Northern Ireland Public Services Ombudsman

Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 17450

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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SUMMARY

I received a complaint about the actions of the Western Health and Social Care Trust (the Trust). The complaint concerned the care and treatment provided to the complainant's late mother (the patient) by the Trust while she was a resident in Culmore Manor Nursing Home. The patient was a resident in the Home following an assessment that her needs could be met in a care home. The Trust continued to oversee her psychiatric care and had responsibility for her care management.

Issues of Complaint

I accepted the following issues of complaint for investigation:

i. Was the patient's dosage of Quetiapine appropriate?
ii. Whether the complainant's concerns about the level of sedation administered to his mother since January 2016 were adequately addressed by the Trust?
iii. Whether the Trust's investigation of the complaint was reasonable and in accordance with relevant standards?

Findings and Conclusion

I have investigated the complaint and I have not found a failure in care and treatment of the patient in relation to the dosage of Quetiapine. I have also found that the complainant's concerns about the level of sedation administered to his mother were adequately addressed by the Trust. However I consider it a failure that the Consultant in Rehabilitative Medicine did not respond to the complainant's concerns about his mother's condition. I am satisfied that the maladministration I found caused the complainant to experience the injustice of frustration and uncertainty from his attempts to communicate his concerns with the Consultant in Rehabilitative Medicine.

I have also found a failure in care and treatment in aspects of the planning of the patient's care namely; (1) the lack of a fundamental care plan that would detail the frequency of CPN visits to the patient (2) the risk assessment was not updated to include the management of her medication. I also found no evidence that the CPN

routinely monitored her medication and side effects. I have not identified an injustice to the patient regarding these failures.

I have found the Trust appropriately investigated the complaint. However I found deficiencies in the reporting of the outcome of the complaint investigation which I consider constitutes maladministration. The complainant experienced the injustice of uncertainty and frustration regarding the Trust's investigation as the response to his complaint did not clearly set out the evidence and reasons for the Trust's decision.

Recommendations

I recommended that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to him as a result of the maladministration identified (within **one month** of the date of this report).

In relation to service improvements, the CPN IPA had identified areas where she considered the Trust could improve its practice. The Trust indicated its acceptance of these issues as learning from the complainant's complaint and its intention to implement these. I will follow up with the Trust regarding these recommendations to ensure they have been implemented (within **three months** of the date of this report).

THE COMPLAINT

1. The patient was a resident in the Home following an assessment that her needs could be met in a care home. The Trust continued to oversee the patient's psychiatric care and had responsibility for her care management. I have investigated a separate complaint in relation to the Home. The complainant said that he was concerned with his late mother's level of sedation as he repeatedly found her drowsy and hard to wake up. He stated that starting from 18 January 2016 he had raised concerns with his mother's psychiatric nurse and the secretary of her Consultant about his concerns of over-sedation. He believes that she may have aspirated due to over-sedation. The complainant believes his concerns were ignored and the patient was rushed to Altnagelvin Hospital from the Home with aspiration pneumonia on 20 February 2016. She passed away the following day. In particular the complainant believes that the drug Quetiapine[1] was the cause of his mother's over sedation. He also complained about the Trust's investigation of his complaint.

Background

2. The patient had been an inpatient in Altnagelvin Hospital following a cardiac arrest, resulting in hypoxic brain injury and cortical blindness. She had a medical history of breast cancer, hip replacement, pneumonia, vascular disease, osteoarthritis, anxiety and low mood. She became a resident of the Home on 20 December 2012. As a result of her hypoxic brain injury the patient experienced ongoing visual and auditory hallucinations, which necessitated input from the Community Mental Health Team.

Issues of complaint

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

    1. Was the patient's dosage of Quetiapine appropriate?

[1] This medication is used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder). Quetiapine is known as an anti-psychotic drug (atypical type)

2. Whether the complainant's concerns about the level of sedation administered to his mother since January 2016 were adequately addressed by the Trust?
3. Whether the Trust's investigation of the complaint was reasonable and in accordance with relevant standards?

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. As the complainant also submitted a complaint against the Home (17497), information relating to the handling of the complaint by both the Home and the Trust and the patients relevant medical and nursing home records were also reviewed.

