Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Antrim Care Home

NIPSO Reference: 17509

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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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SUMMARY

I received a complaint about the care provided to the complainant's mother by Antrim Care Home (the Care Home). The complainant was concerned about how her mother's medications were managed and how the Care Home managed her Motor Neurone Disease (MND)[1] symptoms. She also complained that the Care Home did not properly respond to her complaint in an open and transparent manner.

The investigation of the complaint identified several failings relating to the administration and recording of medicines. The investigation also identified other failings relating to the patient's care, including failures on the part of the Care Home to properly respond to a panic attack she experienced and failings related to the Care Home's management of her MND.

The investigation also identified a failure to properly investigate the complaint in an open, honest, and transparent manner and to respond to the concerns in a reasonable time.

I recommended that the Care Home:

(i) Issues the complainant with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified in this report, and should be issued within **one month** of the date of my final report.

(ii) Provides the complainant with a payment of £400 by way of solatium for redress in respect of the injustice of distress, upset, time and trouble, frustration and uncertainty she experienced within **one month** of the date of my final report.

Given the concerns that this investigation has raised, I intend to provide a copy of the report to the RQIA so it can provide assurance about the care currently being provided and to identify any wider areas for action, or learning and improvement.

[1] [1] A progressive disease that involves degeneration of the motor neurons and wasting of the muscles

THE COMPLAINT

1. The complaint concerns the care and treatment provided to the complainant's late mother (the patient) at the Care Home. The patient was diagnosed with Motor Neurone Disease[2] (MND) in March 2016. She was discharged from the Royal Victoria Hospital (the RVH) on 6 June 2016 to her home with an extensive care package. She was cared for at her home by the complainant, other members of her family and Marie Curie health professionals. She was admitted to the Care Home on 6 July 2016 for one month's respite care[3]. On 24 July 2016, she was taken from the Care Home via ambulance after experiencing difficulty breathing and collapsing. Sadly, the patient suffered a suspected respiratory arrest and passed away. The complainant submitted a complaint about the care and treatment provided to her mother at the Care Home and the Care Home's handling of her complaint.

Issues of complaint

2. The issues of the complaint which I accepted for investigation were:

   Issue 1: Whether the care and treatment provided to the patient was reasonable and appropriate?

   Issue 2: Whether the complaint was dealt with by Antrim Care Home in accordance with policy, procedure and guidance?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Care Home all relevant documentation together with the Care Home's comments on the issues raised. This documentation included information relating to the Care Home's handling of the complaint. The Investigating Officer also made enquiries of the Northern Health and Social Care Trust (the Trust) as the patient was a care managed patient and was placed in the Care Home by the Trust. The patient's GP records were also obtained and considered.

[3] Temporary institutional care of a sick, elderly, or disabled person, providing relief for their usual carer.

Independent Professional Advice Sought

4. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

    - A Registered Nurse; Registered Public Health Nurse; Nurse Teacher; (Bsc) Hons Palliative Care Nursing; MSc Medical Anthropology; PG Cert. Education MSc Health Research (Palliative Care) who works as a consultant nurse in community palliative care.

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

Relevant Standards

6. 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.

7. The general standards are the Ombudsman's Principles[4]:

    - The Principles of Good Administration
    - The Principles of Good Complaints Handling
    - The Principles for Remedy

8. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Care Home staff whose actions are the subject of this complaint.

9. I have considered the following relevant policies.

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

- The Regional Residential Nursing Provider Contract between the Northern Health and Social Care Trust and the Care Home *(The Care Home Contract*);
- Nursing and Midwifery Council (2007) Standards for Medicines Management *(NMC Guidelines);*
- National Health Service advice for Assessing Capacity; Consent to Treatment;[5]
- Department of Health Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning (1 April 2009) (*HSC Complaints Procedure*);
- Nursing and Midwifery Council Professional standards of practice and behaviour for nurses and midwives (2015) (the NMC Code); and
- The Nursing Home Regulations (NI) 2005.

10. I have not included all of the information obtained in the course of the investigation in this report, but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

11. As part of the NIPSO process, a draft copy of this report was shared with the Care Home and the complainant for comment on the factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1 Whether the care and treatment provided to the patient was reasonable and appropriate?

12. I intend to consider this issue of complaint under a number of discreet sub-issues:-

(i) Should the Care Home have provided a Riser Recliner Chair to the patient?

[5] https://www.nhs.uk/conditions/consent-to-treatment/capacity/

(ii) Was Oramorph[6] properly administered to the patient and properly recorded by the Care Home's staff?

(iii) Was Atropine correctly provided to the patient and did the Care Home correctly document the administration of Atropine?

(iv) Did the Care Home staff appropriately follow the care plan in relation to the patient's bed position?

(v) Were Staff Handovers properly carried out in relation to the patient's care?

(vi) Did the Care Home staff act appropriately in response to the request to call an ambulance on 13 July 2016?

(vii) Did the Care Home appropriately ensure that the patient had access to her call bell?

(viii) Was the patient's RIG tube properly cared for?

Should the Care Home have provided a Riser Recliner Chair to the patient?

Detail of Complaint

13. The complainant said that a riser recliner[7] chair should have been provided by the Care Home as her mother was at high risk of choking, vomiting and aspiration. The complainant accepts that a riser recliner chair was not in the care plan, but said that the social worker told her that she informed the Care Home that her mother needed one. On 7 July 2016, the patient's family brought her own riser recliner chair to the Care Home as none was provided.

Care Home's Response to investigation enquiries.

14. In relation to the rise recliner chair, the Care Home stated that the patient's social worker advised *'the patient had a riser recliner chair in her own house but [the social worker] did not feel it was necessary for her time in the home. [The Care Home] had made it clear that there was no such chair in the Home at that time and … also refer to the Care Plan which does not evidence any need for a riser recliner chair, backing up the social worker's assessment.'*

[6] Oramorph (morphine) belongs to a class of drugs known as opioid (narcotic) analgesics.
[7] Riser recliner chairs are a specialist type of chair that use a rising and reclining mechanism to lift and tilt the chair.

Information received from the Trust

15. As a result of a request from NIPSO, the Trust explained that on 1 July 2016 the Social Worker during a telephone call *'verbally advised'* the Care Home Manager *'rise recliner chair required (not in nursing care plan').* Social Work notes of this call state *'[…] advised of equipment required.'* However, the social worker could not recall what specifically was discussed in relation to this entry. The Investigating Officer asked the Trust why the need for a rise recliner chair was not included in the patient's care plan. In response, the Trust advised that *'For the purposes of a short break, the correct positioning of this patient could be managed whilst in a profiling bed, therefore requests for riser recliner chairs would not be routinely requested.'*

Relevant Medical Records.

16. The social work notes reflect that the complainant called to complain about the absence of the riser recliner chair on 6 July 2016. On the same date, the social worker phoned the district nurse *'to see about recliner getting transferred to [the patient], [the district nurse] advised nursing home should provide but to leave it with her.'* The district nurse advised *'she spoke to OT (as checked [and] they commissioned chair) and they advised it is a standard chair and homes normally have them.'* The social work notes recorded that the patient's family brought a riser recliner from home to the Care Home on 7 July.

Care Home Contract.

17. I have reviewed the Care Home Contract between the Trust and the Care Home in place at the time of the patient's placement. I note that Paragraph 2.1 of the Care Home Contract states that *'The purpose of the Contract is to set out the terms and conditions under which the Services in the Home will be delivered to the Provider.'* I note that Paragraph 16.1 of the Care Home Contract indicates the respective responsibilities of the Care Home and the Trust for the provision of equipment, including specialist equipment for individual residents are detailed in Appendix 3 of the Contract. Appendix 3 is titled '*Equipment List for Nursing and Residential Home Providers'*. I have reviewed Appendix 3 and note it requires the Care Home provide certain equipment without any requirement for a needs assessment. Such items include 'general beds', a 'range of back rests', 'over the

bed trolley tables' etc. I note that the Care Home Contract records that it is the Care Home's responsibility to arrange the provision of a *'[r]ange of chairs and seating to include: riser chairs, recliner chairs, postural chairs with varying heights, including a number with in-built pressure relief'.* There is no indication within the Contract that such a chair is to be provided pursuant to a needs assessment.

Independent Professional Advice.

18. The IPA was asked to comment on whether a riser recliner chair should have been provided to the patient by the Care Home and if it was improper not to do so. The IPA commented that, pursuant to the Care Home Contract*, '[t]he Care Home themselves, have stated they see the provision of riser recliner chairs to be within their sphere of responsibility…[the] Hospice assessment undertaken in April 2016, which notes the Occupational Therapist has recommended this.'* The IPA was asked to comment on the potential impact to the patient and noted that '[*g]iven problems with drooling, and enteral feeding, I can understand that these symptoms may have been better managed had she had access to a riser recliner chair…I am not able to understand why the patient would not have been provided with a riser recliner chair to meet her mobility/seating needs. This is disappointing, and I can understand this would have been a source of dissatisfaction for the patient and her daughter'*

19. In response to the IPA's advice, the Care Home acknowledged that *'[p]rior to admission of the patient to the nursing home, the social worker did advise our client that the patient had a riser recliner chair at home.'* However, the Care Home's response also reiterated that *'the Trust care plan does not evidence the need for a riser recliner, just that the patient needed to be in an upright position for feeding. On 6 July [the Care Home manager] spoke to the complainant regarding*
the matter and she indicated that she would bring her mother's chair from home.'

Responses to Draft Report

20. In response to the Draft Report, the Care Home's solicitors reiterated that the Riser Recliner was not in the care plan.

Analysis and Findings

21. I have carefully considered this issue of complaint. I note that although not provided for in the care plan, the patient was using a riser recliner chair at home. I have also considered that the Trust has indicated it felt that the patient's positioning could be managed whilst in a profiling bed for the purposes of a short break and for this reason, a riser recliner chair was not included in the care plan. I have also considered the conversation between the Social Worker and the Care Home Manager on 1 July regarding the equipment required for the patient. It is unclear what was discussed during this call. I note that the Trust has indicated that the Care Home was advised that a riser recliner chair was required and the Social Worker note of the conversation only records that *'equipment required'* was discussed. However the record of this conversation is unclear and the Social Worker did not recall what exactly was discussed. I have also considered the Care Home Contract which states that the Care Home is responsible for providing a range of chairs, including riser recliner chairs. I note that the complainant had anticipated that the Care Home would provide such a chair for her mother. I have had regard to the benefit that the patient derived from having access to a riser recliner chair as detailed by the IPA. I note the IPA's advice that a riser recliner chair would help manage the patient's symptoms, in particular her drooling and managing her feeding.

22. There are two factors to consider in determining whether the Care Home should have provided the patient with a riser recliner chair. The first is whether there was an express instruction from the Trust that a riser recliner chair should be provided. Although not expressly provided for in the care plan, there is evidence that the provision of a riser recliner chair was discussed on 1 July when the social worker called the Care Home manager. However, this evidence is inconclusive and therefore I cannot determine whether the Trust ever expressly requested that the Care Home provide a riser recliner chair for the patient.

23. The second factor to consider is whether a riser recliner chair should have been provided by the Care Home pursuant to the Care Home Contract. I have reviewed Appendix 3 of the Care Home Contract and note that at times, the

comments on certain items in Appendix 3 indicate those items are to be provided based upon an 'assessed need'. There is no such caveat in relation to the provision of a riser recliner chair. The Contract address the provision of riser recliner chairs in the same way it addresses the provision of '*basic shower chairs'*, a *'range of bath boards'*, and '*basic shower stools'* and other such items which the Care Home would be expected to provide. This stands in contrast to equipment such as a 'specialist shower chair', which is to be provided by the Trust *'[a]s individually prescribed for [a] complex need'*. The Care Home Contract clearly distinguishes between equipment that should be provided as part of a needs assessment and equipment that the Care Home is expected to have within its own inventory. Pursuant to the terms of the contract, a riser-recliner chair, falls within the latter. I note that this is consistent with the district nurse's record where she advised *'she spoke to OT (as checked [and] they commissioned chair) and they advised it is a standard chair and homes normally have them.'*

24. The Care Home Contract clearly states that the Care Home was responsible for providing a range of seating, including riser recliner chairs. Accordingly, the Care Home should have had a riser recliner chair available pursuant to the terms of the Care Home Contract. I have also considered the IPA advice about the importance of a riser recliner chair and the fact that the patient had relied on using a riser recliner chair while at home.

25. I have considered the Care Home's response to the Draft Report at paragraph 21. This point is not in dispute. However, the Care Home's response does not account for, or contradict, the terms in the Care Home Contract establishing that a Riser Recliner Chair should be available within the Care Home as discussed above at paragraphs 23 to 25.

