hospital's record of the meeting documents that clinical staff advised the Resident was fit for discharge and that options for his discharge were discussed. The meeting record also documents that the Resident's son requested a determination of his father's eligibility for CHC, and that the Trust's (then) Acting Assistant Service Manager, Older Peoples Services ('the Older Peoples Services Assistant Service Manager'), advised *'there was no specific piece of legislation in Northern Ireland in relation to [CHC] and cannot be accessed by [the Trust]'.*

55. The information the Trust provided to the complainant on that occasion was inaccurate because the 2010 Circular makes it clear that there was provision for CHC in Northern Ireland at the time of the 31 October 2017 meeting. Specifically, the 2010 Circular states, in paragraph 88, *'When contracting with homes, HSC Trusts should contract for the full cost of the placement, and where there has not been a determination of continuing healthcare, seek reimbursement …'*

56. The existence of CHC in Northern Ireland at the time of the 31 October 2017 meeting was also made clear in the Department of Health's June 2017 public consultation on future arrangements for CHC. As I highlighted earlier in this report, the Department's consultation document explained the term 'continuing healthcare' describes the practice of the health service meeting the cost of any social need which is driven primarily by a health need. Specifically, the consultation document stated, *'…At present, if the outcome of an assessment [of an individual's needs] indicates a* ***primary need for healthcare****, then the HSC is responsible for funding the complete package of care in whatever setting. This is what is known as* ***continuing healthcare*** *in the local context.'*

57. I note the complainant, the Resident's son and the Resident's daughter attended a further meeting with Trust social workers on 5 December 2017. The Resident's GP was also present. The matter of the Resident's eligibility for CHC was raised again. The Trust's record of the meeting documents that the

Older Peoples Services Assistant Service Manager informed the Resident's family members that there were *'no structures in place at present in relation to continuing health care'.* Again, this was inaccurate information about CHC because as described above, the 2010 Circular and the Department of Health's 2017 public consultation on future arrangements for CHC both confirm that CHC did exist in Northern Ireland in 2017. Both documents also confirm that an individual's eligibility for CHC is determined on the basis of an assessment of their care needs.

58. In commenting on the draft of this report, the Trust maintained that the Older Peoples Services Assistant Service Manager's comment on 5 December 2017, that there were *'no structures in place at present in relation to continuing health care'*, was *'an accurate statement and reflects the position the Trust has been in for a number of years and is borne out in the findings of [[2023] NIKB 72]'.* I do not accept the Trust's position.

59. This is because I am aware that the written judgement[7] in [2023] NIKB 72 highlighted that, in 2015, the Trust informed the Department of Health, *'… [the Trust] does not consider the concept of "continuing healthcare" relevant or easily definable within an integrated health and social care system. The term continuing healthcare … pertains to GB where health and social care systems are quite separate … individuals [who request determinations of continuing healthcare eligibility] are referred to their MDT or Care Manager. We do indicate that [for] anyone assessed for placement in a nursing home the primary need will be personal and social care, not "continuing healthcare" as the concept does not apply in a [Northern Ireland] setting.'* I consider this response from the Trust, coupled with the statement the Older Peoples Services Assistant Service Manager made at the previous meeting with the complainant on 31 October 2017, that '*there is no specific piece of legislation in Northern Ireland in relation to Continuing Health Care and cannot be accessed by [the Trust]'*, is a strong indication that around the time the complainant was requesting a determination of the Resident's CHC eligibility, the Trust held the view that there was no provision for CHC in Northen Ireland.

[7] [2023] NIKB 72, paragraphs [58] and [59]

60. I do not, therefore, accept that the Trust's 5 December 2017 statement, that there were *'no structures in place at present in relation to continuing health care'*, was a reference to an absence of a proper framework for determining CHC eligibility and not an intention to convey the belief that CHC did not exist within this jurisdiction. Consequently, my finding that the Trust provided inaccurate information to the complainant on that occasion stands.

61. My investigation found that the Older Peoples Services Assistant Service Manager wrote to the complainant on 5 January 2018. She acknowledged the complainant's request *'for the [the Resident] to be considered as eligible for [CHC]'* and advised the complainant that the Trust was '*currently in the process of reassessing [the Resident] for eligibility for same*.'

62. I note that the Older Peoples Services Assistant Service Manager wrote to the complainant again on 22 January 2018. She informed the complainant that a number of MDT assessments had been completed for the Resident at the time he *'was first deemed medically fit for discharge [from the Ulster Hospital]'.* The Older Peoples Services Assistant Service Manager also informed the complainant that the purpose of these MDT assessments was '*to allow [the Resident's] discharge from an acute medical bed'.* The Older Peoples Services Assistant Service Manager further stated that the MDT assessments '*confirmed at the time that [the Resident] did not have a primary healthcare need and that a placement in a nursing home was entirely appropriate'.* She also advised that the Trust's position on the Resident's eligibility for CHC, which had been reached *'following the outcome of these MDT assessments'*, remained unchanged.

63. When it responded to my investigation enquiries, the Trust stated that throughout the period the Resident was in the Ulster Hospital (8 October 2017 to 2 July 2018), he was cared for by a MDT *'who continually monitored, reviewed and assessed him.'* The Trust said, '*One of the key assessments used to inform care plans is the Northern Ireland Single Assessment Tool (NISAT) … [The social worker who completed the Resident's NISAT assessment] had access to [the Resident's] hospital records and had discussions with the professional team involved with [the Resident] both of*

which informed her assessment. She also sought the views of [the complainant] and the family as part of her assessment.'

64. The Trust informed me that it did not complete a '*separate standalone assessment to determine [the Resident's] eligibility for [CHC]'*, relying instead on the MDT assessments to determine *'whether [the Resident's] primary need was for healthcare or social care as set out in [the 2010 Circular]'.* The Trust referred to several particular assessments of the Resident's needs. These were: a Speech and Language Therapy assessment on 7 September 2017; a Physiotherapy assessment on 9 October 2017; an Occupational Therapy assessment on 1 December 2017; a NISAT complex assessment on 18 December 2017; and a NISAT GP report of 9 January 2018. The Trust also pointed out that it had sought the views of the Resident's family as part of its assessment of his needs, referring to contact with them on 31 October, 5 December and 19 December 2017.

65. I sought the advice of the IPA regarding the MDT assessments that had already been completed for the Resident by the time the Older Peoples Services Assistant Service Manager wrote to the complainant on 22 January 2018. I asked the IPA if these assessments were appropriate and sufficient to determine the nature of the Resident's primary need at that time, that is, whether his primary need was for healthcare or for social care. The IPA advised she considered these assessments were sufficient and appropriate for that purpose. The IPA highlighted that by the time the Trust wrote to the complainant on 22 January 2018, a number of assessments of the Resident's needs had been completed in the Ulster Hospital. The IPA advised that the fact the Resident had been in hospital for several weeks by the time the MDT concluded he was fit for discharge would have *'allowed time for [his] usual range of presenting needs to observed and assessed prior to the discharge planning process'*.

66. The IPA pointed out that the assessments completed by the time of the Older Peoples Services Assistant Service Manager's email of 22 January 2018 is time included a NISAT complex assessment on 18 December 2017. She advised this assessment *'considered the family's view and included reports*

from the MDT involved in the Resident's care including Social Care, Nursing, Physiotherapy, Occupational Therapy, and Speech and Language Therapy'. The IPA further advised, *'The information within the NISAT with the associated reports and records adequately established the range and extent of the Resident's health and personal care needs. These assessments were of sufficient detail and depth for an MDT to determine if the Resident had a primary need for health or personal care services at that time'.*

67. In commenting on the draft of this report, the Trust contended this element of the IPA's advice was factually inaccurate. The Trust said the judgement in [2023] NIKB 72 '*determined that NISAT MDT assessments are not in themselves sufficient to determine CHC eligibility.'* I acknowledge the MDT assessments the Trust completed of the Resident's needs would not, in themselves, have determined his eligibility for CHC. Rather, I consider it was for the Trust, having completed those assessments, to then take the necessary steps to determine whether the Resident had a primary healthcare need or a primary social care need. The requirement for the Trust to do so was made clear in paragraph 17[8] of the 2010 Circular, which states, *'… it is for clinicians, together with other health and social care professional colleagues and in consultation with the service user, his/her family and carers, to determine through a comprehensive assessment of need whether an individual's primary need is for healthcare or for personal social services'.*

68. I also sought the IPA's advice as to whether there was evidence within the records I had provided to her that, on the basis of the assessment of the Resident's needs while he was still in the Ulster Hospital, the Trust had made a determination of the nature of his primary need, and consequently, his eligibility for CHC.

69. The IPA referred to the Older Peoples Services Assistant Service Manager's email of 22 January 2018 to the complainant. She pointed out this stated the Resident did not have a primary healthcare need. The IPA advised that

[8] Paragraph 17 of the 2010 Circular remained in effect until 11 February 2021 and therefore still applied at the time of the complainant's requests for a determination of the Resident's eligibility for CHC.

although this indicated the Trust <u>had</u> reached a determination on the Resident's eligibility for CHC, the records I had obtained from the Trust suggested it had reached that view not on the basis of *'the extent and range of the Resident's assessed health needs'* but on *'where his needs could be met'.*

70. The IPA advised, '*There is no information within the records that the MDT considered the Resident's needs in the context of [CHC], or came to any conclusion [as to] whether his primary need was for healthcare or social care. This is supported through the records of communications with the family. An example being during a meeting [on] 06 December 2017 with the complainant, [the Older Peoples Services Assistant Service Manager] advised that "there is* [sic] *no structures in place at present in relation to continuing healthcare".'* The IPA added, '*This statement to the complainant suggests that no local processes were in place for the MDT to follow when considering if an individual had a primary need for healthcare and therefore may be eligible for CHC funding.'*

71. I accept the IPA's advice. I am satisfied that the MDT assessments already completed by the time the Older Peoples Services Assistant Service Manager wrote to the complainant on 22 January 2018 were appropriate and sufficient to inform the Trust's further consideration of a determination of the nature of the Resident's primary need and, therefore, his eligibility for CHC. However, contrary to the Trust's position at that time, which was that a decision on the Resident's CHC eligibility had been taken *'following the outcome of these MDT assessments',* my investigation found no evidence of any determination of the nature of Resident's primary need and, consequently, his eligibility for CHC, having been made by that time.

72. My investigation found the complainant contacted the Trust on 1 February 2018 to complain about its handling of her requests for a determination of the Resident's eligibility for CHC. The complainant later wrote to the Trust, on 22 February 2018, *'once again formally requesting that [the Trust] begin the process of assessing [the Resident], for eligibility for NHS Continuing Healthcare'.* I note the complainant informed the Trust that the Resident's family considered he had *'a primary health need'* and that he should be assessed for CHC '*because of his complex medical needs as a result of his*

Advanced Complex Parkinson's Disease which comprehensively affects all parts of his body and mind'. The complainant also pointed out in her letter to the Trust that the Department of Health had informed her that CHC was accessible, as set out in the 2010 Circular.