Independent Professional Advice Sought

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

- A Consultant Psychiatrist with 20 years experience as a NHS Consultant Old Age Psychiatrist working in community and inpatient settings (Psychiatrist IPA);
- A Community Psychiatrist Nurse (CPN) who has worked in UK mental health services since 1992 and is currently an operational lead and team leader in a community mental health team (CPN IPA).

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

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the

standards, both of general application and those which are specific to the circumstances of the case.

The general standards are the Ombudsman's Principles[2]:

- 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 functions of the Trust staff whose actions are the subject of this complaint.

9. The specific standards relevant to this complaint are:

- NICE guidelines *'Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence'* (CG76, 2009) (NICE guidelines 76)
- NICE guidelines *'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services'* (CG136, 2011) (NICE guidelines 136)
- Department of Health guidelines *'Best Practice in Managing Risk Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services'* (March 2009) (DoH guidelines)
- Nursing Midwifery Council (NMC) *'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'* (2015) (the NMC Code)
- General Medical Council (GMC) *'Good Medical Practice'* (2013) (GMC Guidelines)

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

- The Western Health and Social Care Trust Policy for Managing Complaints (2011) (the complaints policy).

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 investigation process, a draft of this report was shared with the Trust and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Was the patient's dosage of Quetiapine appropriate?

Detail of Complaint

12. The complainant stated that the Trust's mental health team previously prescribed his mother Quetiapine as she had episodes of intermittent hallucinations. He complained that this drug was recommenced on 18 January 2016 following return from a period in hospital; however he was unaware of this change in medication until 31 January 2016. Having researched this drug, the complainant stated that his mother was very drowsy since she recommenced this drug and he believed this was the cause of her drowsiness.

Evidence Considered

The patient's clinical records

13. I note the contents of a letter from a Consultant Psychiatrist to the patient's GP dated 21 December 2015 following a visit to the Home on 9 November 2015. This states

her current dosage of Quetiapine was 25mgss nocte[3] plus 25mgs as required for agitation. I note the following extracts from this letter:

'…I spoke with[…] nurse on duty at the time before interviewing [the patient]. […] reports that [the patient] continues to have periods were she will call out and appeared to be seeing things including people in her room. She is unclear if the regular Quetiapine at night-time has helped with the frequency of this but has noted that a prn[4] Quetiapine has been very effective in reducing the patient's agitation when these episodes occur. […] felt that [the patient's] mood was largely unchanged from where it has been…

…<u>Impression</u>

The overall impression is that [the patient's] psychotic symptoms appear to have responded well to the low dose of Quetiapine.

<u>Plan</u>

- *Given the fact that nursing staff do use prn dose with her on occasion I would advise introducing a small morning dose 12.5mgs to see if this restricts the use of the prn more. I advise no other changes to her medications…'*

14. I note from the patient's nursing home records that her Quetiapine was withheld on 30 December 2015 following an instruction from her GP as she was being treated for a respiratory tract infection. The patient was admitted to hospital on 6 January 2016 and returned to the Home on 13 January 2016. Her GP contacted the Home on 18 January 2016 and gave an instruction to recommence her Quetiapine (12.5mgs in the morning and 25mgs at night).

15. I have included a table below to further outline the changes in the patient's dosage of Quetiapine.

Date	**Dosage**	**Comments**
Prior to Oct 2015	25mgs NOCTE 25 mgs PRN	Family informed by CPN.
9 Nov 2015	Review by the Consultant	Family not informed of

[3] Every night
[4] As required

	Psychiatrist. Recorded in nursing home notes that he will increase Quetiapine to 12.5mgs mane in addition to 25mgs NOCTE.	this change.
21 Dec 2015	The Consultant Psychiatrist advises GP to introduce a 12.5mgs AM dose to restrict the use of the PRN dose	
30 Dec 2015	GP instructs care home to withhold Quetiapine	
6 Jan-13 Jan 2015	The patient in hospital	
18 Jan 2016	GP instructs care home to introduce the Consultant Psychiatrist's recommendation of 12.5mgs AM	
18 Jan -20 Feb 2016	12.5mgs AM 25mgs NOCTE	

The Trust's response to investigation enquiries

16. The Trust stated that the Consultant Psychiatrist's team was contacted by the Home in October 2014 as it was concerned about the patient having visual hallucinations, experiencing a man in her room at times and that she was shouting and distressed. The Home was advised to complete investigations to determine if the patient was experiencing delirium (confusion secondary to an underlying medical cause). A nurse was scheduled to visit her. She was later seen by a nurse during a visit to the Home in March 2015. Input from a CPN was also advised to make efforts to engage the patient and her family in an effort to reduce her alcohol use with consideration to be

given to referral to an Addictions Support Worker. The patient was prescribed Quetiapine 25mgs once per day.