26. For these reasons, I accept the advice of the IPA, who advised that he is '*not able to understand why the patient would not have been provided with a riser recliner chair to meet her mobility/seating needs.'* I further accept the advice of the IPA that, pursuant to the Care Home Contract, *'[t]he Care Home themselves, have stated they see the provision of riser recliner chairs to be within their sphere of responsibility'.*

27. Accordingly, I find that the Care Home should have provided a riser-recliner chair to the patient when they were made aware by the complainant that it was used to meet her needs, as it was part of a range of equipment that the Care Home should have available. **I therefore uphold this element of the complaint.**

28. In relation to the impact this failing had on the patient and the complainant, I have considered the IPA's advice that '[*g]iven problems with drooling, and enteral feeding, [he] can understand that these symptoms may have been better managed had she had access to a riser recliner chair'.* I also note that the complainant and other members of the patient's family brought the patient's riser recliner chair from home as no riser recliner chair was available as required by the contract with the Trust.

29. I acknowledge that the care plan did not specify the patient should be provided with a riser-recliner chair. However, the Care Home should have had such a chair available and provided it when requested by the complainant. I also note the advice of the IPA, who advised that the patient's symptoms may have been better managed in a riser recliner chair. Thankfully, as a result of the prompt attention of her family, the patient was only without her riser recliner chair for one night. Accordingly, I find that the complainant and the other members of the patient's family suffered the injustice of time and trouble associated with bringing the riser recliner chair to the Care Home at an already stressful time for the family. I also find that the patient suffered the injustice of upset and discomfort as she did not have the benefit of the riser recliner chair from 6 July 2016 to 7 July 2016.

(ii) Was Oramorph[8] properly administered to the patient and properly recorded by the Care Home's staff?

Detail of Complaint

30. The complainant said that the Care Home staff did not properly administer her mother's Oramorph prescription. The patient's prescription was for Oramorph to be given 'PRN' (meaning, 'as required') In particular, the complainant has complained that the Care Home staff did not administer her prescription PRN and did not know that the Oramorph prescription was for anxiety, not pain.

[8] Oramorph (morphine) belongs to a class of drugs known as opioid (narcotic) analgesics.

The complainant said that her mother was not given Oramorph when she needed it and vice versa and this continued even after she complained to the head nurse.

31. The patient had a Kardex[9] which was used by the complainant and Marie Curie nurses when being cared for at home (The Original Kardex). The complainant gave the Kardex to the Care Home when her mother went there for respite. The complainant stated that on 6 July, she sat with the Care Home's head nurse to go through her mother's medications. During this meeting, the head nurse then wrote out a new Kardex (the Care Home kardex). The complainant stated that she showed the Original Kardex to the head nurse, who recorded on the Care Home Kardex that morphine was to be given at 10pm every night (as a regular dose).

Relevant Policies and Protocols.

32. I have reviewed the NMC Guidelines in relation to medication administration. I note that the NMC Guidelines require nursing staff to ensure that medications are given at *'the right time'.* This means that nursing staff are required to *'accurately document medication administration times.'* Section 2.13, *'Management of MDA Schedule 2 drugs'*, requires that *'[a]ppropriate documentation of the administration of MDA Schedule drugs should be entered in the patient's/service user's chart/noted and in the ward controlled drug register.*

33. I have also reviewed the Nursing Home Regulations (NI) 2005. I note that Schedule 3, part (i) requires nursing homes to maintain *'a record of all medicines kept in the nursing home and the date on which they were administered to the Patient.'*

34. I have also reviewed the NMC Code in relation to record keeping. I note that Section 10 of the NMC Code requires nurses to '*keep clear and accurate records relevant to [their] practice'.* Section 10.3 requires nurses to *'complete all records accurately'.*

Care Home Responses to the complaint.

35. The Care Home stated that the patient *'was given Morphine [Oramorph] as*

[9] A trademark for a card-filing system that allows quick reference to the particular needs of each patient for certain aspects of nursing care.

prescribed and all PRN as and when required.' The Care Home's response then sets out the times at which Oramorph was given, indicating that it was given *'every night plus – 15/7 at 19:00; 16/7 at 09:00, 17/7 at 17:00; 18/7 at 12:30; 19/7 at 14:20; 20/7 at 08:30; 21/7 at 08:30; 22/7 at 08:30, 13:30, and 23:30; 23/7 at 04:20; and 24/7 at 13:00.'*

Care Home Responses to Investigation Enquiries.

36. The Care Home stated that *"[t]he Deputy Manager and staff nurse can clearly remember the complainant advising them on the day of the patient's admission that the Oramorph was for anxiety, especially at night. The [Care Home] Kardex was written up to reflect this by the deputy manager, checked by the staff nurse and then double checked by [the complainant]. It was confirmed that Oramorph should be given at 10.00 pm and then as required throughout the day.'* In response to the Draft Report, the complainant disputed this occurred during this meeting and does not believe she indicated her mother should be given Oramorph at 10:00 pm and then as required throughout the day. The Care Home also advised that *'[t]he Oramorph was given as required from 15 July onwards due to the specific request of the complainant.'* The Care Home also indicated that '*[t]here were occasions when the Oramorph was given during the afternoon and was not given again at night.'* The Care Home Kardex made no reference to the indications for administering Oramorph. It also states that she should receive the dose daily at 10pm and as required with 4 hour periods between doses. The Care Home Kardex recorded that the patient was given Oramorph every evening, at approximately 9:30pm, from 6 to 14 July and on some dates after this.

Relevant Medical records.

37. The GP records show that the patient was prescribed Oramorph on 24 June 2016 to be given when required for acute anxiety/shortness of breath as per Palliative Care team. This was prior to the patient going into the Care Home. The prescription states that the Oramorph is to be administered 'PRN', meaning 'as required'. This is also how it was recorded on the Original Kardex. The Original Kardex stated that Oramorph should be taken as required for acute anxiety, shortness of breath/ breathlessness.

Hospice Nurse Telephone Interview.

38. As part of the investigation enquiries, the Investigating Officer spoke with the patient's Hospice Nurse. The Hospice Nurse reviewed her notes and confirmed that Oramorph was to be given as and when required. She commented that the patient was to be given a low dose, namely 0.5mls. She stated that ultimately it was down to the nurse's clinical judgement along with input from the patient, as to when she needed to be provided with Oramorph. She also noted that the complainant had concerns that her mother was being given it every evening regularly instead of 'as required'. She said that her notes indicated that the patient could have been more agitated in the evenings.

Relevant Medical Records

39. The care plan states that nurses should *'[a]dminister prescribed medication as per NMC guidelines.*' I have reviewed the relevant nursing notes regarding conversations between the nursing staff and the complainant about the administration of Oramorph. I note that a record entered on 12 July documents a discussion with the complainant. This note records that the nurse said morphine (Oramorph) was a pain relief drug, but the complainant said no, her mother gets it for anxiety. I also note that another record entered by a different nurse at 05:41 on 13 July indicated that nurse also believed that morphine was to be given when the patient was in pain. This note was entered in reference to a conversation that occurred on 11 July.

40. The Care Home's nursing records record the following entries relating to the administration of Oramorph to the patient.
    - 7 July entry at 00:43 – the patient was a *'bit anxious stated she fell(sic) sick, Oramorph administered and reassurance given by staff.'*
    - 12 July entry at 10:28 – *'[…] was concerned about the Oramorph, which [the patient] receives every night.'*
    - 12 July at 20:17 – The nursing notes record a conversation with the complainant who complained that the staff the night before had thought that the complainant received morphine for pain. The deputy manager replied that '*it's a pain relief drug and used in palliative care for comfort'.*
    - 13 July – entry from the patient's GP on Care Home medical records

regarding his examination of the patient on 13 July 2016 – *'[patient] and family keen for her to have oramorph regularly and prn apparently.no concerns identified. Care excellent.'*

- 15 July entry – the patient given Oramorph *'for anxiety.'*
- 22 July entry – *'After lunchtime [the patient] complained about her breathing and becomed (sic) anxious. Oramorph was given with good effect.'*
- 24 July – Oramorph given for anxiety.

41. In summary, the nursing notes record four instances of the patient receiving Oramorph for anxiety: on the first night of 6 July, 15 July, 22 July and 24 July.

42. During a case discussion on 19 July 2016, the complainant '*raised the issue of certain staff not knowing that [the patient] had Motor Neurone Disease which alarmed her.'* The discussion also noted that there was *'some confusion around when [Oramorph] should be given and how much given.'* Social work notes on 14 July 2016 record that the complainant advised her *'morphine still being given routinely at night instead of as and when.'* That same day, a nurse noted that she '*advised Kardex completed and advised morphine PRN but [the complainant] advised [the patient] usually given every night at 10ish, Social Worker discussed sending Kardex to GP to get him to check. [nurse] advised [GP] here yesterday and checked over Kardex and all okay.*

The Drug Administration Record.

43. I have reviewed the drug administration record. This record is intended to record the regular prescriptions administered to a patient. The administration of Oramorph by the nursing staff is documented on this record. Oramorph is recorded on this document as being given at the following times:
    6 July to 14 July: 21:30 each night.
    15 July: 19:00 and 21:30
    16 July: 08:30
    17 July: 08:30, 12:30 and 16:30
    18 July: 12:30 and 21:30
    19 July: 14:20 and 21:30
    20 July: 08:30

21 July: 08:30
22 July: 08:30 and 13:30
23 July: 04:20
24 July: 08:30 and 13:10

44. In total, the drug administration record records 26 instances of Oramorph being administered to the patient.

The Controlled Drug Book (CD Book)

45. I have reviewed the CD Book maintained by the Care Home. This is a distinct document and is separate to the drug administration record and is used to record the use of MDA Schedule 2 drugs. In relation to the patient, I note that the CD Book records the use of Oramorph at the following times:
6 July to 14 July: Every evening at approximately 21:30.
15 July: 08:30 and 21:30
16 July: 08:10 and 19:20
17 July: 08:45 and 17:15
18 July: 12:30 and 19:15
19 July: 14:20 and 21:30
20 July 09:00 and 21:30
21 July 09:00 and 21:30
22 July 08:30, 13:00, and 23:20
23 July 04:20, 08:30 and 20:30
46. 24 July 08:30 and 13:10.In total, I note that the CD Book records 31 instances of Oramorph being administered to the patient.

Review of Regulation and Quality Improvement Authority (RQIA) Inspection Reports.

47. I have obtained and reviewed copies of reports published by RQIA following Inspections of the Care Home. With particular regard to this element of the complaint, I have reviewed the RQIA report dated 27 April 2015, which was prepared following an unannounced medicines management inspection of the Care Home. I have noted the following requirements contained within the report:

'Requirement 1: The registered manager must ensure that all medicines are administered as prescribed and records of administration are accurately maintained.'

Requirement 2: The registered person must implement robust monitoring arrangements for liquid medicines to ensure these medicines are administered in strict accordance with the prescriber's instructions.'

48. I have also noted the following recommendations contained within the report:

'Recommendation 1: It is recommended that the registered person should closely monitor the record keeping in the [CD Book] to ensure the details recorded are accurate.'

Recommendation 3: It is recommended that the registered person should ensure that where medicines are prescribed on a "when required" basis for the treatment of distressed reactions, a care plan is in place and staff record the reason for and the outcome of the administration of the medicine on every occasion.'

49. I have also reviewed the follow up inspection by RQIA, conducted on 28 September 2016 and note that RQIA found that each of these requirements and recommendations *'were met'.*

Independent Professional Advice.

50. The IPA was asked to comment on the Care Home staff's administration of Oramorph. In particular, whether the indications for the administration of Oramorph were properly documented and considered. From his review of the records, the IPA advised that *'[t]here appears to be some confusion around the use of Oramorph, it cannot be said the indications for administration were appropriately documented or considered. This highlights a misunderstanding, which may have led to the inappropriate administration, or lack of to the patient, thus worsening symptoms related to her disease.'*

51. In support of this position, the IPA noted the disagreement on 12 July 2016 between the nursing staff and the complainant discussed above. The IPA advised that *'[w]hilst this sounds like a difficult encounter, it did not appear to change practice.'* The IPA advised that even after this conversation, *'when an ambulance was called due to a panic attack, there is no evidence that the patient was given extra doses of Oramorph to help manage this distressing symptom. It is concerning then, that no change in practice came about as a result of the daughter's concerns, highlighted on 12th July.'*

52. The IPA was asked to comment on whether Oramorph was given PRN, or regularly every evening. Based on a review of the medical records, the IPA advised that aside from 6 July to 14 July where it was *'never given PRN'*, generally *'[t]hroughout the drug administration chart,[11] [there is] evidence that the Oramorph was given PRN, as prescribed, and around a specific evening time of 22.00hrs. However, there are discrepancies between the drug administration chart, and the Controlled Drug Record book' (CD Book)[12].* The IPA detailed these discrepancies as follows:

    "6th July -14th July at 21.30hrs only: Therefore, never given PRN between these dates.