73. I note the Trust's (then) Director of Adult Social and Primary Care ('Director A') wrote to the complainant on 11 September 2018 advising that the Resident's eligibility for CHC was being considered by the Court, as part of the declaratory judgement proceedings[9] the Trust had initiated some months earlier. Director A informed the complainant that given this circumstance, her complaint about the Trust's handling of her requests for a determination of the Resident's CHC eligibility would be *'stood down until such time as the Court proceedings have concluded'.*

74. I also note the Older Peoples Services Assistant Service Manager, on behalf of the Trust, signed an affidavit on 17 October 2018, in relation to the declaratory judgement proceedings. The affidavit included a report on the Trust's consideration of the Resident's eligibility for CHC. This report stated that the Trust had completed a *'comprehensive assessment of need'* to establish the Resident's eligibility for CHC. A number of MDT assessments were listed in the affidavit as having informed that assessment of need. These were: an Occupational Therapy assessment on 25 July 2018; Physiotherapy and Nursing assessments on 30 July 2018; and a NISAT complex assessment on 1 August 2018. The affidavit also referred to a review of the Resident, which his Consultant Neurologist had completed on 25 July 2018. The affidavit stated, '*These assessments conclude that [the Resident's] identified needs can be met in a community setting outside of hospital and within a nursing home placement. They also conclude that [the Resident] does not have a primary healthcare need and that his primary need remains for personal social services.'*

75. I sought the advice of the IPA as to whether the assessments of the Resident's care needs that were referenced in the Trust's affidavit of 17 October 2018

[9] Legal proceedings relating to the determination of the Resident's place of residence.

were sufficient and appropriate to determine the nature of his primary need at that time, that is, whether his primary need was for healthcare or for social care.

76. The IPA advised she considered the assessments of the Resident's care needs that were referenced in the Trust's affidavit were *'sufficient and appropriate to determine the nature of his primary need at that time.'* She highlighted that the Trust completed a NISAT complex assessment on 1 August 2018 and that *'as part of this assessment had reports from the MDT including Nursing, Physiotherapy and Occupational Therapy.'* The IPA advised, *'This is the appropriate process within Northern Ireland for an MDT to determine whether an individual's primary need is for healthcare or for personal social services'.*

77. The IPA advised that at the time the Trust completed the NISAT complex assessment of 1 August 2018, *'no significant change was identified since [the Resident's] discharge from hospital in July 2018'.* She also advised, *'This is also supported by [the Resident's Consultant Neurologist's] opinion [of] 25 July 2018 who confirmed "no change in presentation".'*

78. The IPA further advised, *'The information within the NISAT with the associated reports and records adequately established the range and extent of the Resident's health and personal care needs at that time, and any events and changes that had happened whilst resident at the Nursing Home. These assessments considered the family's view and were of sufficient detail and depth for an MDT to determine if the Resident had a primary need for health or personal care services.*

79. I also sought the IPA's advice on whether there was evidence within the records I had provided to her that, having assessed the Resident's needs following his discharge from the Ulster Hospital to the Nursing Home on 2 July 2018, the Trust then went on to make a determination of the nature of his primary need at that time, and consequently, his eligibility for continuing healthcare.

80. The IPA advised that the outcome of the Trust's assessment was that the Resident's needs were being adequately met within the Nursing Home. She advised, *'There is no information within the records that the MDT considered*

the Resident's needs within the context of [CHC] or came to any conclusion whether his primary need was for healthcare or social care.'

81. I accept the IPA's advice. I am satisfied that the MDT assessments referenced in the Trust's affidavit of 17 October 2018 were appropriate and sufficient to inform the Trust's further consideration of a determination of the nature of the Resident's primary need and, therefore, his eligibility for CHC. However, I consider there is a lack of evidence to demonstrate that the Trust made a formal determination of the nature of the Residents primary need and therefore, his eligibility for CHC, at that time, despite it having had the information that would have allowed it to do so. The basis for the Trust's statement in its affidavit of 17 October 2018 - that the *'comprehensive assessment of need'* it had completed for the Resident in late July/early August 2018 concluded that he *'does not have a primary healthcare need and that his primary need remains for personal social* services' - is therefore unclear.

82. My investigation established that, in the event, the order the High Court made following the conclusion of the declaratory judgement proceedings on 11 December 2018 did not address the matter of the Resident's eligibility for CHC. I note the complainant highlighted this when she wrote to the Trust on 10 May 2019, asking it to *'reinstate'* her complaint about the Trust's consideration of the Resident's CHC eligibility.

83. The Trust provided its formal response to the complainant's complaint (about the Trust's handling of requests for a determination of CHC eligibility) when its (then) Interim Director, Adult and Social Primary Care Directorate ('Director B') wrote to the complainant on 8 April 2021. I note Director B stated that the Older Peoples Services Assistant Service Manager's correspondence of 22 January 2018 to the complainant had *'outlin[ed] the Trust's decision regarding [CHC]'* at that time. She stated this decision was that MDT assessments completed while the Resident was in the Ulster Hospital (from 7 October 2017 to 2 July 2018) *'confirmed he did not have a primary healthcare need and that a nursing home placement was appropriate to meet his needs'.* Director B also stated in her letter that the Trust's decision on the Resident's eligibility for CHC was '*again reviewed and set out in [the Older Peoples*

Services Assistant Service Manager's affidavit of 17 October2018] for the court hearing … which was shared with [the complainant] as part of the court papers …'

84. It is evident from Director B's letter of 8 April 2021 that the Trust did not consider the Resident's eligibility for CHC at any time following the conclusion of the declaratory judgement proceedings in December 2018. This is also clear from the Trust's response to my investigation enquiries, in which it stated, *'There has been no substantive change in the level of care [the Resident] has required [since his admission to the Nursing Home] which would have warranted a review of the decision regarding [his] eligibility for [CHC]'.*

85. Having examined the circumstances of the Trust's handling of the complainant's requests for a determination of the Resident's eligibility for CHC, I am satisfied that during the nine-month period the Resident was a patient in the Ulster Hospital and, subsequently, during the period in which the declaratory judgement proceedings were ongoing, the Trust (and the SEHSCT) completed numerous assessments of his care needs. Having accepted the advice of the IPA on the matter, I am also satisfied that those assessments were appropriate and sufficient to inform the Trust's further consideration of a determination of the nature of the Resident's primary care need.

86. However, I consider there is a lack of evidence to demonstrate that having completed those assessments, the Trust then took the necessary steps to determine, on the basis of the information obtained through the assessments, whether the Resident had a primary healthcare need or a primary social care need. Consequently, I conclude the Trust did not determine the Resident's eligibility for CHC, in accordance with the policy direction set out in the 2010 Circular, in response to the complainant's requests for it to do so.

87. In addition, for the reasons I set out earlier in this report, I consider information the Trust provided to the complainant and other members of the Resident's family at meetings on 31 October and 5 December 2017, in response to their enquiries about CHC, was inaccurate and contrary to CHC policy position set out in the 2010 Circular.

88. I referred earlier in this report to the Principles of Good Administration being the standards against which the administrative actions of public bodies are to be judged. These principles (which are reproduced at Appendix One to this report) require public bodies to get it right; be customer focused; be open and accountable; act fairly and proportionately; put things right; and seek continuous improvement.

89. The First Principle of Good Administration, *'Getting it Right'*, requires a public service provider to act in accordance with the law, policy and guidance. The Third Principle, *'Being Open and Accountable'*, requires a public body to be open and clear about policies and procedures, and to ensure information it provides is clear and accurate. The failings disclosed by my investigation of this first issue of complaint indicate that in its handling of the complainant's requests for a determination of the Resident's eligibility for CHC, the Trust did not meet the standards required by these Principles. I consider this to be maladministration on the part of the Trust.

90. I am satisfied this maladministration caused the complainant to sustain the injustice of frustration and uncertainty. I also consider she had a reasonable and justifiable expectation that the Trust would deal appropriately with her requests for the Resident's CHC eligibility to be determined, in accordance with the policy that applied at the time. My investigation established that this expectation was not met.

91. I cannot be certain what the outcome would have been had the Trust dealt appropriately with the complainant's requests for a determination of the Resident's CHC eligibility, in accordance with the 2010 Circular. I am clear that the Resident's records show that during the period my investigation examined he had a comprehensive range of complex social care needs, nursing needs and healthcare needs, many of which resulted from his Parkinson's disease. That said, I am mindful that even if an individual has a comprehensive range of complex needs, that, in itself, does not necessarily mean the individual's primary need is for healthcare.

92. I note the IPA provided advice on the nature of the Resident's primary need during the period July 2018 to April 2021. The IPA's analysis of the Resident's care needs is summarised in her advice report (which is at Appendix Six to this report). Extracts of the Resident's records, which the IPA considers illustrate the range of his care needs during that same period, are reproduced at Appendix 1 to the IPA's advice report.

93. The IPA's view is that the Resident did not have a primary healthcare need during the period I considered, that is, July 2018 to April 2021. While I note this advice, I am conscious it is based on the IPA's review of the Resident's records, rather than on the application of a clear, formal framework for determining CHC eligibility or with the involvement of the Resident and his family. In view of this, I do not make any determination in this report in relation to the nature of the Resident's primary need and his eligibility for CHC.

94. However, having found a number of instances of maladministration on part of Trust in relation to its handling of the requests the complainant made for the Resident's CHC eligibility to be determined, and being satisfied that this maladministration caused the complainant to sustain injustice, I uphold this first issue of her complaint.

Issue of Complaint Two:

Whether the Trust responded appropriately to concerns raised in 2018 about the Resident's care in the Nursing Home, in accordance with relevant policies, procedures and guidelines, in particular:

(i) whether the Trust dealt appropriately with the concerns the complainant raised in September 2018 and with the concerns a whistleblower raised in October 2018; and

(ii) whether the Trust responded appropriately to the complaint the complainant made in September 2019 about its handling of reported concerns regarding the Resident's care in the Nursing Home.

Detail of Complaint

95. The complainant considers the Trust failed to deal properly with concerns she raised about the Resident's deteriorating condition. She brought these concerns, which related primarily to the amount of weight the Resident had lost since his admission to the Nursing Home in July 2018, to the attention of the Resident's Key Worker in an email dated 25 September 2018. Subsequently, on 4 October 2018, a whistleblower raised similar concerns, through RQIA, about the Resident's weight loss in the Nursing Home. When she complained to my Office, the complainant said the Trust did not investigate these concerns properly and that it failed to inform her about the whistleblower allegations at an early stage. She also expressed her dissatisfaction with how the Trust dealt with the complaint she made to it about its handling of the whistleblower allegations.

Evidence Considered

Legislation, Policies and Guidance

96. I considered the following legislation, policies and guidance:
    - the 2010 Circular;
    - the 2006 Safeguarding Vulnerable Adults Regional Policy and Procedural Guidance;
    - the 2016 NIASP Adult Safeguarding Operational Procedures;
    - the Trust's Quality Monitoring Reporting Process;
    - the 2014 Whistleblowing Good Practice Guide; and
    - the 2019 HSC Complaints Procedure Guidance.

97. Relevant extracts of the legislation, policies and guidance I considered are at Appendix Three to this report.

The Trust's response to investigation enquiries

98. I made written enquiries of the Trust about the issues the complainant raised. Relevant extracts of the Trust's response to my enquiries are at Appendix Four to this report.

Documentation and records examined

99. I completed a review of the copy documentation the Trust provided in response to my investigation enquiries; documentation the complainant provided in support of her complaint; the records I obtained from the Nursing Home; the Resident's GP records; records relating to the Resident's hospital admissions during the period my investigation considered; and records I obtained from PCC relating to the support and assistance it provided to the complainant in raising her concerns with the Trust. Relevant extracts of the documentation I reviewed are at Appendix Five to this report.