17. The Trust stated the patient's care was subsequently discussed with the Consultant Psychiatrist again in September 2015 as she was experiencing distressing hallucinations and lowered mood. A decision was made to introduce an extra dose of Quetiapine on an 'as required' basis. This change was subsequently discussed with the patient's family by the CPN. The CPN liaised with the Home over the following weeks and some concerns are recorded at this stage from the Home that the use of the 'as required' Quetiapine was having little impact when the patient was distressed. Also there were some concerns that she was drowsy and that her mood was 'flat'. On the strength of this information provided by the Home, the Consultant Psychiatrist made the decision to continue the Quetiapine. Her CPN was to assess the patient at the Home subsequent to this to determine if there was any drowsiness.

18. The Trust added that Quetiapine in this case was prescribed to treat the patient's distressing hallucinations. The prescription was initiated in primary care but continued in secondary care[5] due to the perceived efficiacy of this treatment. The Trust stated the initial dose was 25mgs at night which was later increased to 25mgs at night with an additional 25mgs to be used 'as required'. In November 2015, the Consultant Psychiatrist recommended the dose should be changed to 12.5mgs in the morning. The Trust further stated these are recognised to be small doses of this drug[6], however it is clinically recognised that antipsychotic medications are powerful medicines and certainly have the potential for sedation.

19. The Trust further explained that the Consultant Psychiatrist assessed the patient at the Home on 9 November 2015 as she was experiencing significantly distressing periods. Staff reported that the use of the 'as required' Quetiapine did make her

[5] The NHS is divided into primary care, secondary care, and tertiary care. Primary care is often the first point of contact for people in need of healthcare, and may be provided by professionals such as GPs, dentists and pharmacists. Secondary care, which is sometimes referred to as 'hospital and community care', can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture.

[6] British National Formulary lists a dose of 50mgs initially for elderly persons with Schizophrenia increased in 50mgs increments according to response)

drowsy but did have a settling effect. Given her ongoing fluctuating psychotic experiences it was recommended an addition of a small dose of Quetiapine 12.5mgs to her regime in an effort to reduce the ‘as required’ dose. The Trust stated plans were made to see her again at the request of her CPN who would monitor the impact of the change in medication. The recommendation for this medication change was sent to the patient’s GP in a letter dated 21 December 2015 which detailed her current medications and the planned changes.

20. In relation to whether changes were made to her prescription of Quetiapine as a result of her alcohol intake, the Trust stated that in February 2016 the Consultant Psychiatrist was asked to make a decision on whether or not to continue prescribing Quetiapine. Having considered the risks and benefits to the patient based on information provided by the CPN and nursing home staff, the Consultant Psychiatrist advised that she should continue with the prescribed medication as the benefits outweighed any risks. In relation to whether nursing staff ever raised concerns about the patient’s level of sedation, the Trust stated the Consultant Psychiatrist became aware her son had expressed concerns about the prescription of Quetiapine causing his mother to be drowsy and had spoken to Home staff. However the CPN informed the Consultant Psychiatrist that Home staff did not have the same concern as the complainant and reported an improvement in her mental health with a reduction in her hallucinations. Therefore from the Consultant Psychiatrist's discussions with staff at the time he recorded that the use of Quetiapine on an ‘as required’ basis did make her drowsy but did have a definite settling effect.

Response from the Consultant Psychiatrist, Consultant Psychiatrist

21. The Consultant Psychiatrist stated he would like to pass on his condolences to the family at the passing of the patient. He referred to the change he implemented to her dosage of Quetiapine following his visit in November 2015. He stated his usual practice would be to discuss any medication changes with patients and their family however on this occasion he did not do so. He apologised for this oversight and stated it is a point of learning for him for future practice. He stated he understood the family’s concern in this case as the patient was on a number of drugs that could cause sedation. He added it is certainly possible that they observed her to be drowsy

on occasions and this may have been due to the timing of doses of her medication in some instances. He said this was clearly a very complex case and he understands the family's concerns with regards to her medications and possible side effects.