    15th July at 19.00hrs and 21.30hrs – later dose not in CD book.

    16th July 8.30hrs and not at 21.30hrs

    17th July 8.30 and 14.30 but not 21.30hrs – CD book states 8.45hrs and 17.15hrs

    18th July 12.30hrs (not clear) and 21.30hrs CD book states later dose was given at 19.15hrs

    19th 14.20 but not 21.30hrs – nothing in administration sheet around 21.30hrs dose being given

    20th July only at 8.30hrs not 21.30hrs – CD book states 21.30hrs dose given but nothing in administration sheet around 21.30hrs dose being given

    21st July 8.30hrs and not 21.30hrs again discrepancy between admin chart and CD book – CD book states later dose given.

    22nd July 8.30hrs and 13.30hrs but not 21.30hrs – CD book states dose for 23.20hrs but this not on admin chart

    23rd July 04.20hrs only – not 21.30hrs – CD book states evening dose given but this not on admin charts

    24th July 8.30hrs and 13.20hrs".

53. The IPA was asked to comment on whether the applicable standards and guidelines had been followed regarding the recording and administration of

[11] A working document used to record administration of medicines, often referred to as a drug administration chart or a medicine administration chart.
[12] The Controlled Drug Book (CD Book) is used for the recording of controlled drugs, such as Oramorph, and error reduction by facilities who keep a stock of controlled medications.

Oramorph. The IPA advised *'[g]iven the discrepancies between the two records, the NMC guidelines (2007) have not been adhered to, as the drug administration chart should match the CD book… The NMC guidance is clear about two issues relevant to this case. Firstly, that nurses must understand why they are administering a medicine. There is no evidence to support this throughout the care home notes in relation to Oramorph. Secondly, nurses must maintain clear records in relation to drug administration. The records in relation to the Oramorph are not clear, and actually provide a confusing picture. Therefore, there are omissions in relation to how the NMC see good clinical practice.'*

54. As the Care Home kardex noted that Oramorph was to be given at 22:00, the IPA was asked to comment on whether it was reasonable for the care home staff to administer Oramorph at 22:00 in accordance with the Kardex. The IPA advised that it this '*does not appear unreasonable for the care home staff to administer Oramorph'* noting that *'it is common practice for people to have a dose of Oramorph at bed time to help ease symptoms at night. However … the Oramorph was not consistently administered at 10pm each evening… As before, this does not demonstrate that the NMC guidance was being adhered to.* Regarding the prescription and administration of Oramorph generally, the IPA advised that *'[a]s medication was not given as prescribed, and if not given, there is no documented evidence around why it was not given, this too, is an expectation held within the NMC (2007) guidance.'*

55. Based on this analysis, the IPA concluded that *'[t]here is no evidence that the NMC (2007) guidelines, or the recommendations of the GP were consistently followed in relation to the administration of Oramorph to the patient*.'

56. Regarding the impact to the patient, the IPA advised '*[n]ot administering the medication as it was prescribed, was likely to have exacerbated the patient's symptoms at night.' '[d]espite the nursing staff's misunderstanding around the use of Oramorph, it was prescribed to reduce breathing difficulties and distress. As it was not given as required for these symptoms, it is unsurprising to know that the patient experienced a worsening of these symptoms during her stay in the care home*.'

Care Home's response to IPA's advice

57. The Independent Professional Advice was shared with the Care Home, who responded via its solicitor. Regarding the administration of Oramorph from 6 July to 14 July, the Care Home stated that Oramorph was provided at 21:30 only and contends that *'this is entirely in accordance with the PRN prescription. i.e. that Oramorph was not needed at other times.'* From 15 July to 24 July, the Care Home has acknowledged that there were recording errors regarding the administration of Oramorph. Although having previously stated the drug administration record was correct, the Care Home stated in response to the IPA advice that the drug administration record is not correct, but the CD book is correct. In summary, the Care Home has acknowledged *'some partial recording errors',* but maintain that '*every dose was provided PRN and was recorded, although admittedly on occasion not everywhere in the records should have been kept. In relation to the question regarding the administration of Oramorph every evening at 10:00pm, same was given to the patient, as recorded in the administration chart, at 21:30pm, save for the evenings when the patient requested same earlier.'*

Response to Draft Report.

58. The Care Home's solicitors have responded to the draft by indicating that Oramorph is very rarely used for anxiety and it would be logical for staff to assume the prescription was for pain. The Care Home also stated the patient did not experience any worsening of her breathing difficulties and distress symptoms until two days before her death.

59. Both the complainant and the Care Home have made comments relating to the meeting on the first evening between the complainant and the Care Home Staff. The complainant has suggested that the Care Home should provide a clear explanation about why the Kardex noted a regular dose to be given at 22:00 There is a dispute between the complainant and the Care Home regarding whether the complainant told the head nurse that the her mother received a dose of Oramorph at 22:00 every night. The Care Home have indicated the 22:00 dose was included at the complainant's instruction and the complainant rejects this claim.

60. The complainant has also referred to the CD Book indicating two doses being withdrawn at 08:45 and 17:00 on 17 July 2016. These doses are shown to have been administered at 08:30 and 16:30. As the withdrawal times on the CD Book are noted to be after the medication was noted to have been administered, the complainant is concerned these records indicate doses of Oramorph were being withdrawn on 17 July without being signed for or checked. The complainant also queried whether disposal records were provided by the Care Home.

Analysis and Findings.

61. There are two points to consider as part of this element of the complaint. The first is whether Oramorph was correctly administered to the patient by the Care Home staff in accordance with the patient's prescription. The second is whether the Care Home staff properly recorded administering Oramorph, both in terms of documenting the indications for administering Oramorph, as well as documenting the times when it was administered.

62. In considering the first point, I note that it is undisputed that the patient was prescribed Oramorph 'PRN' and that Oramorph was prescribed for anxiety, not for pain.

63. Accordingly, I have reviewed entries in the nursing notes, the drug administration chart, and the CD book, regarding Oramorph administration. I note that despite receiving Oramorph every evening up to 14 July regularly at around 9:30pm, the nursing notes do not record whether the patient was experiencing anxiety on any of these evenings, aside from the first night.

64. I have had particular regard to three entries in the nursing notes prior to 15 July. Two of these entries concern conversations with the complainant on the 11 July and 12 July, with two separate nursing staff members. According to the nursing notes, it was relayed to the complainant during both conversations that the nurses were under the impression that the patient's Oramorph prescription was for pain, not for anxiety. The third entry, on 12 July at 10:42, indicates that a nurse told the complainant that the patient was receiving Oramorph every night – indicating that it was being given regularly and not 'PRN' (as required).

65. I have also had regard to the advice of the IPA who advised that despite suffering a panic attack on the night of July 13, there is '*no evidence that the patient was given extra doses of Oramorph to help manage this distressing symptom.'* Additionally, despite the paramedics noting the patient was 'settled' after being called to see her, the records indicate she was given Oramorph at around 21:30. It appears the patient was not given Oramorph when was having a panic attack, but was given Oramorph an hour and a half later when she was settled. I also accept the advice of the IPA that *'[i]t is concerning then, that no change in practice came about as a result of the daughter's concerns, highlighted on 12th July.'* Based on the documented conversations between Care Home staff and the complainant on 11 and 12 July, the drug administration chart, and the failure to consider administering Oramorph when the patient was having a panic attack, I cannot agree with the Care Home's position that Oramorph was administered as prescribed. Having considered the medical records, I accept the advice of the IPA who, based on his review of the nursing notes and the drug administration chart, concluded that there is no evidence to suggest that Oramorph was being given as required between 6 July and 14 July. Accordingly, I find that the Care Home failed to properly administer Oramorph to the patient from 6 July to 14 July. This constitutes a failure in care and treatment. **I therefore uphold this element of the complaint.**

66. Regarding the second point, as to whether the Care Home staff properly documented and recorded the administration of Oramorph. I have considered the NMC Guidelines which require that *'[a]ppropriate documentation of the administration of MDA Schedule drugs should be entered in the patient's/service user's chart/noted and in the ward controlled drug register.'* I note that after initially insisting that the complainant received Oramorph as documented in the drug administration chart, the Care Home, through its solicitor, acknowledged that there are discrepancies between the controlled drug register and the drug administration chart about when Oramorph was given. I have had regard to the IPA's advice that '[*g]iven the discrepancies between the two records, the NMC guidelines (2007) have not been adhered to, as the drug administration chart should match the CD book… [t]herefore, there are omissions in relation to how the NMC see good clinical practice.'*

67. The IPA also advised that *'[t]here is no evidence that the NMC (2007) guidelines, or the recommendations of the GP were consistently followed in relation to the administration of Oramorph to the patient.*'

68. As there are undisputed discrepancies between the drug administration chart and the CD Book, I accept the IPA's advice that the NMC (2007) Guidelines were not adhered to and the Care Home failed to properly record when the patient was given Oramorph and also failed to properly record the indications for administering Oramorph. I consider this constitutes a failure in care and treatment. **I therefore uphold this element of complaint**.

69. I have reviewed the nursing notes, CD Book, and drug administration record and note that these documents contain inconsistencies. The indication for administering Oramorph is only recorded on four occasions within the nursing notes. This is wholly inconsistent with the CD Book, which documents 30 separate doses of Oramorph being used. Further inconsistencies are apparent between the CD Book and drug administration record, where Oramorph is recorded as being administered on 26 occasions.

70. I have considered the requirements and recommendations set out in the RQIA report of 27 April 2015. Requirement 1 concerns the need to accurately administer medications pursuant to the prescription and to accurately document medication administration. Requirement 2 highlights the need for robust monitoring arrangements concerning the administration of liquid medications. Recommendation 1 concerns the close monitoring of the CD Book for accuracy and Recommendation 3 states that documentation regarding the administration of prn medications should accurately reflect the reason for, and the outcome of, the administration of the medication on every occasion.

71. Although not directly related to this element of the complaint, I am concerned that the issues identified above demonstrate that these recommendations and requirements were not being adhered to in July 2016. I am particularly concerned that I cannot determine whether the patient was given Oramorph which was then not recorded in her notes, or if Oramorph was removed by a member of staff without ever being administered to the patient. I note that the Care Home's

solicitor contends that Oramorph was given as prescribed, but not always documented '*everywhere the records should have been kept'*. It is unclear what evidence there is to support this position. Assuming the solicitor is correct that Oramorph was given correctly, but not properly documented, this admission taken at face value is still extremely concerning.

72. Regarding the impact to the patient, I accept the IPA's advice that '*[n]ot administering the medication as it was prescribed, was likely to have exacerbated the patient's symptoms at night.' '[d]espite the nursing staff's misunderstanding around the use of Oramorph, it was prescribed to reduce breathing difficulties and distress. As it was not given as required for these symptoms, it is unsurprising to know that the patient experienced a worsening of these symptoms during her stay in the care home.*' Accordingly, I find that the patient would have suffered the injustice of anxiety and distress as a result of the Care Home's staff failure to correctly administer Oramorph as required. I further find that the complainant suffered the injustice of uncertainty and frustration as a result of the Care Home staff not properly understanding the reason for the patient's prescription of Oramorph, when it should be given, and failing to record why it was being administered.

73. As noted previously the Care Home's solicitors have responded to the draft by indicating that Oramorph is very rarely used for anxiety and it would be logical for staff to assume the prescription was for pain. While this may be true, it is undisputed that this prescription was for anxiety and the indications for Oramorph was clearly communicated to the Care Home by the prescription records, the complainant, her family, and the palliative care staff on multiple occasions. The Care Home should have ensured its staff knew the correct indications for the administration of Oramorph to the patient.

74. Both the complainant and the Care Home have made comments in relation to the circumstances when the patient was to be administered Oramorph. The complainant has suggested that the Care Home should provide a clear explanation about why the Kardex noted a regular dose to be given at 22:00. I have considered the complainant's request, but note that the Care Home has made its position clear as to how this occurred. As noted previously the Care

Home's position is the regular evening dose was added at the complainant's request. However, I note the complainant disputes that she told the Care Home staff to add a 22:00 evening dose. Assuming she had, the Care Home was still under an obligation to review the prescription records showing the patient's Oramorph prescription was 'as required'.