100. Based on my review of the documentation, I compiled a chronology of key events relating to the Trust's response to the concerns the complainant, and later, the whistleblower, raised about the Resident in the Nursing Home. This chronology is at Appendix Eight to this report.

Analysis and Findings

101. The complainant complained to my Office about the way in which the Trust dealt with concerns that she, and subsequently, a whistleblower, raised about the Resident's deteriorating condition and the care he was receiving in the Nursing Home. These concerns related primarily to the amount of the weight the Resident had lost since his admission to the Nursing Home. The complainant also complained that the Trust did not inform her about the whistleblower allegations at the time the allegations were made, and she expressed her dissatisfaction with how the Trust's dealt with the complaint she made to it in September 2019 about its handling of the whistleblower allegations. My findings on each of these three matters are set out below.

(i) The Trust's response to concerns about the Resident's care in the Nursing Home

102. My investigation of this first element of the second issue of complaint examined the Trust's response to the concerns the complainant set out in her email of 25 September 2018 to the Resident's Key Worker and the Trust's response to the concerns a whistleblower raised with RQIA on 4 October 2018.

103. My investigation established that the Resident began a temporary placement at a local nursing home on 3 August 2017 for period of emergency respite care. The Resident became unwell and was admitted to the Ulster Hospital on 7 October 2017, from the respite care home. I note this hospital admission was due to the Resident having had an unresponsive episode and having experienced poor oral intake, weight loss and general decline since moving into the respite care home approximately eight weeks previously.

104. By the end of October 2017, the Resident was considered medically fit for discharge from hospital. He was discharged from the Ulster Hospital to the Nursing Home on 2 July 2018.

105. I note that shortly following the Resident's discharge, the Ulster Hospital's Department of Nutrition and Diet Therapy wrote to his GP. The Dietician's letter, dated 20 July 2018, advised that the Resident had been referred to Dietetics due to '*low BMI and weight loss'* and that while in the Ulster Hospital, he had received nutritional assessment, which indicated that his food intake was not adequate to meet his daily nutritional requirements. The Ulster Hospital Dietician's letter further advised that the Resident's appetite was variable; that he had received nutritional supplements while in hospital; and that his weight, which had been monitored regularly in hospital, had remained stable. The Dietician asked the Resident's GP to prescribe the nutritional supplements the Resident had received in hospital. She also advised that she had referred the Resident to the Community Dietetic Service.

106. My investigation found that the Resident's Key Worker completed a Care Home Review for the Resident, in the Nursing home, on 7 September 2018. The complainant, the Resident, the Resident's son and a Nursing Home Staff Nurse were present at the Care Home Review. I note the Resident's Key Worker's record of the Review documents there was discussion of the Resident's weight and nutritional needs. It is documented that the Resident's weight had been 55.3kg on his admission to the Nursing Home on 2 July 2018 and that although he had subsequently gained 2kg in weight, he had since lost that weight. It is also documented that because of this weight loss, the Nursing Home had referred the Resident, through his GP, to the Community Dietetic Service on

4 September 2018. It is further documented in the Care Home Review record that the Nursing Home Staff Nurse expressed concern that the Resident was only taking part of his nutritional supplements; that it was acknowledged he *'prefers his supplements cold and direct from the* fridge'; and that the complainant voiced her concern about the quality of some of the meals offered to the Resident in the Nursing Home.

107. My investigation also found that on 17 September 2018, there was a further meeting at the Nursing Home to follow up on issues raised at the Care Home Review on 7 September 2018. The complainant, the Resident, the Resident's son, the Nursing Home Manager and the Resident's Key Worker attended this meeting. I note the Resident's Key Worker's record of the meeting makes no reference to any concerns having been raised at that particular time about the Resident's weight.

108. However, on 25 September 2018, the complainant sent an email to the Resident's Key Worker, referring to the Resident's *'rapidly deteriorating situation'.* The complainant advised she had visited the Resident at the Nursing Home the previous afternoon and had found him in *'an extremely dyskinetic*[10] *state'*. She also stated that the Resident's family had asked the Nursing Home to check his weight as he had '*visibly lost weight and his clothes were falling off him'.* The complainant informed the Resident's Key Worker that when the Resident was weighed, his weight was 47.5kg, which she considered meant he had '*lost 10kg in total within [the Nursing Home's] care'.* The complainant sought the Resident's Key Worker's '*advice as to where to seek help'* regarding the Resident's *'condition [and] his state of mind'.*

109. On the basis of the extensive documentation and records I obtained during the investigation, I established the following events and actions took place in the period between the Resident's Key Worker's receipt of the complainant's email of 25 September 2018 and the date on which the whistleblower concerns were

[10] Dyskinesias are involuntary, erratic, writhing movements of the face, arms, legs or trunk. They are not a symptom of Parkinson's disease itself; rather, they are a complication from some Parkinson's medications.

made known to RQIA, that is, 4 October 2018. (I will return later in this report to the actions the Trust took in response to the whistleblower allegations.)

- On 25 September 2018, having received the complainant's email, the Resident's Key Worker telephoned the Nursing Home Manager to enquire about the Resident. The Nursing Home Manager acknowledged the Resident had lost *'considerable weight'* since the Care Home Review on 7 September 2018. She also informed the Resident's Key Worker that the Nursing Home had checked with the Resident's GP about the referral to the Community Dietetic Service, which the Nursing Home had requested on 4 September 2018, but that the GP practice had stated it had no knowledge of any such referral.

- Later on 25 September 2018, the Resident's Key Worker visited the Nursing Home and spoke with the Nursing Home Manager who advised she considered the Resident had shown some improvement since the previous day. The Nursing Home Manager also advised the Resident's Key Worker that Nursing Home staff had documented they had requested a referral to the Community Dietetic Service on 4 September 2018. The Resident's Key Worker spoke with the Resident's son and, later, with the complainant. When the Resident's son expressed concern that the Resident was unable to swallow all of his medication, there was discussion about the possibility of making a referral to Speech and Language Therapy and it was agreed that the matter would be reviewed the following day.

- Also, on 25 September 2018, the Resident's Key Worker contacted the Resident's GP practice and requested that the Resident's GP contact him.

- On 26 September 2018, the Resident's Key Worker telephoned the Nursing Home Manager to enquire about the Resident. The Nursing Home Manager reported some further improvement in the Resident's general wellbeing. She also advised that his fluid intake remained good, he had taken his medications that morning and he had begun to eat more.

- The Resident's GP telephoned the Resident's Key Worker on 26 September 2018, in response to the Resident's Key Worker's request of the previous day and they had a discussion regarding the Resident.

- On 27 September 2018, the Resident's Key Worker sent an email to the Assistant Service Manager of the Trust's Care Review and Support Team (CReST), providing an update regarding the Resident. The Resident's Key Worker advised of the Care Home Review held on 7 September 2018; the concerns expressed about the Resident's weight loss since his admission to the Nursing Home; and the Nursing Home's referral on 4 September 2018 to the Community Dietetic Service. He also referred to the follow up meeting held on 17 September 2018 and advised that the Resident had *'appeared to be in reasonable form'* and that neither the Nursing Home nor the Resident's family had raised any concerns about further weight loss. In addition, the Resident's Key Worker informed the CReST Assistant Service Manager that the complainant was concerned the Nursing Home had only weighed the Resident (on 24 September 2018) on her request, and that it had only been as a result of that request that it had been discovered the Resident had lost a further seven to eight kilograms since the Care Home Review on 7 September 2018. The Resident's Key Worker advised the CReST Assistant Service Manager that he had asked the Nursing Home to weigh the Resident weekly rather than monthly.

- Also on 27 September 2018, the Resident's Key Worker telephoned the Nursing Home Manager, to enquire about the Resident. The Nursing Home Manager advised that staff reported the Resident had slept well the previous night, was eating much better and had taken his medication.

- In addition, on 27 September 2018, a nurse from the Trust's Care Home Nursing Support Team ('the Care Home Nursing Support Team Nurse') assessed the Resident at the Nursing Home. The Care Home Nursing Support Team Nurse documented in her nursing notes that the Nursing Home staff had referred the Resident for this nursing assessment on 25 September 2018. The Resident was found to be unwell during the

assessment, with suspected infection and dehydration, and after contact with his GP, it was decided that he should be admitted to hospital.

- Following his attendance at the Emergency Department of the Royal Victoria Hospital, the Resident was admitted to hospital on 27 September 2018.

- On 29 September 2018, the Resident's Key Worker telephoned the Nursing Home Manager to seek an update regarding the Resident. The Nursing Home Manager advised that she had just telephoned Royal Victoria Hospital and had been informed that the Resident did not have an infection but that he was still not eating or drinking.

- On 30 September 2018, a Royal Victoria Hospital Speech and Language Therapist assessed the Resident. She found the Resident *'presented with a mild oral dysphagia'* and that *'absent dentition, reduced cognition and dyskinesia all impact on eating and drinking'.*

- The following day, 1 October 2018, a Royal Victoria Hospital Dietician assessed the Resident. She documented that the Resident's current weight was 50.2kg and that he had weighed 52kg in January 2017 and 62kg in March 2017. The Dietician noted the Resident had experienced a significant weight loss over the previous 18 months and queried whether this was related to *'disease progression'.* The Dietician also documented although the Resident ate well at times, on other occasions he refused meals and that weight maintenance, rather than weight gain, was the most realistic goal for him at that time.

- On 4 October 2018 (within the context of discussion about arrangements for the Resident's discharge from hospital back to the Nursing Home) the Resident's Key Worker informed a hospital social worker that he would ensure that the Nursing Home monitored the Resident's weight on a weekly basis.

- On 4 October 2018, the Resident was discharged from the Royal Victoria Hospital back to the Nursing Home.

110. Turning then to the Trust's response to the whistleblower allegations about the Resident's care in the Nursing Home, my investigation found that on the day of the Resident's discharge from the Royal Victoria Hospital, 4 October 2018, a whistleblower, who identified as an employee of the Nursing Home, contacted RQIA to express concern about weight loss five Nursing Home residents had experienced. One of the five named residents was the Resident. RQIA made CReST aware of the whistleblower allegations the same day.

111. Again to establish the chronology of the Trust's response to the whistleblower allegations, in so far as those allegations concerned the Resident, I had regard to the Trust's response to my investigation enquiries and the records and documentation I obtained.

112. When I asked the Trust about the action taken in response to the whistleblower allegations concerning the Resident, it provided a chronology of activities related to the Resident's care, which had taken place during the period 4 to 25 October 2018. The Trust stated, '*There was a high level of activity to support [the Resident] and reassure his family as he settled into [the Nursing Home] … The specific issue raised in the whistleblowing allegation concerning [the Resident] related to weight loss. [The Resident] had a long history of fluctuating weight and this was an area of focus throughout his hospital admission of October 2017 to July 2018 and subsequently. The activities before and after the notification of the whistleblowing allegations were focused on bringing the best support to [the Resident].'* The Trust advised that the chronology it had provided to me included *'all activity linked to the care of [the Resident] in the weeks following the whistleblower allegation'.* It stated, *'Unfortunately it has not been possible to distinguish if these activities are in direct response to the [whistleblower] allegations or as part of the ongoing monitoring of [the Resident's] care needs.'*

113. My examination of the Resident's records found they document the following events and interventions in the days and weeks after RQIA made the Trust aware of the whistleblower allegations:

- On (Friday) 5 October 2018, a CReST Senior Social Work Practitioner contacted the whistleblower to obtain further detail of their concerns about the care the Nursing Home was providing to a number of residents, including the Resident.