Independent Professional Advice

22. The Psychiatrist IPA advised that *'Quetiapine is a second generation antipsychotic, licenced for the treatment of schizophrenia, bipolar disorder and major depressive disorder in bipolar. Use of quetiapine for the treatment of visual hallucinations following brain injury and cortical blindness is not a licenced indication. Nevertheless, I think it is entirely reasonable that an antipsychotic is prescribed under such circumstances…'* The Psychiatrist IPA further advised that *'My only reservation is quetiapine is a relatively sedative antipsychotic (usually sedation is more prominent in the first few weeks of prescribing). However at the doses used sedation is unlikely to be significant. On the other hand quetiapine has less incidence of movement disorder side effects compared with many other antipsychotics, which makes it a reasonable choice. It does appear that the quetiapine was monitored; for example, by a visit from the community nurse on 20/01/2016 and discussion in the multi-disciplinary team on 09/02/2016. I am therefore of the opinion that the decision to prescribe the patient quetiapine to treat her hallucinations was reasonable and is in accordance with accepted clinical standards.'*

23. In relation to the dosages of Quetiapine prescribed to the patient, the Psychiatrist IPA advised that *'I consider the dosages of quetiapine that the patient received are relatively low… In my opinion, the Consultant Psychiatrist was right in using the lowest possible doses of quetiapine and increasing these incrementally after suitable intervals.'* In relation to whether these dosages of Quetiapine would have caused drowsiness, the Psychiatrist IPA advised that *'I have certainly seen patients who have become drowsy on very low doses of quetiapine such as 25mgs or 50mgs, but this, in my experience is relatively rare. I point out that the nursing home notes, which appear to be reasonably comprehensive, do not point to the patient being drowsy during the day as a regular occurrence…'* The Psychiatrist IPA advised it had been recorded that the patient had been intermittently drowsy since her return from hospital on 13 January 2016 following a chest infection. The Psychiatrist IPA

advised *'…It was therefore not clear to me whether the intermittent drowsiness observed was due to the quetiapine or the residuum of the chest infection.'*

24. In relation to the Consultant Psychiatrist's acknowledgement and apology that he did not discuss this change to the patient's medication with her family, the Psychiatrist IPA advised the Consultant Psychiatrist had made a small increase in the dose of quetiapine (12.5mgs) and did not discuss this with the family. The Psychiatrist IPA advised *'Although it is desirable to discuss medication changes, I am of the opinion that* (sic) *it is not necessary (or always possible) to discuss every dose adjustment with the family. I am of the opinion that the Consultant Psychiatrist should not be censured for omitting that discussion. I find his response both reasonable and appropriate.'*

Analysis and Findings

25. The complainant raised concerns that his mother's drowsiness and over-sedation was caused by Quetiapine during her time in the Home, particularly from January 2016. As the Home is not responsible for prescribing a patient's medication, this issue of complaint has sought to establish whether it was appropriate for the Consultant Psychiatrist to recommend Quetiapine to control the patient's symptoms and whether the dosages were appropriate. I have established that the patient was prescribed Quetiapine to assist with the control of hallucinations and agitation. The Consultant Psychiatrist advised her GP via a letter dated 21 December 2015 to introduce a dose of 12.5mgs in the morning and 25mgs at night, with the intention of reducing the need for an 'as required' dose. The Trust and the Consultant Psychiatrist have acknowledged that drowsiness is certainly a side effect of Quetiapine, however the dosages prescribed to the patient were relatively low.