75. There is a dispute between the complainant and the Care Home regarding whether the complainant told the head nurse that her mother received a dose of Oramorph at 22:00 every night. The Care Home have indicated the 22:00 dose was included at the complainant's instruction and the complainant rejects this claim. Unfortunately, I am unable to conclude on what exactly occurred during this initial meeting. However, following this initial meeting it was made clear to the staff on multiple occasions (via the GP prescription records and further conversations with the complainant and her family) that the prescription was an 'as required' prescription for anxiety. This has informed my findings.

76. The complainant has referred to the CD Book indicating two doses being withdrawn at 8:45 am and 17:00 pm on 17 July 2016. These doses are shown to have been administered at 08:30 and 16:30. As the withdrawal times on the CD Book are noted to be after the medication was noted to have been administered, the complainant is concerned these records indicate doses of Oramorph were being withdrawn on 17 July without being signed for or checked. I have considered this response and I note the Drug Administration record contains approximate times of administration and not exact times. The complainant has correctly stated the Drug Administration record notes Oramorph was given at 08:30 and 17:00, but this record does not mean these medications were given at exactly 08.30 and 17:00. The record means Oramorph was given at approximately these times. In this instance, at 08:45 am and 16:30.

77. In response to the draft report, the Care Home stated the patient did not experience any worsening of her breathing difficulties and distress symptoms until two days before her death. However this is contradicted by the fact the patient had anxiety and breathing problems, resulting a panic on 14 July 2016. The complainant also noted her mother's anxiety increased while in the Care Home.

In response to the draft report, the complainant queried whether disposal records were provided by the Care Home. I note that a review of the CD Book indicates there was 80ml left in the Oramorph bottle when the patient passed away. The CD Book also indicates that a new 100ml bottle of Oramorph was received from the pharmacy on 11 July 2016. The CD Book reflects that the 80ml was destroyed and notes the remaining balance was zero. The Investigating Officer consulted with RQIA regarding the documentation of the destruction of Oramorph. RQIA commented that the 100ml received on 11 July 2016 '*has disappeared off the sheets [that were reviewed]. This is evidenced by the change in the balance from 192 mls on 11 July to 91.5mls on the 12 July, having administered 0.5mls. The sheet gives no explanation for this and it should have done.'* Regarding the destruction of the final 80mls of Oramorph. RQIA commented that the '*last entry just states "destroyed" which would imply that it was denatured prior to collection.'*

(iii) Was Atropine correctly provided to the patient and did the Care Home correctly document the administration of Atropine?

Detail of Complaint

78. The complainant said that she believes staff stopped giving her mother Atropine[13] drops as prescribed. She stated that her mother was always to be given four drops, four times a day and that the Care Home then decided to start giving her two drops four times a day. She said the hospice nurse phoned her on 19 July and told her this and she had told Home staff to put them back up to four. The complainant said that these drops helped dry up secretions in her mother's mouth and that her mother's symptoms worsened due to staff giving her two drops instead of four.

Care Home's responses to the complaint.

79. The Care Home noted that *'[t]he hospice nurse attended [the patient] on 20 July and advised that the [glycopyronium[14]] injection be increased to 4 times per day'* and '*the Kardex administration sheets retained by [the Care Home] show that this was changed and the dose increased as prescribed*.' The Care Home's response also state that its records indicate that the patient was receiving her atropine

[13] Atropine drops are often used sublingually to help oral secretions
[14] Glycopyrronium bromide is an antimuscarinc drug that can potentially reduce saliva secretions.

drops and that *'the confusion regarding the drops has arisen because, at one of [the complainant's] meetings with staff, [the Care Home] believe it was indicated to you that the atropine drops had been increased to four drops daily. This was in fact incorrect. It was the Glycopyronium injection which was increased to four times daily; the drops were already being given to your mother four times per day.'*

80. The Care Home reiterated that *"[t]he Atropine drops were not reduced. There was, as previously indicated, some confusion during the course of a meeting as to the changes in medication, but the Kardex records are absolutely clear indicating that the correct drops were provided.'*

Relevant Clinical Records.

81. I have reviewed the Original Kardex provided by the complainant and the Care Home's Kardex which both indicate that the complainant was to receive four drops of atropine. I have also reviewed the Care Home's drug administration chart, which indicates that Atropine was given as prescribed.

82. I have reviewed the relevant entries in the hospice and Care Home records regarding atropine administration. I note that concerns about the patient's worsening secretions were initially raised on 15 July and again on 17 July when the complainant expressed concern that the *'atropine drops [were] not working'* and this was to be discussed with the hospice nurse.

83. I note the entry of 18 July, which records that the hospice nurse received an update from a staff nurse at the Care Home, who reported '*she had not given atropine 1% eye drop on 16/7, as [the patient] had not wanted it administered. Recommenced again at 2 drops QDS [four times daily].'* The record indicates that the hospice nurse *'advised to increase again to 4 drops QDS, 4 hourly. Met with [the patient]. We discussed the use of the atropine eye drops and [the patient] aware of plan to use 4 drops QDS as family had been concerned that she had increased saliva. [The patient] gave thumbs up sign to indicate she understood.'*

84. I note a further entry by the hospice nurse on 19 July, which documents she received a call from the staff nurse who reported that the complainant was

'concerned that the patient has increased secretions.' These records state that the staff nurse *'reports she had given atropine 1% drops 2 drops this morning and 4 drops at 12MD. [the hospice nurse] advised to give 4 drops QDS.'*

85. The Care Home nurse also recorded this conversation in the records, noting that '*after 13:00 [the patient] had excess saliva, her daughter […] being very worried*.' The Care Home nurse recorded that she spoke with the hospice nurse who '*advised [her] to ring GP, because she can't change any medication. So [she] rang GP for a home visit.'* A further entry on 19 July stated that the hospice pharmacist confirmed to the hospice nurse that *'Atropine 1% could be given on tongue or S/L 4 drops four hourly.'*

86. The Investigating Officer spoke with the hospice nurse who explained that when the patient had excessive saliva, atropine drops would dry up secretions. She referred to her notes in which she advised the Home to increase the number of atropine drops from two to four. She noted that at times the patient may have declined getting the drops. She was unable to comment on why the Care Home would have been giving her two drops instead of four.

87. I have reviewed the minutes from 19 July Case Discussion in the Care Home. In particular, I note that the issue of the patient's secretions was discussed. *'[The complainant] advised secretions have been noted as an issue since last Thursday, with saliva falling out of the patient's mouth. Initially family queried volume of drops and felt medication may need to be reviewed, staff queried if it may also be due to pineapple juice being taken. Secretions still an issue this week so family contacted Palliative Care nurse, as opposed to GP, to review medication. Currently presents that there was some confusion around the frequency and amount of drops which should be given, […] to speak to GP regarding same.'*

88. I note that following this meeting, the GP visited the patient and recorded an entry as follows*: 'Seen at 18.29 concern from family re excessive saliva. Following discussion with [hospice nurse] option is to increase glycoperronium to QDS 10, 14, 18, and 22 hours. Review if required.'*

Independent Professional Advice

89. The IPA was asked to comment on the administration of Atropine by the Care Home staff. In particular, the IPA was asked to review whether there were any discrepancies in the record about how and when atropine was administered. The IPA advised that '[t]*here is evidence of discrepancies in the records around how often, and how much atropine should be given.'* The IPA went on to outline the discrepancies in the records. On 5 April, the hospice letter and GP note indicate four drops should be administered, but commented that this was not done on 16 July. On 18 July, the IPA advised there were some discrepancies surrounding how atropine should be administered, the hospice nurse *'advises need to give atropine for secretions and advises can give two drops QDS [four times daily] and also four drops QDS, hospice notes conflicting on this. Then confirmed later that could give four drops QDS.'* The IPA advised that '*[g]iven the conflicting information as outlined here, it is not surprising that there were some discrepancies in how this was given.'* However, the IPA also advised that '*[t]he drug administration chart appears to show that the atropine was given as prescribed by the care home staff.'*

90. The IPA was also asked to comment on what the effect to the patient would be if the Atropine drops were not being correctly administered. The IPA advised that *'If the atropine drops were being administered incorrectly, that is, missed doses, then there may have been a worsening in the patient's symptom of drooling, excess saliva. As the atropine appears to have been given as prescribed, I cannot see that this issue can be further explored. However, it is worth noting that the symptom of drooling in people with MND, can become very difficult to manage, as the illness progresses. I understand that as the patient was on two different medicines for this symptom, she must have had a particular difficulty with this distressing symptom. Therefore, the symptom may have worsened despite the medicines being administered as prescribed.*

Response to Draft Report

91. In response to the Draft Report, the Care Home's solicitor stated the IPA's advice *'is that the record shows that atropine was given as prescribed.'* The Care

Home's solicitor also contends that it is inappropriate to equate the recording of Oramorph with the recording of Atropine as Oramorph is a controlled drug *'and the recording systems are therefore different for the two drugs.'* In relation to how Atropine was recorded, the Care Home's solicitor states 'there would have been no need to write '4 drops' on [the Drug administration Record]'.

Analysis and Finding

92. It is undisputed that the patient's drooling and secretions worsened for a time while she was in the Care Home. It is also undisputed that the prescription for Atropine was for four drops, S/L [Sublingually], four times per day. The patient was first noted to have worsening drooling and saliva on or about 15 July and this was persistently noted in the nursing records over the next five or six days. The complainant believes her mother's worsening symptoms were caused by the improper administration of Atropine. Based on conversations with the nursing staff, she has complained that the nurses were giving an incorrect dosage of two drops, instead of four.

93. I note that the IPA considered the possible causes of the patient's worsening symptoms. The IPA advised '*the symptom of drooling in people with MND, can become very difficult to manage, as the illness progresses …as the patient was on two different medicines for this symptom, she must have had a particular difficulty with this distressing symptom. Therefore, the symptom may have worsened despite the medicines being administered as prescribed.* However, the IPA also advised that *'[i]f the atropine drops were being administered incorrectly, that is, missed doses, then there may have been a worsening in the patient's symptom of drooling, excess saliva.'*

94. In assessing this element of complaint, I have reviewed the drug administration record regarding the administration of Atropine. I note the IPA's advice that the drug administration record *'appears to show that the atropine was given as prescribed by the care home staff'.* However, it is important to note that this document contains limited information. In particular, I note that it does not record how many drops were given to the patient. Although the Care Home's position is that the *'records are absolutely clear indicating that the correct drops were*

provided', this record does not confirm the dosage that was given. If there was confusion amongst the staff about how much atropine was to be given to the patient, as the complainant has claimed and as appears to evident from the conversations recorded in the nursing notes, this would not be reflected in the drug administration record as it does not record the quantity administered.

95. For this reason, I have focused my review on the nursing records form 15 July to 21 July, when the patient is noted to have worsening secretions. In particular, I have focused on documented conversations with Care Home staff about the administration of Atropine. I note the hospice team's entry on 18 July indicating that the '*nursing staff [were] administering Atropine eyedrops 2 drops 4 hourly.'* On 18 July, the hospice nurse received an update from a staff nurse at the Care Home, who reported '*she had not given atropine 1% eye drop on 16/7, as [the patient] had not wanted it administered. Recommenced again at 2 drops QDS [four times daily].'* The record indicates that the hospice nurse *'advised to increase again to 4 drops QDS, 4 hourly'* and she *'discussed the use of the atropine eye drops and [the patient] aware of plan to use 4 drops QDS as family had been concerned that she had increased saliva. [The patient] gave thumbs up sign to indicate she understood.'*

96. I note a further entry by the hospice nurse dated 19 July, which documents she received call from the staff nurse who reported that the complainant was *'concerned that the patient has increased secretions.'* These records again document that the staff nurse *'reports she had given atropine 1% drops 2 drops this morning [19 July] and 4 drops at 12MD. [the hospice nurse] advised to give 4 drops QDS.'*

97. The Care Home nurse also recorded this conversation in the records, noting that '*after 13:00 [the patient] had excess saliva, her daughter the complainant being very worried*.' The Care Home nurse recorded that she spoke with the hospice nurse who '*advised [her] to ring GP, because she can't change any medication. So [she] rang GP for a home visit.'* A further entry on 19 July stated that the hospice pharmacist confirmed to the hospice nurse that *'[a]tropine 1% could be given on tongue or S/L[16] 4 drops four hourly.'* The confusion regarding how many

drops were to be given was again raised during the 19 July meeting, with the understanding that it would be discussed with the GP. This was then addressed with the GP on 20 July. Having reviewed these entries about Atropine administration from 16 July to 19 July, I consider there is ample evidence of confusion amongst the Care Home Staff about the administration of Atropine.