- On 5 October 2018, the CReST Senior Social Work Practitioner made the Resident's Key Worker aware of the whistleblower allegations concerning the Resident. CReST asked the Resident's Key Worker to review the Resident. CReST also noted that the Resident's Key Worker was *'investigating weight loss'.*

- On (Monday) 8 October 2018, the CReST Senior Social Work Practitioner contacted the Nursing Home Manager about the whistleblower allegations. The Nursing Home Manager informed the CReST Senior Social Work Practitioner that the Resident was now being weighed weekly rather than monthly.

- Also on 8 October 2018, the Resident's Key Worker telephoned the Nursing Home Manager to enquire about the Resident. The Nursing Home Manager advised the Resident had slept *'quite well'* the previous night and that his appetite had improved.

- In addition, on 8 October 2018, the CReST Senior Social Work Practitioner made an adult safeguarding referral to the Trust's Adult Protection Gateway Team[11] (APGT). The APGT subsequently notified the CReST Senior Social Work Practitioner that the referral had been screened as 'a level two investigation' by CReST. The CReST Senior Social Work Practitioner informed the CReST Assistant Service Manager of the outcome of the adult safeguarding referral to APGT and advised that CReST was to *'follow up on quality related issues'.*

- Later on 8 October 2018, the Resident's Key Worker visited the Nursing Home and spoke initially with the Nursing Home Manager. The

[11] The Adult Protection Gateway Team is the Trust's central referral point for all concerns about an adult who is, or may be, at risk.

Resident's Key worker spoke subsequently with the Resident, the complainant and the Resident's son.

- On 11 October 2018, the Care Home Nursing Support Team Nurse telephoned the Nursing Home to obtain an update on the Resident. The Care Home Nursing Support Team Nurse informed the Nursing Home of her plan to review the Resident the following week.

- The Resident's Key Worker made a further visit to the Nursing Home on 15 October 2018. He spoke initially with the Nursing Home staff who advised the Resident's weight had decreased by 1kg since his discharge from hospital on 4 October 2018 and that his appetite was very poor. The Resident's Key Worker later spoke with the Resident.

- Also on 15 October 2018, the Care Home Nursing Support Team Nurse telephoned the Nursing Home, in response to a request the Nursing Home had made on 13 October 2018 for advice regarding the Resident's 'switched off'[12] episodes. The Care Home Nursing Support Team Nurse advised she would visit the Nursing Home the following day.

- On 16 October 2018, a Community Dietician assessed the Resident, in response to the referral the Ulster Hospital Dietician had made on 20 July 2018 (at the end of the Resident's October 2017 to July 2018 admission) and further assessment requests made on 5 September and 12 October 2018. The Community Dietician documented the Resident's weight had been 50.4kg on 11 October 2018. She also noted it was her plan to review the Resident in four to five weeks' time.

- Also on 16 October 2018, the Care Home Nursing Support Team Nurse reviewed the Resident at the Nursing Home. She later had a telephone discussion with the Resident's GP about the Resident's care.

[12] The on/off phenomenon in Parkinson's disease is related to the fluctuating benefit of the medications used to treat Parkinson's disease. Being 'off' describes the time when the person with Parkinson's' disease feels that their medication is not working as well as usual, and some of their symptoms may have returned.

- On 22 October 2018, the Care Home Nursing Support Team Nurse telephoned the Nursing Home to obtain an update on the Resident and to provide advice regarding his care.

- On 24 October 2018, the Resident's Key Worker telephoned the Nursing Home Manager to obtain an update on the Resident. The Nursing Home Manager advised that the Resident's weight was approximately the same as the previous week and that his appetite was variable.

- The Resident's Key Worker visited the Nursing Home on 25 October 2018. He and the Nursing Home Manager noted the Resident's weight on 24 October 2018 had been 0.65kg less than the previous week; that the Community Dietician had made changes to the Resident's nutritional supplements when she had assessed him on 16 October 2018 and that she was due to review him in five to six weeks' time; that the Resident's appetite and mood were variable; and that he was refusing his medication. The Resident's Key Worker informed the Nursing Home Manager that the Trust had agreed to fund a week of one-to-one support for the Resident (beginning on 29 October 2018) to obtain a more detailed assessment of his food and fluid intake. The Resident's Key Worker later spoke to the complainant to update her in relation to his visit to the Nursing Home earlier that day.

- Also on 25 October 2018, the Resident's Key Worker made an urgent referral to the Community Speech and Language Therapist for a swallow assessment for the Resident. He noted in the referral that the Resident had been *'having difficulty swallowing medication especially parkinsons [medications]'* and that he had also *'reported choking feeling.'*

- On 1 November 2018, the Resident's son informed the Resident's Key Worker that the Resident's condition was deteriorating. The Resident's Key Worker advised he would visit the Nursing Home that afternoon.

- Also on 1 November 2018, the Resident's Key Worker tried, unsuccessfully, to contact the Care Home Nursing Support Team Nurse. He left a message asking that she contact him.

- Later on 1 November 2018, the Resident's Key Worker visited the Nursing Home. He spoke initially to the Nursing Home Manager and a Nursing Home Staff Nurse and, later, to the Resident. The Resident's Key Worker reviewed the notes relating to the Resident's one-to-one support. He found these documented that, at times, the Resident had been refusing food, fluids and medication.

- On 2 November 2018, the Resident's Key Worker advised the Care Home Nursing Support Team Nurse of the Resident's deteriorating condition. The Care Home Nursing Support Team Nurse reviewed the Resident at the Nursing Home later that day. The Care Home Nursing Support Team Nurse subsequently telephoned the Resident's GP to provide an update. She also arranged a case review meeting in the Nursing Home on 5 November 2018.

- Also on 2 November 2018, a Community Speech and Language Therapist completed a swallow assessment for the Resident in the Nursing Home (in response to the urgent referral the Resident's Key Worker had made on 25 October 2018).

- On 5 November 2018, there was a Case Review Meeting at the Nursing Home. The complainant, the Resident's son and daughter, the Resident's Key Worker, a Nursing Home Staff Nurse, the Nursing Home Manager and the Care Home Nursing Support Team Nurse attended. Although the Resident's GP was unable to attend, the Care Home Nursing Support Team Nurse sought his input prior to the meeting and provided him with an update afterwards.

- On 6 November 2018, the Care Home Nursing Support Team Nurse telephoned the Nursing Home. She obtained an update on the Resident and provided advice regarding his food and fluids intake. The Care Home

Nursing Support Team Nurse later visited the Nursing Home. The Nursing Home Manager provided an update on the Resident, including that he had been sleepy all day and that Nursing Home staff had experienced difficulty in getting him to take food, fluids and medication.

- On 7 November 2018, the Resident's Key Worker asked the Community Speech and Language Therapist, who had assessed the Resident's swallow on 2 November 2018, to complete a further assessment at a time when the Resident was 'switched off'.

- Also on 7 November 2018, the Resident became unwell with poor coordination and incoherent speech. He attended the Emergency Department of the Ulster Hospital and was subsequently admitted.

- On 12 November 2018, the Resident's Key Worker telephoned the Ulster Hospital to enquire about the Resident. Nursing staff advised that the Resident was receiving intravenous fluids and was taking his medication but also that his appetite remained very poor.

- On 19 November 2018, the Resident's Key Worker telephoned the Ulster Hospital again, to seek a further update regarding the Resident. Nursing staff advised that the Resident's condition was *'largely unchanged'* and that no decision had yet been made regarding his discharge from hospital.

- On 4 December 2018, a discharge planning meeting took place at the Ulster Hospital. It was noted that a possible date for the Resident's discharge from hospital was 10 December 2018. The Resident's Key Worker agreed that a further week of one-to-one support would be provided for the Resident on his discharge back to the Nursing Home.

- The Resident was discharged from the Ulster Hospital back to the Nursing Home on 10 December 2018.

- On 14 December 2018, a Community Dietician reviewed the Resident, in response to a referral an Ulster Hospital Dietician had made on 10 December 20198. The Community Dietician documented the

Resident's weight was 47.8kg, noting that recent hospital admission may have been a factor in a seven per cent weight loss he had experienced during the previous two months. The Community Dietician also noted her plan to review the Resident in six weeks' time.[13]

- On 17 December 2018, the Resident's Key Worker completed a monitoring visit to the Nursing Home, to check on the care being provided to the Resident. The Nursing Home Manager reported the Resident had '*put on some weight'* since his discharge from hospital the previous week. She also requested a further week of one-to-one support for him. The Resident's Key Worker agreed to extend the Resident's one-to-one support for a further week.

- On 19 December 2019, a Community Speech and Language Therapist reviewed the Resident, in response a referral the Ulster Hospital Speech and Language Therapist had made on 17 December 2018. The Community Speech and Language Therapist noted the Resident was continuing to tolerate the food and fluid recommendations the Ulster Hospital Speech and Language Therapist had made during his recent hospital admission. She discharged the Resident from the Community Speech and Language Therapy Service, noting that *'further progress is not anticipated'.*

114. My investigation found no evidence that CReST had any role in investigating the whistleblower allegations that related specifically to the Resident. Rather, as set out in paragraph 109, I found that CReST's involvement in the Trust's response to the allegations relating to the Resident was limited to contacting the whistleblower to establish further detail of the nature of their concerns (about all five named Nursing Home residents); making the Resident's Key Worker aware of the whistleblower allegations (concerning the Resident) and asking him to review the Resident; contacting the Nursing Home Manager to

[13] The Community Nutrition and Dietetic Service continued to keep the Resident under regular review throughout 2019. At an assessment on 19 December 2019, when the Resident's weight was 61.5kg, the Community Dietician noted that no further dietetic assessment was required at that time.

discuss the whistleblower allegations; and making an adult safeguarding referral to the Trust's APGT.

115. In this regard, I note that when the Trust's (then) Director of Community Learning Disability and Community Older People ('Director C') wrote to the complainant on 10 April 2020 about the Trust's response to the whistleblower allegations, she advised that CReST *'were not involved with [the Resident] as he is not a permanent resident in [the Nursing home] and therefore not known to their team'.* I asked the Trust to explain the role of CReST and why the temporary, rather than permanent, nature of the Resident's placement in the Nursing Home meant that CReST were not involved with him at the time of the whistleblower allegations.

116. In response, the Trust explained, *'CReST is … made up of a team of Nursing, Social Worker and Allied Health Professionals. This specialist team oversee and review the care of permanent residents within the care home sector.'* The Trust also informed me that when the Resident was admitted, on a temporary basis, to the Nursing Home on 2 July 2018, '*the Trust and [the complainant] were awaiting the outcome of the decision of the Court as to whether the Trust's actions in this case had been reasonable. The Court could have directed that the Trust needed to consider other options for [the Resident]. It is also good practice that a decision regarding a person's change in domicile should not be made without due time to consider that is suitable. Generally the decision that a person is placed permanently is not made until the first review point and only if all issues are settled.'* The Trust also explained that as a temporary resident of the Nursing Home, *'[The Resident's] key worker [was] from the … Community Social Work Team and not CReST'.*

117. I note the reason for CReST not being involved in any investigation of the whistleblower allegations about the Resident was also explained in emails the CReST Assistant Service Manager sent to PCC on 30 and 31 July 2019. These emails stated, *'… [the Resident] was not seen by CReST team at this time as he is not known to the CReST. [The Resident's Key Worker] would have investigated concerns at that time'* and *'… [The Resident] did not fall under the remit of the CReST team as he is not known to CReST as his key*

worker is [the Resident's Key Worker] … Any resident within the care home sector not known to the CReST team remains the responsibility of their key worker in the community teams'.