26. I welcome the Consultant Psychiatrist's acknowledgment that he did not discuss the changes to the patient's medication in November/December 2015 with her family and that this will be a point of learning for him. I also accept the Psychiatrist IPA's advice that it is not necessary or always possible to discuss adjustments to medication and that the Consultant Psychiatrist's response is reasonable and appropriate

27. I accept the advice of the Psychiatrist IPA that the decision to prescribe the patient Quetiapine to treat her hallucinations was reasonable and in accordance with clinical standards. I accept the advice of the Psychiatrist IPA that the dosages are relatively low and the Consultant Psychiatrist was correct in using the lowest possible doses and increasing these incrementally. I also accept the advice of the IPA that there is no evidence that the dosages of Quetiapine caused the patient to be drowsy on a regular basis and *'on balance of probabilities I am of the opinion it did not put the patient at risk of aspiration pneumonia'*. I have therefore not identified a failure in the care and treatment of the patient. I therefore do not uphold this issue of complaint.

Issue 2: Whether the complainant's concerns about the level of sedation administered to his mother since January 2016 were adequately addressed by the Trust?

Detail of Complaint

28. The complainant stated that from 18 January 2016 his family raised concerns about his mother's level of sedation as they and other visitors repeatedly found her drowsy and hard to wake. He complained they were worried about the potential for her to aspirate and raised these concerns initially with the Home's nursing staff. He attempted to contact the Consultant in Rehabilitative Medicine's secretary and also raised concerns with Trust staff such as his mother's CPN. However his efforts were in vain. The complainant stated he disagreed with the Consultant Psychiatrist's decision to continue the Quetiapine as he only listened to the Home staff who were denying she was drowsy.

29. In considering this issue, I have reviewed the complainant's email of complaint to the Trust on 7 March 2016. This email outlined the dates via a timeline in which he raised concerns about his mother's sedation and when she was found to be drowsy. According to the complainant's timeline, he contacted the Consultant in Rehabilitative Surgery's secretary to raise concerns on 19 January 2016. The complainant stated he raised concerns on 31 January 2016 regarding his mother's

Quetiapine and his mother's CPN contacted him on 5 February 2016.

Evidence Considered

Legislation/Policies/Guidance

30. The following national guidance and standards have been considered.

- NICE guidelines 76
- NICE guidelines 136
- DoH guidelines
- GMC guidelines

I have also considered the following extract of the NMC Code to be of particular relevance:

> *'10. Keep clear and accurate records relevant to your practice*
> *This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records. To achieve this, you must:*
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event*
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need 10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
> *10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation*
> *10.5 take all steps to make sure that records are kept securely*
> *10.6 collect, treat and store all data and research findings appropriately.'*

The Trust's response to investigation enquiries

31. The Trust stated the patient was on a number of drugs that could cause sedation and due to the nature of the drugs and their side effects it was certainly possible that her family observed her to be drowsy on occasions. The Trust added this may have been due to the timing of doses of her medication in some instances. In relation to the Consultant Psychiatrist's decision to continue the medication on 9 February 2016, he indicated that the medication prescribed had positive benefits for the patient and he formed his view having received information from the Home and the CPN.

32. In relation to what action was taken based on concerns regarding the patient's alcohol consumption, the Trust stated the team made efforts to advise on the importance of reducing her alcohol intake. The Trust stated the patient had refused support to assist her in addressing her alcohol intake in April 2015; however she was within her rights to refuse this treatment and her autonomy was respected. The Trust added advice had also been offered surrounding a period of abstinence from alcohol. The Trust stated the decision to continue or discontinue medications in the context of alcohol is based on potential risks and benefits of either decision. Due to the distressing nature of the patient's symptoms the decision was made that the potential benefits outweighed the risks in this case.

Response from the Consultant Psychiatrist, Consultant Psychiatrist

33. The Consultant Psychiatrist recalled that the patient was discussed at the community mental health MDT meeting on 9 February 2016. He stated it was explained to him that the complainant had expressed concerns about the prescription of Quetiapine causing his mother to be drowsy and that the CPN had spoken to the Home about this. he stated however the Home staff did not share his concerns and reported an improvement in her mental health with a reduction in her hallucinations. The Consultant Psychiatrist stated he made the decision to continue this medication on the strength of this information provided by the Home.

The patient's CPN records

34. I have reviewed the patient's CPN records on the dates that the complainant stated he had contact with the CPN. On 1 February 2016, the CPN received a call from a nurse in the Home advising that the complainant had spoken to staff regarding his concerns about his mother being recommenced on Quietiapine. The CPN advised that she would make contact with the complainant to discuss his concerns. The nurse stated she believed the Quetiapine has helped his mother with an improvement in her mood and reduction in the frequency and intensity of the hallucinations. The CPN left a voicemail with the complainant who returned the call on 5 February 2016.