98. The Care Home was asked to explain how the confusion regarding the administration of atropine arose and whether it had any impact on how Atropine was administered to the patient. In response, the Care Home indicated that *'[t]he Atropine drops were not reduced. There was, as previously indicated, some confusion during the course of a meeting as to the changes in medication, but the [drug administration] records are absolutely clear indicating that the correct drops were provided.'* Having considered this explanation, the 'confusion' described at this meeting on 19 July does not explain why, on multiple occasions prior to this meeting, the medical records indicate that Care Home staff were under the impression that the patient should be receiving two drops of atropine and not four. Furthermore, although the Care Home stated the cause of the confusion was the increased frequency of glycopyrronium injections, which were increased *'to four times daily',* the change in the glycopyrronium injections did not occur until the day after the meeting. Furthermore, the 'confusion' was about the number of the drops, not the number of times per day.

99. I have compared the timing of the patient's worsening symptoms beginning on 15 July with the documented confusion amongst staff regarding the correct dosage of atropine. The nursing notes from July 16 to July 20 and the minutes from the July 19 meeting correlate with the documented concerns about the patient's increased secretions and drooling. Although I have considered the IPA's advice that the drug administration record gives the impression that *'atropine appears to have been given as prescribed',* due to the documented confusion within the clinical records, I cannot be confident that the drug administration record accurately reflects how atropine was being administered. The conversations documented in the nursing notes provide a more detailed description of the Care Home staff's actions during that time.

100. In response to the Draft Report, the Care Home's solicitor stated the IPA's advice *'is that the record shows that atropine was given as prescribed.'* The Care Home's solicitor also contends that it is inappropriate to equate the recording of Oramorph with the recording of Atropine as Oramorph is a controlled drug *'and the recording systems are therefore different for the two drugs.'* In relation to how Atropine was recorded, the Care Home's solicitor states 'there would have been no need to write '4 drops' on [the Drug administration Record]'.

101. There are several issues to be clarified here. First, regarding the Drug Administration Record, this record does not record the number of drops given on each occasion. The crux of this element of complaint is not whether atropine drops were given at the correct times (which *is* correctly noted on this record). The crux of this element of complaint is *how many* atropine drops were being given to the patient on each of those occasions (which *is not* noted on this record). This is not to say that the number of drops *should* have been recorded, but only to note that despite evidencing that atropine was given at the correct times, this record does not provide evidence of the number of drops that were given on each occasion.

102. The IPA correctly stated this record *appears to show that atropine was given as prescribed'.* However, the IPA also pointed out that there was *'evidence of discrepancies in the records around…how much atropine was given'.* In considering how to weigh these conflicting records, I was ultimately persuaded by several factors. First, the numerous entries describing a clear misunderstanding over how many drops the patient was to receive; second, the records establishing the patient's worsening symptomology, which was concurrent with the documented misunderstanding over how many drops were to be given; and third, the confusion over the number of drops to given which was noted at the 19 July meeting.

103. For these reasons, I accept the advice of the IPA that there was *'[c]learly confusion about how Atropine should be prescribed'* and *'discrepancies [in the record about] how it was given – 2 drops vs 4 drops. Not given vs being recorded*

as being given.' On the balance of probabilities, I have concluded that Atropine was not correctly administered in accordance with the prescription. Although the limited information in the drug administration record appears to indicate that it was given as prescribed, there is ample evidence within the documented conversations with Care Home staff that this record does not accurately reflect the dosages that were being given to the patient. Furthermore, as discussed above, the administration of Oramorph was not accurately recorded on the drug administration record. Therefore, I cannot be confident that the administration of Atropine was not similarly misrecorded. I find that the Care Home's failure to correctly administer Atropine to the patient constitutes a failure in care and treatment and **I therefore uphold this element of the complaint.**

104. Regarding the impact to the patient, as noted above, the patient experienced a worsening of her secretions and drooling while admitted to the Care Home. Having found that this was a result of the improper administration of Atropine, I find that the patient suffered the injustice of discomfort and distress as a result of the Care Home's staff failure to administer Atropine in the correct dosage.

(iv) Did the Care Home staff appropriately follow the care plan in relation to the patient's bed position?

Detail of Complaint

105. The complainant has complained that her mother was 'lying flat' on various occasions, despite this posing a significant risk to her health. She complained that the Care Home staff knew that her mother was not to be 'lying flat', but that on multiple occasions she witnessed her mother in this position. In particular, the complainant took a photo of her mother on 13 July which she states shows her 'lying flat'. She also complained that on 15 July, she asked her mother if she had put the bed flat herself, to which her mother replied 'No' via her wipe board.

Care Home's response to the complainant following her complaint.

106. The Care Home stated that *'[a]ll beds within Antrim Care Home are profiling beds and it would be extremely rare for any resident to lie flat. In addition to this, we understand that you brought a number of extra pillows from home and*

showed staff exactly how your mother like to be positioned in bed. For the avoidance of doubt, our client absolutely denies that at any time your mother was flat in bed. We note, in addition, that your mother did have capacity and would have been able to adjust the handset on the bed herself.' In its follow up response, the Care Home acknowledged that the patient '*may have been lying flat on one occasion during her stay in the care home but that this was not the situation during the vast majority of her stay*'.

Care Home's response to investigation enquiries.

107. The Care Home stated that *'[a]ll staff were aware that the patient was not to be left lying flat. We have no records to suggest that she was lying flat and therefore indicated that we did not believe this was the case. However, the complainant has advised that she has photographic evidence of her mother lying flat and this is the reason why we acknowledged that this may have happened on one occasion. However, your reference to this happening on more than one occasion is denied.'*

108. The Care Home also stated that *'[a]ll staff within the Home knew that the patient was not to be laid flat. They were all briefed on this and had been advised by the complainant how to position her mother's pillows, etc. It is also not the policy of the home to have any resident lying completely flat. We understand that the complainant has stated she has photographs showing her mother lying flat and we would be grateful for sight of these. Thankfully, however, there were no episodes of choking, or distressed breathing brought on by poor positioning. If the patient was lying flat on occasion, we would also like to apologise for any oversight which lead to this.'*

Relevant Clinical Records

109. I have reviewed the relevant medical records regarding the patient's positioning while in bed. I note that the Feeding Regimen states that *'during feeding and flushing and for 60 minutes after ensure that the client is in an upright position.'* I also note that in the district nursing general notes, it is recorded that the physio came to visit the patient regarding her positioning. I further note that the complainant has recorded in the records that the patient '*just wants to lie down regardless of advice'.*

110. Nursing records from 13 July document that at 08:20 the complainant raised the issue of her mum not being in *'upright'* position and that the complainant took photos. The nurse noted that she *'ask apologies (sic).'* This was identified prior to her mother's feeding at 08:30.

111. In a 13 July email sent to the Social Worker, the dietician documents that she had spoken with the Care Home regarding patients being left flat in bed. The Care Home advised her *'that patient hadn't been left lying completely flat.'* The dietician advised the Care Home of the *'importance of patient being positioned at 30-45 degrees during and for 60 mins post feed.'*

112. Social Work records document the Social Worker asked the Nursing Home manager about this on 14 July, who '*advised the patient has control of button and at times they have found she is putting herself flat, they try and monitor but it is not 24/7 sitting service.'*

113. I have also reviewed the Minutes of Case Discussion between the complainant and the Care Home staff. In particular I note the discussion around the patient being found flat in bed on the morning of 13 July. I note that it was *'acknowledged that the patient only had access to buttons to move her chair and she was unable to lower her bed.'*

114. The Dietician's feeding regime care plan dated 13 July 2016 states that *'during feeding and flushing and for 60 mins after ensure that the client is in an upright position at 30-45 degrees.'* The Trust advised me that *'The District Nursing care plan submitted to the Care Home makes reference to RIG[17] tube feeding and the need to adhere to the Dieticians prescription. This care plan also references breathing difficulties and advises of suitable positions to aid breathing and makes reference that this patient sleeps in a semi prone[18] position. The prescription from the Dieticians includes the correct positioning of patients during the feeding regime. This will also have been accompanied by Looking after your Gastrostomy care plan which identifies the management of feeds and recommended position for the patient.'*

[17] A RIG or PEG tube is a small feeding tube connecting your stomach cavity directly to the overlying skin. It enables you to receive food, fluids and medicines directly into your stomach when it is difficult or unsafe to use the normal route via the mouth. It can be put in via two methods: PEG or RIG

[18] Lying on one's side, with the thigh on the upper side flexed against the abdomen and the arm on the lower side

extended back.

Independent Professional Advice.

115. The IPA was asked to comment on whether the patient should have been allowed to lie flat and the potential dangers or effect to the patient in being allowed to lie flat. The IPA was provided with a copy of the photo taken by the complainant. In response, the IPA advised that the photo shows a female lying on her right side, in a completely horizontal position. The IPA noted that the patient *'appears comfortable'* in the photo and that *'[s]he appears to have only one or two pillows under her head, therefore being in any other position would have proved difficult.'*

116. Regarding the impact to the patient as a result of lying flat, the IPA advised that *'as the patient has difficulty with breathlessness and panic, as it is known that lying people flat, can exacerbate breathing difficulties, and therefore it is an obvious aspect of basic nursing care, that she should not be laid flat, unless this was her expressed wish.'* The IPA advised that lying flat posed '*a risk relating to increasing breathing difficulties, aspirating feed, [and] increasing problems with nausea.'*

117. The IPA advised that at times in the past, the patient had expressed a wish to lie flat, noting that the complainant documented on 28 June that *'the patient wants to lie flat in bed, despite the advice of the physiotherapist.'* The IPA advised that '*if the patient wanted to lie flat, then this choice needed to be respected. [The patient] was considered to have capacity to make decisions relating to her health and welfare.'* The IPA also advised that *'the patient prefer[red] to sleep in a semi- prone position, the photograph appears to show the patient lying in a semi-prone position. She is laid flat on her side – semi-prone. I am not able to see if she is supported by pillows.'*

Analysis and Findings.

118. I note that initially the Care Home '*absolutely denie[d] that at any time [the patient] was flat in bed.'* The Care Home later stated that the patient '*may have been lying flat on one occasion during her stay in the care home but that this was not the situation during the vast majority of her stay'* and stated '[*i]f the patient was lying flat on occasion, we would also like to apologise for any oversight which lead to this'.* I further note that the Care Plan required that '*during feeding*

and flushing and for 60 mins after ensure that the client is in an upright position at 30-45 degrees.' Although despite this care plan, the complainant and the Care Home agree that the patient should never have been laid flat.

119. I also note the conflicting responses by the Care Home regarding whether the patient actually had the ability to put herself flat in the bed. On 14 July, the Nursing Home manager '*advised the patient has control of button and at times they have found she is putting herself flat, they try and monitor but it is not 24/7 sitting service.'* Later, during a meeting on 19 July, this position was clarified when it was '*acknowledged that the patient only had access to buttons to move her chair and she was unable to lower her bed.'*

120. The IPA reviewed the photo taken by the complainant and commented that it showed the patient *'lying on her right side, in a completely horizontal position'*. I have had regard to the IPA's advice that, at times in the past, the patient had expressed a wish to lie flat, noting that the complainant documented the patient's desire to lie flat on 28 June 2016. I accept the advice of the IPA that *'[i]f the patient wanted to lie flat, then this choice needed to be respected. [The patient] was considered to have capacity to make decisions relating to her health and welfare.'* The IPA also noted that *'the patient prefer[red] to sleep in a semi-prone position, the photograph appears to show the patient lying in a semi-prone position. She is laid flat on her side – semi-prone. I am not able to see if she is supported by pillows.'* I also accept the IPA's advice that '*as the patient's has difficulty with breathlessness and panic, as it is known that lying people flat, can exacerbate breathing difficulties, and therefore it is an obvious aspect of basic nursing care, that she should not be laid flat, unless this was her expressed wish'*.

121. It is undisputed that the patient should not have been positioned by the Care Home staff to be lying in a completely flat position unless, according to the advice of the IPA *'this was her expressed wish'*. Had the patient expressed such a desire to lie flat, this should have been documented in the records. I have reviewed the record note that the patient had previously indicated a preference to lie flat on 28 June, however there is no record of her ever expressing this wish during her stay at the Care Home. I am concerned that the complainant has reported that she found the complainant lying flat on several occasions. Although

it is clear from the IPA review of the photograph that the patient was lying flat, in a semi-prone position on this occasion, I am unfortunately unable to verify how often the patient was lying flat. Nor am I able to verify how she came to be in that position, although it appears clear that the patient did not have access to the bed controls and therefore could not have been putting herself flat. Accordingly, I am unable to conclude on this element of complaint. I am however concerned that the patient was left lying flat on occasion and there is no record as to why this was the case.

(v) Were Staff Handovers properly carried out in relation to the patient's care?

Detail of Complaint.