118. My investigation established therefore that when the Trust's APGT screened the referral of the whistleblower allegations back to CReST for investigation, responsibility for following up on the whistleblower's concerns, in so far as they related to the Resident, fell on the Resident's Key Worker, rather than CReST. This was because the temporary nature of the Resident's placement in the Nursing Home at the time meant that CReST did not have a role in overseeing his care.

119. I found no evidence that, other than the activities and interventions I have detailed in paragraph 109, the Resident's Key Worker completed any formal 'investigation' of the whistleblower allegations relating to the Resident. In this regard, I note that on 21 May 2019, the Resident's Key Worker spoke with a PCC Complaints Support Officer who had contacted him, on the complainant's behalf, to obtain information about how the Trust had responded to the whistleblower allegations. I obtained the Resident's Key Worker's record of that telephone conversation, as well as the record the PCC Complaints Support Officer made.

120. I note that in his record of the telephone call, the Resident's Key Worker documented that he informed the PCC Complaints Support Officer of the Resident's dietetic referral in July 2018 and of the Nursing Home having followed up on that referral in September 2018. He also documented that he advised the PCC Complaints Support Officer of the involvement of the Resident's GP and the Care Home Nursing Support Team Nurse. I note that when the Resident's Key Worker sent a follow up email to the PCC Complaints Support Officer on 7 June 2019, he advised of *'ongoing concerns'* about the Resident's weight loss during *'the couple of months prior to [the] whistleblowing incident'*. The Resident's Key Worker again referred to the Resident's dietetic referral in July 2018, and the Nursing Home's further request for dietetic assessment in September 2018, pointing out that *'due to lengthy waiting lists'*, the Community Dietician did not assess the Resident until October 2018. The

Resident's Key Worker also referred to the involvement of the Care Home Nursing Support Team Nurse; the Resident's further dietetic assessment on 16 October 2018; and his speech and language therapy swallow assessment on 2 November 2018.

121. I note that in her record of the conversation with the Resident's Key Worker on 21 May 2019, the PCC Complaints Support Officer documented he informed her that the Resident's weight loss had been noted approximately six weeks prior to the whistleblower allegations and that *'GP notified, dietician contacted and family aware'.* The PCC Complaints Support Officer further documented the Resident's Key Worker *'said that [CReST] contacted him to ask … if he was aware of [the Resident's] weight loss and he advised he was. This meant that [CReST] were not alerting him to anything new regarding issues to do with [the Resident]'.*

122. My investigation therefore established that the Trust took the following action in response to the complainant's email of 25 September 2018 to the Resident's Key Worker about the Resident's *'rapidly deteriorating situation'*, and the whistleblower allegations of 4 October 2018 about the Resident's weight loss in the Nursing Home.

- Following receipt of the complainant's email of 25 September 2018, the Trust took action to:
  - review the Resident at the Nursing Home;
  - seek updates from the Nursing Home on the Resident's condition;
  - confirm that the Resident had been referred to the Community Nutrition and Dietetic Service;
  - discuss the Resident's condition and care with his GP;
  - have the Resident assessed by the Care Home Nursing Support Team; and
  - arrange for weekly rather than the usual monthly monitoring of the Resident's weight.

- Following notification of the whistleblower allegations of 4 October 2018 about the Resident's weight loss, the Trust took action to:

- contact the whistleblower to obtain further detail of the nature of their concerns;
- make the Resident's Key Worker aware of the allegations relating to the Resident and request that he review the Resident at the Nursing Home;
- contact the Nursing Home Manager to discuss the whistleblower allegations;
- make an adult safeguarding referral to the Trust's APGT;
- conduct visits to the Nursing Home to review the Resident and discuss his condition and care with Nursing Home staff and his family;
- seek updates (by telephone) on the Resident from the Nursing Home;
- consult with the Resident's GP in decisions regarding the Resident's care;
- arrange continuing review of the Resident by the Care Home Nursing Support Team;
- arrange a case review meeting in relation to the Resident's care, with input from his family, his GP, the Resident's Key Worker, the Care Home Support Team Nurse and Nursing Home nursing staff;
- arrange the involvement of other health professionals, including the Community Dietician and Community Speech and Language Therapist; and
- arrange one-to one support for the Resident (in October and December 2018) to obtain a more detailed assessment of his food and fluid intake.

123. I considered whether in these actions were in accordance with the relevant policies and procedures. When I made enquiries of the Trust about the policies and procedures that were in operation in 2018 to deal with concerns about a nursing home resident's care, it referred to the 2006 Safeguarding Vulnerable Adults Policy and Procedures, the 2016 NIASP Adult Safeguarding Operational Procedures and the Trust's Quality Monitoring Reporting Process.

124. I asked the Trust which of these policies/procedures it had applied in responding to the concerns the complainant had raised in her email of 25 September 2018 to the Resident's Key Worker. The Trust informed me that the complainant's concerns *'were not in relation to adult safeguarding or quality of care so the policies [to which the Trust had referred in responding to my enquiries] were not applied'.* Rather, the Trust stated, the Resident's Key Worker had been *'working in line with the Care Management standards set out in [the 2010 Circular]'*.

125. When I asked the Trust which of the policies/procedures it had applied in responding to the whistleblower allegations of 4 October 2018, it stated, *''The Trust responded to the whistleblower allegations with a referral to [the APGT]. The referral did not meet the threshold of adults in need of protection as per the [2006 Safeguarding Vulnerable Adults Policy and Procedures]. The APGT screened the referral as a level 2 investigation on the part of [CReST] identifying concerns as relating to quality of care.'*

126. I considered the scope and purpose of the 2006 Safeguarding Vulnerable Adults Policy and Procedures, the 2016 NIASP Adult Safeguarding Operational Procedures and the Trust's Quality Monitoring Reporting Process.

127. I note the 2006 Safeguarding Vulnerable Adults Policy and Procedures sets out *'the processes that must be followed in the event of suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect'.* 'Abuse' is defined as, *'The physical, psychological, emotional, financial or sexual maltreatment or neglect of a vulnerable adult by another person …'* In addition, I note the 2016 NIASP Adult Safeguarding Operational Procedures set out the processes to be followed in responding to '*situations where an adult is at risk of being harmed or abused'.* The main forms of 'abuse' are described as *'physical abuse; sexual violence and abuse; psychological/emotional abuse; financial abuse; institutional abuse; neglect; and exploitation'*. 'Neglect' is defined as follows: *'Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult …'* I further note the purpose of the Trust's Quality Monitoring Reporting

Process is to address adverse incidents relating to the quality of services a care home is providing.

128. Given the scope of these adult safeguarding and quality monitoring policies and procedures, I accept the Trust's position that they did not apply to the Trust's response to the concerns the complainant raised in her email of 25 September 2018 to the Resident's Key Worker. This is because the complainant expressed concern about the Resident's *'rapidly deteriorating situation'*, referring specifically to him having lost a significant amount of weight in the previous weeks; to him having been in an *'extremely dyskinetic state'* (a complication of Parkinson's disease medication) the previous day; and to his *'state of mind'*. It is my view that these concerns did not fall within the scope of the adult safeguarding and quality monitoring policies and procedures. Therefore, as the Trust indicated in its response to my enquiries, I consider it was appropriate that the complainant's concerns were dealt with as part of the care management process.

129. In relation to the whistleblower allegations of 4 October 2018, I am satisfied these did fall within the scope of the adult safeguarding policies and procedures and that it was therefore appropriate that the Trust made a safeguarding referral to the APGT. I am satisfied the Trust made and retained an appropriate record of that referral and of the APGT's resulting screening decision on the further action to be taken in response to the whistleblower concerns. (As noted already, that screening decision meant that it was for the Resident's Key Worker, rather than CReST, to follow up on the whistleblower allegations that related to the Resident.)

130. That said, I note 2006 Safeguarding Vulnerable Adults Policy and Procedures highlight that where it is decided to address concerns about an adult's welfare by other types of intervention, rather than under the adult protection procedures, (which was the case in relation to the whistleblower allegations concerning the Nursing Home), *'it is important to record details of any intervention provided or offered on the service user's record.'* In addition, the 2016 NIASP Adult Safeguarding Operational Procedures require that where the APGT Designated Adult Protection Officer (DAPO) decides that an adult

safeguarding referral does not meet the threshold for serious harm, and determines that an alternative course of action is appropriate*, 'there must be mechanisms in place to ensure that the outcomes of this action is reported back to the DAPO.'*

131. My investigation found no evidence that the Trust, in responding to the whistleblower allegations concerning the Resident, met these particular requirements of the adult safeguarding policies and procedures. I found no mention in the Resident's case notes of the fact that whistleblower allegations had been made concerning him. There was also a lack of clear account within the Resident's case notes of the alternative course of action the Trust had taken to address the allegations once a decision had been taken that they did not meet the threshold for a full adult safeguarding investigation. In addition, there was an absence of a record of the outcome of that alternative course of action and no indication of that outcome having been reported back to the APGT.

132. I referred earlier in this report to the First Principle of Good Administration, *'Getting It Right'*, which requires a public service provider to act in accordance with the law, policy and guidance. In addition, the Third Principle, '*Being Open and Accountable'*, requires public authorities to create and maintain reliable and usable records as evidence of their activities, and to give reasons for their decisions. The Trust's failure to properly document its response to the whistleblower concerns about the Resident, in accordance with the requirements of the adult safeguarding procedures, is evidence it did not meet the standards required by these Principles.

133. Despite this failing in the Trust's record keeping, I am of the view, having given careful consideration to all the available evidence, that the action the Trust took in response to the concerns the complainant raised in September 2018 and the allegations the whistleblower raised in October 2018 was appropriate and reasonable in the circumstances. In reaching this view, I am mindful that when the Trust addressed my enquiries about the outcome of its response to the whistleblower allegations concerning the Resident, it stated, *'The Trust in its overview of [the Resident's] care has been made aware from a range of*

professionals over a prolonged period that weight loss is a common symptom in Parkinsons's disease, with changes in weight more likely in later stages. [The Resident's] care plans since his admission to [the Nursing Home] in July 2018 detail the support and attention his diet required to help him maintain a healthy weight.'

134. My examination of the Resident's records found evidence to support the Trust's position that health professionals involved in his care considered the progression of his Parkinson's disease, and the impact of the symptoms of it, affected his ability to eat and drink and to maintain an appropriate weight. I also found evidence that the Resident had a history of weight variation and weight loss, prior to the complainant and the whistleblower bringing their concerns being to the Trust's attention. In this regard, I noted the following:

- A community speech and language therapy swallow assessment on 7 September 2017, during the Resident's temporary placement in a respite care home, found he *'presents with dysphagia characterised by reduced mastication skills and flexed head positioning which impacts on his eating and drinking'*.

- A dietetic assessment completed in the Ulster Hospital, after the Resident's admission on 8 October 2017, noted he had lost 7.4% of his body weight in the seven months prior to the dietetic referral; that his (then) current weight was 55.4kg, almost 15kg less that his ideal weight of 70kg; and that his appetite was variable.

- A speech and language therapy swallow assessment completed in the Royal Victoria Hospital on 30 September 2018, following the Resident's admission on 27 September 2018, found, *'Absent dentition, reduced cognition and dyskinesia all impact on eating and drinking …'*

- A dietetic assessment completed in the Royal Victoria Hospital on 1 October 2018, following the Resident's admission on 27 September 2018, noted his weight had been 52kg in January 2017, increasing to 62kg by March 2017.