35. According to the note of this phone call, it is recorded that the complainant stated he was not happy that his mother was back on Quetiapine as she was very drowsy since recommencing it. The CPN responded that the Home staff had reported that the patient had been drowsy before but that it was around the time that his mother had a chest infection. The CPN did not believe this was caused by the recommencement of Quetiapine. However the CPN stated she would discuss his concerns with the Consultant Psychiatrist next week at the MDT meeting on 9 February 2016 and would revert to him with the outcome.

36. Before the meeting, the CPN contacted the Home to enquire if staff had found the patient to be more drowsy than usual. The Home did not agree that she had been drowsy and that staff had observed a marked improvement in her mood as well as a reduction in the frequency and intensity of her hallucinations. According to the note of this meeting on 9 February 2016 between the CPN and the Consultant Psychiatrist, the CPN communicated the complainant's concerns regarding Quetiapine being the cause of her drowsiness. The CPN also communicated the Home's view that the patient had responded well to the Quetiapine and did not agree with the complainant that it was causing her to be drowsy. It is recorded that the Consultant Psychiatrist recommended that the patient remained on the current dose of Quetiapine as she appeared to have benefited from taking it. The CPN informed the complainant of the outcome of the meeting the following day via a message on his voicemail. The CPN stated he could make contact with her if he had any issues; however no further contact occurred before the patient's death on 21 February 2016.

The complainant's contact with the Consultant in Rehabilitative Medicine

37. The Trust provided a copy of an email sent from the Consultant in Rehabilitative Medicine's secretary dated 28 January 2016. This email stated *'the complainant rang and was asking if you could speak to him tomorrow (Friday 29.01.2016) around **14.00**…He would like to discuss his mother's condition which he feels has deteriorated. You reviewed as DV…'* On the 11 February 2016 the Consultant in Rehabilitative Medicine's secretary sent a further email reminding him to contact the complainant. I note that during the Trust's investigation of the complaint, the Consultant in Rehabilitative Medicine sent an email on 13 April 2016 acknowledging that the complainant did indeed contact his secretary in January about his mother. The Consultant in Rehabilitative Medicine apologised that he did not get an opportunity to make contact with him. He added that he could only cite multiple conflicting demands on his time as a reason.

Independent Professional Advice

38. The CPN IPA outlined the role of the CPN as follows: *'A community psychiatric nurse (CPN) is a fully trained nurse who has experience working in secondary mental health services. A CPN works as part of a mental health team, which includes nurses, doctors, social workers, therapists and psychiatrists. They work in people's homes in the **community** rather than a **psychiatric** hospital (including nursing and residential homes and GP settings).'* The CPN IPA referred to NICE guidelines 76 and advised that a CPN was allocated to the patient on 1 April 2015 and visited the patient in the Home on a number of occasions. In relation to whether the complainant's concerns were adequately addressed by the CPN, the CPN IPA advised *'The notes suggest that the CPN did take enough time and action to address the complainant's concerns regarding his mother's drowsiness.'*

39. However the CPN IPA advised *'There is no evidence that during these visits the CPN reviewed or monitored the patient medication. the patient was prescribed Quetiapine (? dose is unclear in the notes and it is an atypical antipsychotic used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. The*

common side effects to this drug are cold sweats, confusion, dizziness, faintness, or lightheadedness when getting up suddenly from a lying or sitting position, sleepiness or unusual drowsiness.There is a breach in the national guidelines here because there is no evidence that the patient's medication was discussed with her, that she understood what she was taking and if the side effects were explained to her by the CPN. The medication prescribed (Quetiapine) was administered by the nursing home staff, nevertheless the CPN should have monitored concordance and any side effects. I would expect to see a care plan (which plays an important part in mental health nurses' work, not only as a legal record of care given, but as a therapeutic tool)…' The CPN IPA also advised there is no care plan from the CPN to manage the alcohol issue and what effects this would have on her medication.