122. The complainant commented on the lack of staff handovers/inadequate handovers. She complained that on 11 July an agency nurse told her there was no handover and at various times the Care Home staff either did not know her mother had motor neurone disease, did not know why she was receiving certain medications, or did not know the appropriate dosage for those medications. She complained that this shows staff were unaware of mother's condition and care requirements.

Care Home's response to Investigation enquiries.

123. The Care Home responded that *'handovers were provided in respect of the patient at the start of each shift' and '[a]ll staff receive an oral briefing at handover between shifts.' 'If any queries occur to any member of staff which is not dealt with at the time of the handover, all staff have access to paper and computer- based records of each resident.'* The Care Home also stated that '*all staff attend at the Home 15 minutes prior to the start of each shift. This means that they can get a focused time to go through the needs in general of each resident and specific needs for that day or night shift which they are working.'*

124. The Care Home manager confirmed that the Care Home does not keep written staff handover documents. She explained that before each shift staff are given a sheet with the names of each patient and comments besides them regarding things like their condition. The right hand side of the sheet is kept blank for staff notes during the verbal handover. The Care Home manager showed the Investigating Officer an example of a handover for that day which supports this

position. She said they would not keep these handover records as the sheet constantly changes depending on who is staying at the home and their condition.

Independent Professional Advice

125. The IPA was asked to comment on whether staff handovers were properly carried out and whether there was proper continuity of care between shifts.

126. In response, the IPA advised that *'[t]he care home notes on [8 July 2016 (sic)] clearly state the patient's diagnosis of MND, and outline her care needs relating to communication, medications, respiratory problems, anxiety, and personal care needs. Although the notes are relatively brief, they appear to demonstrate some degree of continuity, demonstrating knowledge of the woman's care needs. However, subsequent entries throughout the notes do not appear to demonstrate a continued understanding of this woman's needs, for example the lack of understanding of why the patient needed Oramorph. This appears to be consistently misunderstood.'*

127. The IPA was also asked to comment on whether the lack of understanding regarding the administration of Oramorph was indicative of improper staff handover. The IPA advised that he could see '*no evidence of improper staff handovers'*, but noted that there were *'[s]ome inconsistencies around reasons why Oramorph was to be given, with at least one entry referring to this being needed for pain; however most of the entries relating to breathing difficulties and anxiety are linked to the use of Oramorph to manage this symptom.'*

128. The IPA was also asked whether written handovers should be maintained in the patient's chart. He advised that *'[i]n over 30 years of experience in nursing, I have never been aware of the need to document handovers between one shift to the other.*'

RQIA Report 1 September 2016

129. I have reviewed a report of an unannounced inspection by RQIA. Regarding staff handovers, the investigator noted that *'registered nursing staff attended a handover meeting at the beginning of each shift and discussions at the handover provided the necessary information regarding any change in the patients' condition. This information was then to be shared, in a shorter format, with the*

care staff. Two care staff spoken with stated that this [is] not the case and that communication between the registered nursing staff and carers was not effective. One carer provided written comment on the returned questionnaire that the care staff 'cannot get onto the computer to see if the patients' needs have been changed.' The investigator made a recommendation that '*the time scheduled for handover reports is reviewed to ensure that all staff are fully informed of changes in patients' care needs'.*

Analysis and Findings

130. I note that during a visit to the Care Home, the Care Home manager provided evidence that the Care Home do conduct staff handovers at the start of every shift. In considering this element of complaint, I note that the IPA agrees with the Care Home that it is not necessary to document handovers between one shift to the other. I also note that the IPA has advised that he could '*see no evidence of improper staff handovers'*, despite *'the lack of understanding of why the patient needed Oramorph'* which, according to the IPA, *'appears to be consistently misunderstood.'* As noted previously in this report, there was also a clear confusion amongst the staff regarding the administration of Atropine.

131. I have considered the IPA's advice that *'there is no evidence of improper staff handovers'*. I agree that there is no documentary evidence of improper staff handovers in the complainant's case. However, as noted by the IPA, handovers would not be routinely recorded in the patient's chart. Due to this fact, I am unable to conclude on this element of complaint. However, I am concerned that the RQIA report identified issues with staff handovers around the time the patient was being cared for in the Care Home. I am also concerned that there was a persistent misunderstanding concerning the administration of the patient's medications.

(vi) Did the Care Home staff act appropriately in response to the request to call an ambulance on 13 July 2016?

Detail of Complaint

132. On the evening of 13 July the patient had a panic attack. The complainant has

complained that the patient (via the use of her wipe board) and also members of her family requested that a nurse call an ambulance, however the Nurse initially refused to do so. The complainant said that an ambulance was only called after multiple requests and insistence from friends and family members who were present.

Relevant Policies and Protocols.

133. I have reviewed the 2015 NMC Code. I note that Section 7 of the code requires nurses to *'communicate clearly'.* Section 7.2 requires nurses to *'take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs'.*

134. I have also reviewed the FREDA obligations. I note FREDA required the Care Home to consider the patient's autonomy and her impaired ability to communicate.

Care Home's response to the complaint.

135. The Care Home stated that *'the nurse on duty used his professional judgment having checked [the patient's] observations and felt that there was no need to call an ambulance. When the paramedics did attend, they had also felt that there was no need for any intervention or admission to hospital and our client therefore maintains that there was no need to call an ambulance.'*

Care Home's response to investigation enquiries.

136. The Care Home stated that family members reported that the patient was having breathing difficulties and the complainant, who was on the phone with the family members present, '*insisted that an ambulance was called.'* The Care Home was adamant that *'[a]t no time did the patient actually ask for medical attention. [The patient] did not request an ambulance – her family did.'* The Care Home explained that staff are instructed to call an ambulance *'[b]ased upon medical need, experience and the best interests of the resident concerned …if they believe emergency medical attention or input is required.'*

Interviews with people present on 13 July.

137. The Investigating Officer spoke with a friend of the patient who was present

when the ambulance was called. He recalled that the patient requested an ambulance to him due to shortness of breath – although others had difficulty making her out, he could understand what she was saying. He then attended reception and asked for an ambulance, a nurse came down and spoke to the patient. This friend recalls the patient communicated to the nurse by writing on a board that she wanted an ambulance, but the nurse did not feel she required one. He recalled going back up to the nurse one or two more times to ask to get an ambulance, eventually the nurse rang for an ambulance. He phoned the complainant while this was going on as she was next of kin. The Investigating Officer spoke with the nurse involved who had no recollection of events.

Relevant Clinical Records.

138. The nurse entered a note on 14 July 2016 regarding the events the night before: *'Received the patient in her room (in chair - accompanied by her partner […]. At 20:10 all medications and flushes given via PEG as per regime. At 20:25 the patient complained of breathing problems (unable to communicate, use a wipe board). Clinical observations checked; [Friend] unsettled, phoned [the complainant, who], spoke with nurse by phone. The nurse explained and suggested that it was a panic attack, but family insisted upon an ambulance. At 20:40 called 999 (mentioned is not an emergency-is family request), ambulance arrived at 21:00, paramedics checked the patient and decided that she is not for hospital I- family request visit palliative care team.* The Ambulance record states that *'[t]onight [patient] suffered a panic attack. Resolved. Reassurance @ request of family. Palliative Care Team arranged to visit.'*

Independent Professional Advice

139. The IPA was asked to comment on the nurse's initial refusal to call an ambulance. Assuming the patient did request an ambulance via use of her wipe board, as described by her friend, the IPA advised that *'Of course, a patient should be allowed to call for an ambulance if this is their wish – any adult with capacity to make decisions, must retain the right to make decisions around their health care. Calling an ambulance is one such decision.'* However, the IPA agreed with the Care Home that, *'[g]iven the outcome of the situation, it feels like an ambulance was not required.'*

140. In addition, the IPA queried why the Staff did not consider administering Oramorph in this situation. Specifically, the IPA stated that *'[t]he most difficult thing for [him] to understand around this incident is, it is not apparent what the staff did to calm the patient down, nor is there evidence that they offered the patient medication (Oramorph) to manage this breathlessness/anxiety.'*

141. Even assuming that the patient's friend, and not the patient herself had requested the ambulance, the IPA advised that the staff are under an obligation to verify with the patient whether she would like them to call an ambulance, as they have an obligation to *'respect the patient's right to make decisions relating to her care*'. The IPA advised that *'the staff also must be seen to act to support the patient if in physical or psychological distress. The nursing notes do not appear to evidence this. Ultimately, had the staff being competent to support the patient, at a time of distress, they may not have been requested to call an ambulance.'*

142. Regarding the impact to the patient in not calling an ambulance immediately, the IPA advised that *'[t]he delay appears to have some degree of psychological distress for the patient, but more so her family. However, the notes from the care home, and those of the paramedics describe that the paramedics found the patient to be relatively settled once given some reassurance, and following the decision to call the palliative care team out to visit the patient.'*

Analysis and Findings.

143. I have considered the Care Home's rationale for not calling an ambulance. The Care Home has repeatedly stated that an ambulance was not required, to which the IPA agrees. I note that the issue for consideration is not whether an ambulance was ultimately required, but whether the request for an ambulance should have been acted upon.

144. The Care Home has also defended the decision of the nurse to initially not call an ambulance on the basis that it believes the patient's family requested an ambulance and not the patient herself. In considering this issue, it is important to note that the patient could not speak and communicated through the use of a wipe board. I have considered the medical records and the nurses note that the *'family insisted upon an ambulance'.* I note that when questioned by the

Investigating Officer, the nurse involved did not recall this event. I have also had regard to the patient's friend's recollection of the events. In particular I note that he recalled the patient requesting an ambulance to him, at which point he went to reception and requested an ambulance. I note that he recalled the nurse coming down and the patient again requesting an ambulance by writing on her wipe board.

145. In considering this element of complaint, I have had regard to the Care Home's obligations under the Nursing Home Regulations 2005 (NI) and under FREDA. I note that the Care Home had an obligation to consider the patient's impaired ability to communicate and to *'take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs'.* I have considered the IPA's advice that *'[o]f course, a patient should be allowed to call for an ambulance if this is their wish – any adult with capacity to make decisions, must retain the right to make decisions around their health care. Calling an ambulance is one such decision.*

146. In light of the patient's impaired ability to communicate and in consideration of the patient's right to autonomy, I accept the IPA's advice that the patient retained her capacity to make decisions about her care and that in this instance, '*calling an ambulance [was] one such decision.'* I accept the IPA's advice that even if the patient did not request an ambulance herself via the use of her wipe board, the nursing staff had an obligation to verify with the patient whether she was requesting an ambulance. Pursuant to the requirements of the 2015 NMC Code and the IPA advice, this obligation applied whether the request was made by the patient, or through her family. Accordingly it is not sufficient for the Care Home to rely on its position that the patient did not request an ambulance as there is no evidence in the records that the Care Home staff attempted to appropriately communicate with the patient regarding this issue, or verify whether she was requesting an ambulance.

147. Accordingly, I find that the failure of the Care Home staff to either call an ambulance, or verify whether the patient was requesting an ambulance, was a failure in care and treatment. **Therefore, I uphold this element of the complaint.**

148. Regarding the impact to the patient, I note that the medical records indicate that the patient's friend initially requested an ambulance at 20:25 and the ambulance was eventually called at 20:40. I note that the IPA agrees that, ultimately, an ambulance was probably not required and when the paramedics arrived, the patient was found to be '*relatively settled'*. However, I note that the complainant was on the phone with the patient's friend during this event and therefore, I accept the IPA's advice that '[t*]he delay appears to have some degree of psychological distress for the patient, but more so her family'.* Accordingly I find that the patient and the complainant both suffered the injustice of distress as a result of the nurse's refusal to call an ambulance for the complainant.

149. Although not an issue raised by the patient, it is extremely concerning to note the advice of the IPA outlined at paragraphs 127 and 128. I am particularly concerned by the Care Home's failure to respond to the patient's needs either by providing her with Oramorph or by reassuring her. This was during the period of confusion surrounding the patient's prescription of PRN Oramorph for anxiety, as discussed earlier in this report.

(vii) Did the Care Home appropriately ensure that the patient had access to her call bell?

Detail of Complaint.

150. The complainant said that at times the emergency button was out of her mother's reach, leaving her at serious risk. Her mother told her on either 12 or 13 July that earlier that day her buzzer was taken away for a period.

Care Home's response to the Complaint.

151. The Care Home acknowledged that '*there may have been an occasion when the call button was not within your mother's reach, but this was not an ongoing state of affairs [and] has recorded times when [the patient] was continually pressing the call system.'*

Care Home's response to investigation enquiries.

152. The Care Home stated that *'[s]taff were always fully aware that the call button should be within reach. It is possible that the call button may have been placed within reach of a resident who had normal freedom of movement, but which was*

not within reach of the patient but we wish to make it absolutely clear that at no time, was the call button deliberately placed out of the patient's reach. In any event, given the patient's complex needs, her medications and her feeding requirements, staff were very regularly in and out of her room to check on her condition.'