- A community dietetic assessment on 16 October 2018 found the Resident's energy intake was inadequate for weight gain and noted his weight loss was due to *'recent hospital admission and overall progression of Parkinson's disease'.* It also noted nutritional supplements to be prescribed for the Resident were required due to *'Disease related malnutrition'.*

- A community speech and language therapy swallow assessment on 2 November 2018 noted , *'Impression of mild oropharyngeal dysphagia secondary to [Parkinson's disease]'.*

- A dietetic assessment completed in the Ulster Hospital, after the Resident's admission on 7 November 2018, noted nutritional supplements to be prescribed for the Resident were required due to *'Disease related malnutrition'.*

- Community dietetic assessments on 14 December 2018, 18 January 2019, 8 March 2019, 10 May 2019, 22 August 2019 and 11 December 2019 noted nutritional supplements to be prescribed for the Resident were required due to *'Disease related malnutrition'* and (on some occasions) also due to *'Dysphagia'.*

135. In summary, my investigation of this first element of the second issue of complaint found that the Trust took appropriate and reasonable action to respond to the concerns the complainant raised in her email of 25 September 2018 to the Resident's Key Worker and to the concerns a whistleblower raised, through RQIA, on 4 October 2018. However, I also found the Trust failed to make and retain an appropriate record of its response to the whistleblower allegations relating to the Resident, in accordance with relevant policies and procedures. I consider this is maladministration.

136. I am satisfied this maladministration impacted on the Trust's ability to provide the complainant with full, timely and accurate information in response to her enquiries about its handling of the whistleblower allegations concerning the Resident (a further element of this second issue of complaint, which I will

address later in this report). This meant she had to take the time and trouble to bring a complaint to my Office to obtain a full understanding of the Trust's response to those whistleblower allegations. It also caused her to experience uncertainty and frustration.

137. Having found that the Trust took appropriate and reasonable action to respond to the complainant's and the whistleblower's concerns about the Resident but that it failed to make and retain appropriate records relating to that action, I partially uphold this first element of the second issue of complaint.

(ii) The Trust's communication with the complainant about the whistleblower allegations

138. The complainant said she first became aware of the whistleblower allegations on 19 October 2018. She said her solicitor informed her at that time that an affidavit the Older Peoples Services Assistant Service Manager had signed, on the Trust's behalf, on 17 October 2018[14] stated that the Resident had been named in a whistleblowing allegation concerning a number of residents of the Nursing Home. In this regard, I note the Trust's affidavit of 17 October 2018 states (at paragraph 71) *'I have recently been made aware that [the Nursing Home] is currently subject to a whistleblowing allegation regarding failure to take appropriate action in regards to monitoring food, fluid and the weights of a number of residents on 4th October 2018. With this specifically being in relation to [the Resident] and some other residents. The Trust have investigated these allegations and actions are on-going to monitor and review the issues raised.'*

139. My investigation of this second element of the second issue of complaint found no evidence of the Trust having told the complainant about the whistleblower allegations before it shared its 17 October 2018 affidavit with her solicitor. This is despite there being an appropriate opportunity to do so as early as 8 October 2018, when the Resident's Key Worker met with the complainant and the Resident's son during his visit to the Nursing Home to review the Resident. By that stage, CReST had made the Resident's Key Worker aware that the Resident was one of the five residents the whistleblower had named when they

[14] Affidavit in connection with the declaratory judgement proceedings the Trust had initiated regarding the Resident's place of residence.

reported their concerns to RQIA on 4 October 2018. There was another opportunity for the Resident's Key Worker to inform the complainant of the whistleblower allegations when he spoke to her on 25 October 2018, following a further visit he had made to the Nursing Home. Again, the Resident's Key Worker's record of that conversation with the complainant includes no evidence that he shared information about the whistleblower allegations at that time.

140. The complainant stated that she and the Resident's son attended a meeting with the Resident's Key Worker at the Nursing Home on 5 November 2018. She said the Resident's son asked the Resident's Key Worker about the whistleblower allegations but that the Key Worker was *'vague'* in his response and *'could not provide specific information'*.

141. My investigation established that the meeting on 5 November 2018 was a case review meeting, which the Nursing Home Nursing Support Team Nurse had arranged on 2 November 2018. I note, from the Nursing Home Support Team Nurse's notes of the meeting that the Resident's Key Worker, the complainant, the Resident's son and daughter were present, in addition to the Care Home Nursing Support Team Nurse and a Nursing Home Staff Nurse. When I asked the Trust for a copy of the Resident's Key Worker's record of the case review meeting, it informed me it held no such record. Consequently, while I have no reason to doubt the complainant's assertion that the Resident's son asked the Resident's Key Worker about the whistleblower allegations, I cannot say for certain how he (the Resident's Key Worker) responded. What is clear, however, is that there is a lack of evidence to show that the Trust took this further opportunity to disclose to the complainant and other members of the Resident's family that the Resident had been named in the whistleblower allegations, and to explain the action the Trust had taken, or was taking, in response.

142. The complainant said the Resident's son made similar enquiries of the Resident's Key Worker at a meeting held on 4 December 2018 to discuss plans for the Resident's discharge from the Ulster Hospital.[15] She said the Resident's

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[15] The Resident was admitted to the Ulster Hospital, from the Nursing Home, on 7 November 2018

Key Worker was *'again very vague but mentioned that [the whistleblower allegations] had been investigated by CReST department within [the Trust].'*

143. I note the Resident's Key Worker's record of that meeting on 4 December 2018 documents, *'Spoke to [the Resident's] family after meeting re their concern re whistleblowing incident in [the Nursing Home] in which [the Resident] had been name[d]. Informed them that the incident had been investigated and no significant issues noted'.* I found no reference in the record that, as the complainant recollects, the Resident's Key Worker specifically informed the complainant and other members of the Resident's family that the whistleblower allegations had been investigated by CReST. Consequently, while I again have no reason to doubt the complainant's position on the Resident's Key Worker's reply, I cannot be certain exactly what he (the Resident's Key Worker) told them about the Trust's response to the whistleblower allegations. It is of concern, nevertheless, that there is a lack of evidence within the Resident's Key Worker's record to show that he provided full details of how the Trust had responded to the whistleblower allegations concerning the Resident.

144. I note that when it responded to my investigation enquiries about this element of the complaint, the Trust said*, 'We fully accept that [the complainant] should have been informed when the Trust was first made aware of the whistleblowing allegations on 4 October 2018'.* The Trust also said, *'Best practice in any circumstance which arises in respect of a person's care is that the person or family members who are affected by the information are notified as soon as practicable'.*

145. It is the case then that the Trust was not open and transparent with the complainant about whistleblower allegations concerning the Resident. The Trust has acknowledged this was not in keeping with 'best practice' in managing the care provided to an individual. The Trust's failure to notify the complainant of the whistleblower allegations at an early stage is contrary to the requirements of the First and Third Principles of Good Administration, which require public bodies to 'get it right' by acting in accordance with quality standards and/or established good practice and to be 'open and accountable' by being transparent and providing information that is clear, accurate and

timely.

146. Consequently, I consider the Trust's failure to inform the complainant of the whistleblower allegations at an early stage is maladministration. I am satisfied this maladministration caused the complainant to sustain the injustice of uncertainty and frustration. I uphold this second element of the second issue of her complaint.

(iii) The Trust's handling of the complainant's complaint about its response to the whistleblower allegations concerning the Resident

147. The complainant said she submitted a complaint to the Trust on 11 September 2019 about its handling of the whistleblower allegations concerning the Resident. In her complaint, the complainant referred to the Resident's family not having been informed about the whistleblower allegations *'for more than 2 weeks'* and to only having learned of the allegations through the Trust's affidavit of 17 October 2018. She also referred to her unsuccessful attempts to obtain information about the whistleblower allegations from the Resident's Key Worker at meetings with him on 5 November and 4 December 2018, and to difficulties both she and PCC had encountered subsequently in trying to obtain information from CReST. In addition, the complainant complained to the Trust that an email the Resident's Key Worker sent to PCC (on 7 June 2019) about the whistleblower allegations was *'inaccurate and* vague' and lacked specific information about the allegations, how they were handled and the outcome of the Trust's consideration of them.

148. The complainant is dissatisfied with how the Trust dealt with her complaint of 11 September 2019. The specific matters she raised, when she complained to my Office, relate to:

(a) delay in the Trust providing its response;

(b) failure to provide full information about how the Trust dealt with the whistleblower allegations;

(c) failure to offer an explanation as to how errors occurred and to provide details of the action being taken to ensure the same errors did not reoccur; and

(d) the provision of contradictory information.

My findings on each of these aspects of the Trust's handling of the complaint are set out below.

(a) Delay in responding to the complaint

149. I note the complainant submitted her complaint to the Trust's Complaints Department on 11 September 2019. At this time, the Trust was also dealing with a number of other complaints the complainant had already submitted regarding separate issues concerning the Resident's care.

150. The Trust did not acknowledge receipt of the complaint until 20 September 2019, apologising for the lack of communication in the interim period and explaining this had been due to the Trust's Complaints Department awaiting advice from the service area *'as to how this further correspondence is being processed before replying …'* I note the Trust informed the complainant that her complaint had been *'shared with the relevant service area'* and that it would provide a further update the following week.

151. I note Director A wrote to the complaint on 31 October 2019, responding to another complaint she (the complainant) had submitted to the Trust on 22 July 2019 regarding a separate matter. Director A's letter did not make any reference to the complainant's complaint of 11 September 2019 about the Trust's handling of the whistleblower allegations.

152. The complainant wrote to the Trust's Complaints Department again, on 19 November 2019, providing her response to Director A's letter of 31 October 2019. The complainant pointed out that the Trust had failed to respond to her complaint of 11 September 2019 concerning its handling of the whistleblower allegations.

153. I note the complainant wrote to the Trust again, on 27 November 2019, pointing out that she had not received an acknowledgment of her correspondence of 19 November 2019. The Trust's Complaints Department responded on 28 November 2019, advising that the complainant's email of 19 November 2019 had not been actioned following its receipt. The Trust apologised for *'this*

administrative oversight'. It also advised the complainant's correspondence had been forwarded to the investigating manager the previous day and that the Trust would contact the complainant *'once a response has been received'*.

154. I note that on 17 December 2019, the Trust's Complaints Department provided an update to PCC on the Trust's handling of the complainant's complaint about the whistleblower allegations (and other complaints concerning separate matters). I note the Trust explained that because the complaint about the whistleblower allegations was not dealt separately to the complainant's other complaints, it had been *'overlooked'* at the time Director A had written to the complainant on 31 October 2019 about one of those other complaints. The Trust's Complaints Department advised PCC that the complaint concerning the whistleblower allegations had been forwarded again to the relevant service area.

155. In January 2020, the Trust suggested a meeting with the complainant as a means of seeking to resolve her complaints. I note PCC, on the complainant's behalf, informed the Trust on 14 January 2020 that the complainant did not wish to meet and that she had requested a written complaint response. The Trust's Complaints Department advised PCC at that time that the relevant service areas would be informed that a written response was required.

156. On 3 March 2020, PCC, on the complainant's behalf, sought an update from the Trust's Complaints Department on the anticipated written complaint response. I note the Trust's Complaints Department advised PCC that a response to the complainant was *'in the approval stage'* and would be issued *'shortly'*.