Relevant Medical Records.

153. The Care Home records note that on 21 July, the patient's brother *'complained as buzzer out of the patient's reach – [nurse] advised when she was in yesterday that buzzer there, but hairdresser came in and perhaps it got mislaid.'* A note on 22 July at 11:00 documented that the patient's brother called to follow up on his visit to see his sister the day before. He stated that *'[h]e tried to put the patient in bed and noted that she didn't have her buzzer. He informed one of the members of staff. He won't be saying anything to the family, but he wants to make sure everything is right for his sister as she is dying and will have visitors over the weekend, etc and he doesn't want to create a fuss. I apologised and I gave him reassurance that the patient will be checked constantly and she will always have access to her buzzer.'* A note on 21 July also reflects that the hairdresser was asked to cut the patient's hair.

Independent Professional Advice

154. The IPA was asked to comment on the complaint that the call bell was placed out of reach of the patient and was asked to verify if there was any way of knowing if the call bell was placed out of reach. The IPA advised that *'[t]he nursing home care plan, for communication, written on [1 July 2016] states the call bell should be accessible for the patient. I cannot find documentation stating the call bell was left with the patient at all times. I cannot see how it is possible to verify whether the call bell was left with the patient. However, I can understand that not having access to the call bell at all times, may have been a trigger for the patient's breathlessness and anxiety/panic.' Given the patient's communication, breathing, anxiety and mobility problems, there is no question, the call bell should always have been within easy reach for the patient.'*

155. The IPA was asked to comment on the potential impact to the patient if her call

bell was not within reach. The IPA advised that *'[i]f the call bell was not in easy reach, then this could have exacerbated the patient's symptoms, and created delays in her being attended to for urgent issues, as well as routine ones.'*

Analysis and Findings

156. In considering this issue of complaint, I note that it is undisputed that the patient's care plan required the call bell to be accessible for the patient. Therefore, I accept the advice of the IPA that *'[g]iven the patient's communication, breathing, anxiety and mobility problems, there is no question, the call bell should always have been within easy reach for the patient.'* I also note that it is undisputed that the call bell was not within the patient's reach on at least one occasion. However, I note that the nurse apologised for this at the time.

157. I have had regard to the Care Home's acknowledgment that *there may have been an occasion when the call button was not within [the patient's] reach, but this was not an ongoing state of affairs [and] has recorded times when [the patient] was continually pressing the call system.'*

158. In regards to whether the call bell was regularly, or routinely, left out of reach of the patient, I have considered the IPA's advice that he '*cannot see how it is possible to verify whether the call bell was left with the patient.'* I accept the advice of the IPA that this cannot be verified and I also accept that there were documented occasions when the patient used her call bell. Therefore I am unable to make a finding on this element of the complaint.

(viii) Was the patient's RIG tube properly cared for?

Detail of Complaint.

159. The complainant said that the Care Home failed to properly provide her mother with water for irrigation through her RIG tube. She stated that her mother's RIG tube was not properly flushed at 17:30 throughout her time in the Care Home.

Responses to investigation enquiries.

160. The Care Home '*absolutely den[ied] that the patient was not provided with*

water for irrigation through her [RIG] tube. [The patient] required regular medication and it is absolutely essential that the [RIG] tube be flushed with water before her medications are given. Water to irrigate the tube as well as water for hydration of the patient was regularly provided. Same is recorded on the Kardex, which has been provided, and there is no suggestion in any notes that the patient was, at any time, dehydrated.'

Information received from the Trust.

161. The Trust informed the Investigating Officer that the Community District Nursing Sister advised that before this patient was accepted to the Care home, the manager sought refresher training regarding RIG feeding. The District Nursing Care Plan submitted to the Care Home makes reference to RIG tube feeding and the need to adhere to the Dietician's prescription. This care plan also references breathing difficulties and advises of suitable positions to aid breathing and makes reference that this patient sleeps in a semi prone position. The Dietician's prescription includes the correct positioning of patients during the feeding regime. This will also have been accompanied by Looking after your Gastrostomy Care Plan which identifies the management of feeds and recommended position for the patient.

Relevant Clinical Records

162. I have reviewed the Care Home Kardex and drug administration chart. I note that irrigation was to be carried out, pursuant to the Care Home Kardex, at 08:30; 12:30; 17:30; and 22:00. The drug administration chart does not document that irrigation was provided at 17:30 from 6 July to 16 July, and also on 18 July and 19 July.

Independent Professional Advice

163. The IPA was asked to comment on whether the Care Home's record, including the Care Home Kardex, provided for a 17:30 flush and if water was improperly not provided for the 17:30 flush. The IPA Advised that *'[u]ntil 17/7/16 there is no documented evidence that the patient received the prescribed RIG tube flush at 17.30 hours. On the 17/7, 21/7, 22/7, 23/7, the patient was given a 17.30hrs RIG tube flush.'* The IPA concluded that the '*best practice guidelines for the management of RIG tubes, administering feeds and medication was not always*

followed'. The IPA went on to explain that not flushing the RIG tube as prescribed *'put the patient's RIG tube at risk of becoming occluded with food or medication. This increases the risk of the tube needing to be replaced, or infection.'*

164. The Care Home responded by stating that '*the simple fact that the tube never blocked, despite all feeds having been supplied via said tube, together with the fact that there was no infection, is evidence, even if not recorded, the tube was properly and regularly flushed.'*

Analysis and Findings.

165. I note the IPA's advice that there is no evidence in the record to suggest that the patient's RIG tube was flushed regularly. The IPA advised that *'[u]ntil 17/7/16 there is no documented evidence that the patient received the prescribed RIG tube flush at 17.30 hours.'* A 17:30 flush is documented to have been given on several occasions after this date. In response the Care Home stated that, *'even if it was not recorded'* it must have been properly flushed, yet there is no evidence in the record to suggest that the flushes were given. I also note that the Care Home's position is inconsistent with the advice of the IPA, who advised that not flushing the RIG tube would '*put the patient's RIG tube at risk of becoming occluded'.* Although there was clearly an increased risk of occlusion, it does not follow that the patient's RIG tube would definitely have become blocked as a result of not being flushed. Accordingly I cannot agree with the Care Home's position that *'the simple fact that the tube never blocked, despite all feeds having been supplied via said tube, together with the fact that there was no infection, is evidence, even if not recorded, the tube was properly and regularly flushed.'*

166. The Care Home has not provided any explanation as to why the 17:30 flush was documented on some occasions, but not others. The only consistency in the Care Home's interpretation of the drug administration record is to suit its defence of this complaint, rather than a thoughtful and thorough review of the records. The Care Home relied on this record to support its position that Atropine was properly administered, yet discredits the accuracy of this record concerning administration of Oramorph and the 17:30 flush. I am not persuaded by the Care Home's contradictory positions regarding the accuracy of the drug administration

record and it is impossible to know whether this record is accurate.

167. In the absence of any evidence supporting the Care Home's claim that the patient always received her 17:30 flush as prescribed, I find that on the balance of probabilities, the patient did not regularly receive a 17:30 flush as prescribed. Accordingly, I accept the IPA's advice that *best practice guidelines for the management of RIG tubes, administering feeds and medication was not always followed'.* I find that this constitutes a failure of care and treatment and **I therefore uphold this issue of complaint.**

168. In regards to the impact of this failing on the patient, the IPA advised that although the patient was *'at risk'* of suffering a blockage, he did not identify any instance where the patient actually suffered any complications as a result of her RIG tube not being flushed. Accordingly I find that the patient did not suffer any injustice as a result of this failing.

Conclusion

169. Having considered this issue of complaint, I have been unable to conclude on the following sub-issues:

a. Whether the Care Home staff appropriately follow the care plan in relation to the patient's bed position;

b. Whether proper staff handovers were being carried out in relation to the patient; and

c. Whether the Care Home appropriately ensured the patient had access to her call bell.

170. I have found failures in care and treatment on the part of the Care Home staff in respect of the following:

a. Failure to provide the patient with a riser recliner chair;

b. Failure to properly administer Oramorph to the patient;

c. Failure to properly administer Atropine to the patient;

d. Failure to properly care for the patient in response to her panic attack on the evening of 13 July; and

e. Failure to flush the patient's RIG tube in accordance with the care plan.

As a consequence of these failings, I find that the patient suffered the injustice of upset, distress, discomfort and anxiety. I further find that the complainant suffered the injustice of time and trouble, distress, frustration and uncertainty. I therefore partly uphold this issue of complaint.

Issue 2: Whether the complaint was dealt with by Antrim Care Home in accordance with policy, procedure and guidance?

Detail of the Complaint

171. The complainant said that the Care Home did not properly respond to her complaint. She felt that in responding through a solicitor's office, the Care Home were attempting to intimidate her instead of actually responding to the issues raised in her complaint. The solicitor's letter made her feel anxious that the Care Home were trying to threaten her. She believed the intent of the solicitor's letter was to 'shut her up' and get her to drop her complaint and 'go away' and she had been expecting a response from the Care Home manager, or someone else with knowledge of her mother.

172. In addition to the tone, the complainant also expressed her dissatisfaction with the content of the Care Home's initial response. She felt that she had gone to a lot of effort to write a detailed and through complaint letter and expected more from the response. In particular, she was disappointed that the Care Home had not responded to her complaints about how morphine had been administered to her mother.

173. She also complained that no representative from the Care Home showed up to a local resolution meeting arranged by the Trust to discuss her complaint. She recalled being disappointed that she was told the Care Home representatives felt the meeting was 'too far away' for the manager to attend. She expressed that she was very thankful to the Trust staff who had arranged the meeting and took the time to meet with her.

174. Following the meeting, the complainant wrote another letter to follow up on the initial points of complaint she had raised. She felt angry that the Care Home had again responded through a solicitor with what she perceived to be another threatening letter – which she believed threatened her with legal action if she repeated certain allegations of her complaint. At this point, the complainant felt that the Care Home had not attempted to interact with her regarding her complaint and felt there was no point in continuing with the Care Home's complaints process.

Care Home's responses to investigation enquiries.

175. In its responses to NIPSO's enquiries, the Care Home stated that the Care Home manager was not made aware of the date, time and location of the local resolution meeting and this was why she had not attended. The Care Home stated that the manager had agreed to a meeting, but was never advised that a meeting had been arranged and therefore was not able to attend.

176. In response to the complaint about the Care Home responding through a solicitor, the Care Home stated that it was *'entirely up to [them] whether [they] respond directly to complaints or via [their] solicitor.'* The Care Home's solicitor also explained that *'[t]he threat of legal action arose as a result of the complainant's allegation that records had been amended after her complaint was lodged. This is absolutely denied and we reserve the right to take legal action if such untrue allegations are repeated'*

The Trust's Complaints File

177. The complainant sent her initial complaint on 15 August 2016. She submitted a thirty page document. This included separate headings under the conclusion for each issue of complaint, including a heading for 'Morphine' (Oramorph). This complaint was acknowledged by the Trust the next day. The Trust forwarded the complaint to the Care Home for investigation. The complainant followed up on 8 September 2016 with the complaint manager in the Trust who informed her the complaint had been passed to the Care Home for investigation and would be delayed as key staff were on leave.

178. The complainant again followed up on 5 October 2016, requesting an update. Staff from the Trust contacted the Care Home manager requesting an update. The email to the Care Home manager noted that *'the timeline for this response*

has been severely breached' and therefore would appreciate an immediate response to the complaint. A complaints manager from the Trust contacted the complainant and apologised for the delay. On 10 October, the Care Home Manager responded to the Trust indicating that *'after seeking professional advice, [she] really [felt] at this time it isn't appropriate for [the Care Home] to respond to the complaint directly especially as [the complainant] feels that there would be an issue with impartiality].*

179. The Trust arranged a meeting for 18 October with the Care Home manager to discuss the complaint, but this was cancelled by the Care Home manager the day before. On 26 October, the Care Home manager sent an update to the Trust indicating that the complaint was with the Care Home's solicitor. In response, the Trust requested a timeline for the response *'as [it was] now critically breaching [its] policy on response times.'*

180. On 31 October, the complainant again requested an update. The Trust informed the complainant that the Trust was *'still awaiting a reply from Antrim Care Home'.* A Trust internal email on 18 November stated that the process was *'running on far too long'.* The Trust complaints manager called on 18 November and again on 21 November requesting a response from the Care Home manager, who informed her that the solicitor would have a response prepared by lunch time the next day.