157. I further note that on 6 March 2020, the office of Naomi Long MLA sought an update from the Trust's Complaints Department on the Trust's complaint response. In its response of 9 March 2020, the Complaints Department informed the MLA that the response was *'in the final stage of completion'.*

158. I note that Director C wrote to the complainant on 10 April 2020, providing the Trust's response to her complaint of 11 September 2019 about the Trust's handling of the whistleblower allegations.

159. My investigation established, therefore, that it took the Trust seven months to provide its (initial[16]) written response to the complainant's complaint concerning the whistleblower allegations. I found that to begin with, delay was caused by uncertainty as to how this particular complaint should be handled, given that the Trust was already dealing with a number of other complaints the complainant had made relating to the Resident's care. There was then an *'administrative oversight'* which meant the Trust did not take action on the complainant's follow up correspondence of 19 November 2019 when it was received. Later, further delay occurred when the Trust apparently *'overlooked'* the complaint relating to the whistleblower allegations when it was responding, on 31 October 2019, to another of the complainant's complaints. I found no evidence within the records I examined that explains the further significant delay that occurred after this error was discovered on 17 December 2019, and PCC informed the Trust on 14 January 2020 that the complainant required a written response to her complaint rather than accepting the Trust's offer of a meeting.

160. Paragraphs 3.39 and 3.40 of the 2019 HSC Complaints Procedure Guidance require that a response to a complaint is provided within 20 working days of its receipt and that where that is not possible, the complainant is provided with an explanation for the delay and advised of the anticipated timescale for the response. It is evident that the Trust was aware at an early stage that it was not going to be possible to meet the 20 working day target timescale. However, there is a lack of evidence to show that during the period January to April 2020 the Trust was sufficiently proactive in keeping the complainant informed, either directly or through PCC, about that delay and updated regarding the anticipated timescale for its response, it is clear the updates the Trust provided to PCC on 3 March 2020 and to Naomi Long MLA on 9 March 2020 came about only because PCC and Ms Long had enquired about progress.

161. I note the complainant was dissatisfied with the Trust's response of 10 April 2020 to her complaint about its handling of the whistleblower allegations and therefore wrote to the Trust again, on 2 December 2020. I found the Trust provided an update to the complainant on 11 January 2021, advising that its

[16] The Trust provided a further, and final, response to this complaint on 8 April 2021.

response to her was delayed and that a further update would be provided '*once all information has been received'* from the relevant service area.

162. The Trust provided further updates to PCC on 11 February 2021 (when it advised there had been no further progress since the Trust's previous update on 11 January 2021) and on 9 March 2021 (when it advised the response approval process would be completed *'in a matter of days'* and the response issued *'shortly').* I note both of these updates were provided in response to requests from PCC for information on progress. The Trust provided a further update to PCC on 23 March 2021, advising that its response was *'subject to some final discussion between the Director and Senior Managers before it is signed and sent'* and that these senior managers were to meet that week to finalise the response.

163. I note that Director B wrote to the complainant on 8 April 2021, providing the Trust's response to the complainant's letter of 2 December 2020.

164. My investigation established, therefore, that it took the Trust four months to provide its written response to the complainant's correspondence of 2 December 2020, in which she had expressed her dissatisfaction with the Trust's previous response (of 10 April 2020) to her complaint of 11 September 2019 about the Trust's handling of the whistleblower allegations. Again, I found no evidence within the records I examined to explain this delay. Rather, the evidence shows that it took until early March 2021 for work on the response to be nearing completion and until early April 2021 for the response to be approved for issue.

165. I acknowledge that given the complexity of the complainant's complaint about the Trust's handling of the whistleblower allegations, coupled with the fact that the Trust was also seeking at the time to respond to the other complaints the complainant had made about matters relating to the Resident's care, and was facing additional pressures in 2020 and 2021, responding to the Covid-19 pandemic, it was highly unlikely that the Trust was ever going to be able to respond within the 20-working day target stipulated in paragraph 3.40 of the 2019 HSC Complaint Procedure Guidance.

166. However, having considered the evidence relating to this element of the complaint, I am of the view that there was unreasonable delay in the Trust responding to the complainant; it ought not to have taken the Trust seven months to respond to the original complaint of 11 September 2019 and four months to respond to the follow up complaint of 2 December 2020. I am also of the view that in dealing with the initial complaint, the Trust was not proactive enough in keeping the complainant fully informed of the reason(s) for the delay and updated regarding the anticipated timescale for its response, in accordance with the requirements set out in paragraphs 3.39 and 3.40 of the 2019 HSC Complaints Procedure Guidance. I consider these failures in complaint handling to be maladministration.

(b) Lack of information about how the Trust dealt with the whistleblower allegations

167. In note that in her complaint of 11 September 2019 to the Trust, the complainant made it clear that she, and PCC on her behalf, had been unsuccessful in their attempts to obtain information from the Trust about how it had dealt with the whistleblower allegations concerning the Resident. The complainant also made it clear that the responses they had received were *'vague'*, *'inaccurate'* and lacked detail of the basis for the Trust's conclusion (as set out in the Resident's Key Worker's email of 7 June 2019 to PCC) that the weight loss the Resident had experienced *'was not due to any negligence by the care home'.*

168. I note the Trust's response of 10 April 2020 to the complaint of 11 September 2019 provided some information about the action the Trust had taken in response to the whistleblower allegations. This was that '*staff immediately sought to establish that the residents named were safe and to establish the facts relating to the information received'*; that *'the Trust immediately contacted the caller and gained some further detail in order to screen the details and determine if a full investigation under Safeguarding or Quality should proceed';* that the whistleblower allegations '*were discussed with the Adult Protection Gateway Team to consider if the information presented warranted a safeguarding investigation'*; and that *'It was agreed based on information available that [CReST] and keyworkers from the Community Social Work*

Teams should carry out enhanced monitoring reviews and if additional concerns emerged this should escalate to a full safeguarding investigation'.

169. The Trust's response of 10 April 2020 went on to state that CReST *'were not involved with [the Resident] as he is not a permanent resident in [the Nursing Home] and therefore not known to their team'* and it advised, '*[The Resident's Key Worker] responded on behalf of [the Resident] in his role as key worker'.* I note however, there was a lack of detail in the Trust's response as to how the Resident's Key Worker had responded to the whistleblower allegations concerning the Resident. In fact, the only specific action or intervention referenced in the letter was the Resident's Key Worker's referral of 25 October 2018 to the Community Speech and Language Therapist and even then, there was no explanation of whether that intervention had been a direct response to the whistleblower allegations.

170. In addition, the Trust's complaint response of 10 April 2020 did not address the complainant's concerns about a lack of basis for the Resident's Key Worker's assertion that '*the weight loss experienced by [the Resident] was not due to any negligence by the care home'.* Rather, the response advised only that Resident's Key Worker considered *'that issues in relation to [the Resident's] weight loss were fully investigated with family involvement',* and reiterated that the Resident's Key Worker considered these issues *'could not be attributed to any negligence on behalf of the care home'*. The Trust's response provided no further clarification or explanation of the basis of the Resident's Key Worker's conclusion.

171. I note that when the complainant wrote to the Trust on 2 December 2020, expressing dissatisfaction with its complaint response of 10 April 2020, she requested *'clarity on the processes and terms of reference of any investigation that was undertaken specifically in relation to [the Resident] …'* I note the Trust did not provide any response to this request when it replied to the complainant on 8 April 2021. In fact, the Trust provided no detail at all of the action it had taken in response to the whistleblower concerns about the Resident. Instead, despite providing an assurance that it aimed *'to be open and transparent at all times in [its] communication and partnership working with residents and their*

families', the Trust stated only that *'… staff followed the regional guidance in respect of actions taken in response to the whistle-blower allegations in [the Nursing Home]'.*

172. Paragraph 3.44 of the 2019 HSC Complaints Procedure Guidance explains that a complaint response should be *'clear, accurate, balanced, simple and easy to understand …'* It goes on to state that the response should *'address the concerns expressed by the complainant and show that each element has been fully and fairly investigated'.* I am not in a position to say why the Trust did not provide the complainant with full details of the action it had taken in response to the whistleblower concerns about the Resident; it is possible that, as I alluded to earlier in this report, the absence of clear, detailed records documenting that action may well have been a contributing factor. Whatever the reason, it is case that the Trust did not meet this particular requirement of 2019 HSC Complaints Procedure Guidance in either of the two responses it provided to the complainant's complaint about its handling of the whistleblower allegations. This was further maladministration in the Trust's complaint handling.

(c) Lack of explanation of how the error occurred regarding the failure to inform the Resident's family about the whistleblower allegations at an early stage

173. I note that when she complained to the Trust on 11 September 2019, the complainant expressed her dissatisfaction that she had only learned of the whistleblower allegations as a result of the Trust's affidavit of 5 October 2018, which the Trust had shared with her solicitor. She made it clear there had been no contact from the Resident's Key Worker about the allegations. My investigation found that when the Trust responded to the complainant on 10 April 2020, it apologised that the Resident's family *'were not informed immediately of the complaint'.* I note, however, that the Trust provided no explanation of how that error had been made nor did it provide any information about action it had taken to prevent a reoccurrence of the error.

174. I note that in her follow up complaint of 2 December 2020 to the Trust, the complainant highlighted that *'to date no reason has been given as to why [the Resident's family] were not informed of the whistle blower incident concerning [the Resident] …'.* It is reassuring to note that in its complaint response of

8 April 2021, the Trust accepted that the complainant ought to have been informed '*when the Trust was first made aware of the whistle-blower allegations on 4 October 2018'*, and that it acknowledged it was unacceptable that the complainant only learned of the allegations through a court document. That said, in my view, it is also unacceptable that the Trust, for a second time, failed to explain to the complainant how the error had occurred in the first place and what action it had taken in relation to learning from the error

175. Again, it is unclear why the Trust did not provide this information to the complainant because, in responding to my investigation enquiries, the Trust was able to identify factors it considered had led to its failure to inform the complainant sooner about the whistleblower allegations. I note the Trust stated, *'The issue, which appears to have contributed to this delay is that there were a number of communications with [the complainant] at the time, both in respect of the court hearing, a safeguarding concern which had been noted at the same time and the whistleblowing allegation. A number of different staff were also involved in supporting [the Resident]'.* The Trust also said, '*In clarifying with staff the reason for this failure to keep [the complainant] fully informed, there appears to have been a presumption that information specific to the whistleblowing allegation had been shared when it had not'.* The Trust also informed me of the action it was taking to help ensure the same error did not reoccur in the future, advising of its intention to '*develop local guidance which highlights for staff specifically the communication standard for families in respect of whistleblowing concerns'.*

176. In addition, I note that in its complaint response of 8 April 2021, the Trust referred to the Resident's Key Worker having *'discussed the [whistleblower allegations] with [the complainant] …on 18 October 2018'.* The Trust provided the same information to me, in its response to my investigation enquiries. However, when I subsequently asked the Trust to provide a copy of its record of this discussion on 18 October 2018, it acknowledged the information it had provided, both to the complainant and to me, was erroneous and that the complainant had, in fact, become aware of the whistleblower allegations *'as a result of … correspondence with her solicitor'.*

177. It is not acceptable that the Trust provided incorrect information to the complainant in its response to her complaint. I also find the apology the Trust offered for having done so – it stated, '*The Trust wish[es] to apologise for the lack of clarity in the correspondence of 8 April 2021 [to the complainant]*' - to be insincere because it is evident there was inaccurate information, rather than a *'lack of clarity'*, within the Trust's response.

178. The failings I have highlighted above are further evidence that in dealing with the complainant's complaint about the Trust's handling of the whistleblower allegations, the Trust did not adhere to the standards set out in paragraph 3.44 of the 2019 HSC Complaints Procedure Guidance, namely, to provide a *'clear, accurate, balanced, simple and easy to understand'* complaint response, which addresses '*the concerns expressed by the complainant'.* I consider this to be a further instance of maladministration in the Trust's handling of the complainant's complaint.

(d) Provision of contradictory information

179. The complainant expressed her dissatisfaction that the Trust's complaint response of 8 April 2021 contained contradictory information. She referred to the response having offered an apology that the Resident's family had only learned of the whistleblower allegations from a court document while at the same time stating that staff had followed procedures in relation to the handling of the whistleblower allegations.

180. I note the Trust's letter of 8 April 2021, its final response to the complainant's complaint, stated, *'It is unacceptable that you became aware of the [whistleblower allegations] in a court document and I wish to record my sincere apologies on behalf of the Trust that this occurred … I am satisfied that staff followed the regional guidance in respect of actions taken in response to the whistle-blower allegations in [the Nursing Home]'.*

181. I note that in response to my investigation enquiries, the Trust informed me that the 'regional guidance' referenced in its letter of 8 April 2021 to the complainant was the publication 'Whistleblowing in the Public Sector, A Good Practice Guide for Workers and Employers, November 2014'. I note this publication

does not include any guidance or reference to good practice on how a public sector organisation should communicate with the families of individuals who are named in whistleblower allegations. The Trust highlighted this point in responding to investigation enquiries, stating its whistleblowing policy '*does not specify the detailed arrangements for the notification of incidents to families'.*

182. My investigation established therefore that at the time of its 8 April 2021 complaint response, the Trust did not have guidance or procedures in operation which required it to notify families of whistleblowing incidents. I am satisfied, therefore, there was no contradiction between the Trust's apology to the complainant at that time for not informing her of the whistleblower allegations and its statement that it had followed regional guidance in its response to the whistleblower allegations. I can, nevertheless, understand how uncertainty regarding the compatibility of these two statements could arise. In my view, this uncertainty could have been avoided if, as I recorded earlier in this report, the Trust had disclosed full information in its complaint response about how the communication error had occurred and had explained the action it was taking to seek to avoid its reoccurrence (that is, the development of local guidance regarding '*the communication standard for families in respect of whistleblowing concerns'*).

Summary of findings on the Trust's handling of the complaint concerning whistleblower allegations

183. I found a number of failings in the Trust's handling of the complainant's complaint about its response to the whistleblower allegations concerning the Resident. These are:

- there was unreasonable delay in responding to the initial complaint of 11 September 2019 and the follow up complaint of 2 December 2020;
- the Trust was not sufficiently proactive in keeping the complainant fully informed of the reason(s) for the delay and updated regarding the anticipated timescale for its response to her complaint;
- the Trust did not provide full details in its complaint responses of the action it had taken in response to the whistleblower concerns about the

Resident;

- the Trust did not explain in its complaint responses what had led to its failure to inform her of the whistleblower allegations at an early stage; and
- the Trust provided inaccurate information in its complaint response of 8 April 2021 about when and how the Trust made the complaint aware of the whistleblower allegations.

184. The Ombudsman's Principles of Good Complaint Handling are reproduced in Appendix Two to this report. Good complaint handling by public bodies means getting it right; being customer focused; being open and accountable; acting fairly and proportionately; putting things right; and seeking continuous improvement. The failings I have identified above are evidence that, in dealing with the complainant's complaint concerning the whistleblower allegations, the Trust did always not meet the standards these Principles require of public bodies.

185. I consider the numerous complaint handling failings disclosed by my investigation are maladministration on the part of the Trust. I am satisfied this maladministration caused the complainant to sustain the injustice of uncertainty and frustration. It also meant she had to go to an unreasonable degree of time and trouble over a protracted period in pursing her complaint and securing the support and representation of PCC, and others, to have her concerns and queries addressed. Consequently, I uphold this third element of the second issue of her complaint.

CONCLUSION

186. I received a complaint about how the Trust handled requests the complainant made to it for a determination of the Resident's eligibility for CHC. The complaint was also about how the Trust handled concerns the complainant and a whistleblower raised regarding the Resident's care in the Nursing Home. In addition, the complaint was about how the Trust dealt with a complaint the complainant made to it about its handling of the whistleblower concerns.

187. In relation to the first issue of complaint, the Trust's handling of requests for a determination of the Resident's CHC eligibility, my investigation found that numerous assessments of the Resident's needs were completed during his admission to the Ulster Hospital (from 7 October 2017 to 2 July 2018) and following his placement in the Nursing Home on 2 July 2018. These assessments of need were appropriate and sufficient to inform the Trust's further consideration of a determination of the nature of the Resident's primary care need. Nevertheless, I found that having completed those assessments, the Trust did not then take the necessary steps to determine whether the Resident had a primary healthcare need or a primary social care need. Consequently, the Trust did not determine the Resident's eligibility for CHC, in accordance with the Department of Health's policy direction and guidance, as set out in the 2010 Circular.

188. I also found that the Trust provided inaccurate information to the complainant about CHC arrangements in Northern Ireland when she and other members of the Resident's family raised the matter at meetings on 31 October and 5 December 2017.

189. I consider the Trust's failure to determine the nature the Resident's primary need, in accordance with the policy that applied at the time, and to respond appropriately to the complainant's enquiries about CHC, is maladministration. I am satisfied this maladministration caused the complainant to sustain the injustice of frustration, uncertainty and the loss of opportunity to have her requests for a determination of the Resident's CHC eligibility dealt with appropriately.

190. I uphold the complainant's complaint about the Trust's handling of her requests for a determination of the Resident's eligibility for CHC.

191. With regard to the Trust's handling of concerns about the Resident's care in the Nursing Home (the first element of the second issue of complaint), I am satisfied the Trust took appropriate and reasonable action to respond to the concerns the complainant raised in her email of 25 September 2018 to the Resident's Key Worker, and to the concerns a whistleblower raised, through

RQIA, on 4 October 2018. However, I found that the Trust failed to make and retain an appropriate record of its response to the whistleblower allegations concerning the Resident. I consider this is maladministration, which led to the complainant having to take the time and trouble to bring a complaint to my Office to gain a better understanding of the Trust's response to the whistleblower allegations. I also consider this maladministration caused her to sustain the injustice of frustration and uncertainty.

192. In relation to the Trust's communication with the complainant about the whistleblower allegations (the second element of the second issue of complaint), I found the Trust failed to inform the complainant about the allegations at an early stage. I consider this was a further instance of maladministration on the part of the Trust, which also caused the complainant to sustain the injustice of frustration and uncertainty.

193. As for the Trust's handling of the complaint the complainant made to it about its response to the whistleblower allegations concerning the Resident (the third element of the second issue of complaint), I did not find, as the complainant maintained, that the Trust provided conflicting information in its complaint response of 8 April 2021. However, my investigation disclosed a number of failings in other aspects of the Trust's handling of the complaint. I consider these failings - unreasonable delay in responding to the complaint; failure to keep the complainant updated about that delay and the anticipated timescale for the complaint response; failure to provide full responses to the matters the complainant had raised in her complaint; and providing inaccurate information in the final complaint response - are maladministration. I am satisfied this maladministration caused the complaint to again sustain the injustice of uncertainty and frustration, and also meant she had to go to an unreasonable degree of time and trouble over a protracted period in pursing her complaint.

194. I partially uphold the complainant's complaint about the Trust's handling of the concerns she, and subsequently, a whistleblower, raised about the Resident and his care in the Nursing Home and its handling of her related complaint.

195. Having upheld all elements of the first issue of complaint (the Trust's handling of the complainant's requests for a determination of the Resident's CHC eligibility) and some elements of the second issue of complaint (the Trust's handling of the concerns raised in 2018 about the Resident's care in the Nursing Home), overall, I partially uphold the complaint.

196. In commenting on the draft of this report, the Trust said it was content that my findings were reasonable and that it would take the opportunity to learn from them.

Recommendations

197. I recommend that within one month of the date of this report, the Trust's Chief Executive provide the complainant with a written apology, made in accordance with NIPSO's 'Guidance on issuing an apology'[17] for the injustice she sustained as a result of the maladministration disclosed by my investigation. The letter should include an update on the work the Trust is undertaking, or has already completed, to develop the local guidance it says will highlight for staff *'the communication standard for families in respect of whistleblowing concerns'*. The Trust undertook to implement this recommendation.

198. I also recommend that the Trust implement the following service improvements:

(i) The Trust should ensure the learning highlighted by the failings identified in this report, in relation to both issues of complaint, is communicated to relevant Trust staff;

(ii) the Trust should take action to ensure that it has in place the necessary framework to enable it to consider all requests for the determination of CHC eligibility in a timely, consistent and transparent manner, and in accordance with the Department of Health's policy direction, as set out in the 2010 Circular. I am aware that in implementing this recommendation, the Trust will need to give careful consideration to the judgement of the High Court in ([2023] NIKB 72; and

[17] https://nipso.org.uk/site/wp-content/uploads/2019/07/N14C-A4-NIPSO-Guidance-on-issuing-an-apology-July-2019.pdf

(iii) the Trust should ensure it provides guidance to relevant staff to assist them in handling requests for the determination of CHC eligibility.

199. I recommend that the Trust develop an action plan for the implementation of these service improvements and that within six months of the date of this report, it provide me with an update on progress.

200. In addition, I recommend that within three months of the necessary framework for determining CHC eligibility being established, the Trust make a determination of the Resident's eligibility for CHC during the period he was a resident in the Nursing Home. The Trust should, within six months of the date of the final version of this report, provide me with an update on progress towards its implementation of this recommendation.

201. In commenting on the recommendations made in paragraphs 198 to 200 above, the Trust said, *'Until the Department of Health provides the necessary policy and framework guidance the Trust will continue to record requests for [CHC] and await further guidance from [the Department]. The Trust [will] … keep any service users who have made a request for assessment informed of the progress in the case[18] with the Court of Appeal.'* The Trust also said, *'The Trust will act, as soon as fresh direction is provided by the Department of Health, to ensure the resolution of all legacy cases. We therefore cannot commit to resolving any requests for consideration of CHC until the Department of Health issue the guidance indicated as required by [2023] NIKB 72.'*

202. I accept that the ongoing legal action arising out of [2023] NIKB 72 means it is not possible at this time for the Trust to implement of all the recommendations I make in this report. I acknowledge this is a frustrating situation for the complainant. In the circumstances, it is my expectation that the Trust take steps towards the full implementation of my recommendations as soon as is practicably possible. I will be seeking an update from the Trust in due course

[18] Appeal in relation to [2023] NIKB 72

in relation to developments and progress in this regard.

MARGARET KELLY
Ombudsman **23 April 2024**

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.

Appendix Two

Principles of Good Complaint Handling

1. **Getting it right**

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

2. **Being customer focused**

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including coordinating responses with any other bodies involved in the same complaint, where appropriate.

3. **Being open and accountable**

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.

- Publishing service standards for handling complaints.
- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. **Acting fairly and proportionately**

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

5. **Putting things right**

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.