181. On 21 November, the Care Home provided a draft response (dated 26 October) to the Trust. This was sent on to the complainant the next day with a recommendation that Care Home staff and representatives meet with the complainant to discuss the investigation. The Trust's cover letter also apologised for the length of time taken to respond to the investigation.

The Care Home's initial response to the complaint

182. I have reviewed the Care Home's initial response to the complainant, dated 26 October 2016 and sent on 21 November 2016. I note that the letter was signed by the Care Home's solicitor and concedes that the en-suite bathroom had not been properly cleaned, however, I note there is no apology offered for this oversight, nor does the letter offer any apology for the length of time taken to prepare a response to the initial complaint.

183. I also note that several issues raised in the complaint were not addressed. In particular, the complaint about the Care Home staff's administration of Oramorph, the staff's failure to ensure her mother had access to her call bell, and the complaint about the Care Home nurse's refusal to call an ambulance were all not addressed.

Correspondence Regarding the Local Resolution Meeting.

184. I have reviewed the correspondence exchanged between the Care Home and the Trust regarding the scheduling of the local resolution meeting. On 22 November 2016 the Care Home Manager received an email from the Trust's Complaints Department asking if she *'would be agreeable'* to the Trust arranging a meeting between her, the complainant, and Senior Trust staff. The Care Home informed NIPSO that the Care Home manager agreed, however, the Care Home manager '*was never advised that a meeting had been arranged and therefore obviously was not able to attend.'* The Trust's complaints department advised NIPSO that it received no reply from the Care Home manager to her email of 22 November 2016 asking her if she would be agreeable to a meeting.

185. The Trust's Complaints File documents that on 8 December 2016 the Trust sent an email to the complainant and Trust staff detailing the date, time and location of the proposed meeting. Typed and handwritten notes on file from the Complaints Manager state that on 7 December 2016 she phoned the Care Home Manager to invite her to a meeting on 12 December 2016 with Trust staff and the complainant to discuss the complaint response. The Complaints Manager recorded that the Care Home Manager *'said she would check her diary for availability and would get back to me.'* The Complaints Manager also recorded on the complaints file that on 12 December 2016 the Care Home Manager phoned the Complaints Department and spoke with another named member of Complaints staff and told her *'she was not able to attend today's meeting due to the distance'* and requested a call back. When the Complaints Manager called back, she was informed that the Care Home Manager was unavailable, but would return her call. The Complaints Manager informed NIPSO this call was never returned.

Correspondence following the local resolution meeting.

186. The Trust and the complainant met on 12 December without a representative from the Care Home. Following this meeting, the complainant sent a follow up letter outlining the outstanding issues of her complaint. The complainant emphasised that she felt that there were several points that had not been adequately addressed by the response.

187. The Care Home responded to this letter via its solicitor on 26 January 2017 and indicated that the Care Home *'reserve[ed] the right to take further action should any allegation of a cover up be repeated.'*

RQIA Investigation Report 1 September 2016.

188. The RQIA report identified evidence that *'complaints were not managed in accordance with Regulation 24 of the Nursing Homes Regulations (NI) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.'* The investigator noted that '*Care Staff readily described to the inspector, detail regarding two complaints which relatives had made to the nurse in charge of the home. When raised with the registered manager, she was unaware of these complaints. A formal complaint was also received by the registered manager on the day of the inspection, in relation to the care of a patient who was no longer residing in the home. Through discussion, it was evident that the registered manager was aware of dissatisfaction with the care of this patient and explained that discussions held at relevant meetings would have been recorded in the patient's care record. It was concerning that the registered manager and registered nursing staff did not recognise these matter as complaints and record them as such.'*

Response to Draft Report

189. In response to the Draft Report, the Care Home's solicitor indicated its client had previously provided an apology to the Ombudsman for the condition of the room on 31 July 2017. However, no apology was ever provided directly to the patient's family when the Care Home had the opportunity to do so throughout the complaints process.

Analysis and Findings

190. The complainant has complained about several aspects of the Care Home's

complaints process. I have considered several aspects of how the Care Home considered and evaluated the complaint. These are:

a. The complainant's dissatisfaction with the Care Home's initial response to her complaint, including the length of time taken to respond and the content of the response;

b. The circumstances surrounding the Care Home's failure to attend a local resolution meeting; and

c. The Care Home's response to the complainant's follow up letter.

The Care Home's initial response.

191. I have considered the Care Home's response to the initial complaint. In particular, I have assessed the length of time taken to respond to the complaint and the content of the response. I note that on several occasions, the Trust's staff informed the Care Home that its response had severely breached its internal guidelines for complaints handling. The complaint was sent on 15 August 2016. The Care Home did not provide a draft of its response to the Trust until 21 November 2016. I note that the Care Home did not contact the complainant at any point to explain the nature of the delay, or to apologise for the delay.

192. I have considered the Complaints Procedure. I note that section 3.38 required the Care Home to complete its investigation within 20 days. I also note that Standard 6 required the Care Home to keep the complainant informed of any delays and to respond to all issues raised in the complaint and, where appropriate, contain an apology.

193. Having considered the HSC Complaints Procedure, I note that the Care Home's initial response fell significantly short of the required standards in several ways. The response was extremely late and *'severely breached'* the Complaints Procedure, as noted by the Trust's correspondence.

194. Despite acknowledging that the patient's room was in an appalling state and had not been cleaned, the Care Home did not offer any apology for this and no efforts were made by the Care Home to keep the complainant updated regarding the reason for the delay in responding to her complaint.

195. I have also considered the content of this response and note that several of the

complainant's issues of complaint were not addressed by the Care Home's investigation. Specifically, the content of the response failed to consider several key aspects of the complaint, including her complaint about the administration of Oramorph, and the Care Home nurse's refusal to call an ambulance. Notably, these were failings identified in this report. This was also not in accordance with of Standard 6 of the HSC complaints procedure.

The Local Resolution Meeting.

196. I have considered the circumstances surrounding the unsuccessful meeting scheduled for 12 December at the Trust's office at Causeway House in Ballymoney. This meeting was scheduled to include the Care Home manager, the Trust, and the complainant. The Care Home was first informed about a potential meeting with the complainant on 22 November. The Care Home manager was again contacted on 7 December about arranging a meeting and responded that she would have to check her diary first. I note that the Trust's complaints file indicates that the Care Home Manager called to cancel on the day of the arranged meeting '*due to the distance'*. I have considered the Care Home's solicitor's statement that the Care Home manager '*was never advised that a meeting had been arranged and therefore obviously was not able to attend'*. I am unable to find any support for this position in the material provided. The Trust's complaints file is clear that the Care Home manager was informed of the date and time of the proposed meeting, but chose not to attend. Additionally, the Care Home manager did not apologise to the complainant, nor did she attempt to reschedule the meeting, or return the call as promised to the Trust's complaints department.

197. I have considered section 1.3 of the HSC Complaints procedure and note that *'[t]he purpose of local resolution is to provide an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint.'* As the purpose of the local resolution meeting was to facilitate a conversation between the complainant and the Care Home manager, the Care Home manager was under an obligation pursuant to Sections 3.39 and 3.40 of the HSC Complaints Procedure to attend the local resolution meeting and she failed to comply with the Complaints Procedure by not attending the meeting, or providing

a reasonable excuse for her non-attendance. I note that this was the second time the Care Home manager failed to attend a meeting with the Trust in relation to the complaint.

The Care Home's Response to the complainant's follow up letter.

198. I have considered the Care Home's 26 January response to the complainant's follow up letter. Again, I note that this response came from the Care Home's solicitor and not the Care Home itself. Within this response, I have paid particular attention to the solicitor's threat that the Care Home *'reserve[s] the right to take further action should any allegation of a cover up be repeated'.* I have considered the Care Home's solicitor's reasons for making this threat.

199. It is unclear whether the Care Home, or its solicitor, gave any consideration to the HSC complaints procedure at all during its investigation of the complaint. There appears to have been no effort to deal with the complaint in an open and honest manner. Instead the Care Home responded through a solicitor in an adversarial manner, by threatening the complainant. This is inconsistent with the HSC Complaints Procedure.

200. In addition to the failings identified above, I note the Care Home's solicitor has provided inconsistent responses regarding the times when the patient received Oramorph and regarding the patient being allowed to lie flat.

I have considered the threatening tone of the Care Home's responses, the failure of the Care Home to attend meetings with the Trust and the complainant, and the Care Home's failure to apologise for its admitted failings. I have also noted there is no documentation of the steps taken by the Care Home, or its solicitor, in investigating the complaint. The inconsistencies in the Care Home's responses, paired with the dearth of investigative documentation, establishes that the Care Home has failed to carry out '*[a] thorough, documented investigation.'* Accordingly I find that the Care Home has failed to comply with Standard 5 of the HSC Complaints Procedure.

Conclusion.

201. The First, Third, and Fifth Principle of Good Complaints Handling; '*Getting it*

right'; '*Being Open and Accountable'* and '*Putting Things Right'* requires a public service provider to act '*in accordance with the relevant guidance'*, provide '*honest, evidence-based explanations and giving reasons for decisions'* and '*acknowledge mistakes and apologise where appropriate*'. I am concerned about the scope and severity of the failures I have identified, which were also reflected in the RQIA inspection. From the receipt of the complaint, the Care Home avoided engaging with the complainant and the Trust about this complaint. The initial complaint was not responded to for months and even when a response was issued, it was factually inaccurate, incomplete and adversarial. When the Care Home was presented with an opportunity to remedy this response, the manager declined to engage with the Trust and the complainant at a local resolution meeting.

Finally, when the Care Home responded to the complainant's follow-up letter, the response threatened legal action instead of addressing her concerns.

202. Instead of making an effort to engage with the complainant and the Trust, the Care Home resorted to threats and obfuscation tactics with the apparent attempt to conceal the failings in care and treatment identified in this report. The failures in complaints handling are substantive and substantial; indicative of a process that is not designed to engage with complainants in an open and honest manner, but rather with the goal of silencing them.

203. Accordingly, I find that the Care Home's failure to properly investigate the complainant in line with the HSC Complaints Procedure was inconsistent with these Principles of Good Complaints Handling. I further find that this constitutes maladministration. Regarding the impact to the complainant, I note that the complainant has expressed her anger and disappointment in the way the Care Home responded to her complaint. She has complained that the Care Home attempted to threaten her instead of dealing with her complaint. She also has not received an apology for the Care Home's admitted failings. I consider that the complainant suffered the injustice of upset and frustration as a result of the Care Home's improper investigation of her complaint.

CONCLUSION

204. The complainant submitted a complaint to me about the actions of the Care Home in relation to the care and treatment provided to her mother. She complained about the Care Home's failure to properly care for her mother while she was staying there from 6 July up until her death. She also complained about the Care Home's improper handling of her complaint.

205. I have investigated the complaint and I have been unable to conclude on the following sub-issues:

a. Whether the Care Home staff appropriately follow the care plan in relation to the patient's bed position; and

b. Whether proper staff handovers were being carried out in relation to the patient.

c. Whether the Care Home appropriately ensured the patient had access to her call bell.

206. I have found failures in care and treatment in relation to the following:

(i) Failure to provide the patient with a riser recliner chair;

(ii) Failure to properly administer Oramorph to the patient;

(iii) Failure to properly administer Atropine to the patient;

(iv) Failure to properly care for the patient in response to her panic attack on the evening of 13 July; and

(v) Failure to flush the patient's RIG tube in accordance with the care plan.

207. I am satisfied that the failures in care and treatment that I have identified caused the patient to experience the injustice of upset, discomfort, anxiety and distress. The complainant suffered the injustice of distress, uncertainty, frustration and time and trouble.

208. I have also found maladministration in relation to the following matters:

(i) Failure to apologise for the condition of the patient's room;

(ii) Failure to properly consider the complaint in an open and honest

manner;

(iii) Failure to apologise for the delay in responding to the complaint;

(iv) Failure to appropriately respond to all the issues raised in the complaint; and

(v) Failure to attend the local resolution meeting, or provide a reasonable excuse for not attending.

209. I am satisfied that the maladministration I have identified caused the complainant to experience the injustice of upset and frustration.

Recommendations

210. I recommend that the Care Home:

- Issues the complainant with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified in this report, and should be issued within **one month** of the date of my final report.
- Provides the complainant with a payment of £400 by way of solatium for redress in respect of the injustice of distress, uncertainty, time and trouble, upset and frustration, she experienced within **one month** of the date of my final report.

211. Given the concerns that this investigation has raised, I intend to provide a copy of the report to the RQIA so it can provide assurance about the care currently being provided and to identify any wider areas for action, or learning and improvement.

PAUL McFADDEN
Acting Ombudsman **31 March 2020**

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

Good complaint handling by public bodies means:

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.

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 co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

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.

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.

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.

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.