40. The CPN IPA acknowledged there is a brief care plan dated 11 December 2015 which she considered to be incomplete and brief. The CPN IPA advised *'The care plan explains the support provided by each of the professionals involved in her care (in this case the GP, Nursing home, CPN, Mental Health services and social services). The care plan should also include what to do in a crisis or to prevent a relapse. There is no evidence that the CPN made a care plan which is the basis of nursing practise. The care plan directs patient care. This would involve management of her medication for her physical and mental health.'*

41. The CPN IPA further advised *'The assessment and management of risk is a fundamental aspect of mental health nursing and must always be prioritised. Although there is a risk screening tool completed for the patient on 10 August 2015 which outlines some risks, however it has not been updated from here on.'*

42. In relation to the patient's overall care and treatment, the CPN IPA advised *'the CPN did not create a care plan, nor did she update the risk assessment which would have directed her medication management physical and mental…'* The CPN IPA advised this failing was in breach of DoH guidelines and the NMC Code. The CPN IPA further advised there was a breach in NICE guidelines 76 *'…because the CPN did not appear to monitor her medication and side effects. All nurses are responsible for recording information in patients notes about discussions about medication and giving out information, whether side effects are present or not, and discussing the*

most common and important side effects for each medication with patients.' The CPN IPA further advised *'The impact is such that if the patients may not understand the importance of her mental health medication and the side effects, then if she stopped taking her medication she could become unwell within weeks.'*

43. The CPN IPA outlined a number of service improvements for the Trust and concluded that *'[the patient] was seen at home face to face by the CPN during 2015 and 2016. However, the visits were 'ad hoc', and not planned in a care plan. There is no care plan which should have made clear how often the CPN would visit her and when.*

As part of the care plan it would be written down what medication she was on, how her mediation would be managed and monitored. There is no evidence that the CPN discussed medication and side effects with the patient in the notes. There is a risk assessment, but it has not been updated since 2015 and given that the patient was blind and had issues with alcohol and drowsiness and physical illness, I would expect to see this recorded in the risk assessment and care plan. There is a brief care plan produced by the Trust staff but not by the CPN. Therefore, because a risk assessment and care plans are fundamental elements of nursing practice there is a breach in the national guidelines here. However, the CPN did address the patients son's concerns about his mother's drowsiness.'

44. The Trust stated it accepts the CPN IPA's recommendations and provided details of the following learning which will form an action plan for sharing with colleagues in other teams:

- The Community Health Team Manager completes routine audits to ensure a care plan is in place and risk assessment is updated;
- Care plans and risk assessments are monitored during managerial supervision;
- An action will be completed and noted at the Directorate Governance meeting in relation to these recommendations which occurred in July 2019;
- Information on medication is given by the prescribing consultant.

45. In relation to the Consultant Psychiatrist's decision to continue the Quetiapine, the Psychiatrist IPA advised *'It is not possible or desirable for consultant psychiatrists to*

see patients every time a treatment decision is made and it is very widespread and accepted practice to make such decisions on the basis of a multidisciplinary team meeting. Indeed, I would suggest that this is an exemplar of good practice. I would regard the Consultant Psychiatrist's actions as entirely reasonable and appropriate.' In relation to the impact of alcohol on the medication, the Psychiatrist IPA advised *'I think that the patient's use of quetiapine should have resulted in an adjustment in her intake of alcohol. Care home records refer to bottles of alcohol and it appears the patient probably was drinking alcohol. The quetiapine had a definitive therapeutic target to relieve distressing visual hallucinations. At the doses used, I think it is unlikely that there would have been a significant interaction between the alcohol and the quetiapine…I am of the opinion that the patient should not have been supplied alcohol if there were concerns about her drowsiness.'* The Psychiatrist IPA concluded that *'…[the patient] was appropriately reviewed by members of the Consultant Psychiatrist's team and appropriate multi disciplinary discussions took place in regard to her medication. I am therefore of the opinion that the Consultant Psychiatrist's care was entirely reasonable and appropriate.'*

Analysis and Findings

46. The complainant said that despite raising concerns with Trust staff about his mother's drowsiness, no action was taken and a decision was made to continue her Quetiapine. As the Trust was not responsible for administrating the patient's medication, this issue of complaint has sought to establish whether Trust staff took sufficient action in addressing the complainant's concerns. As the CPN referred the complainant's concerns to the Consultant Psychiatrist, it has also considered whether it was appropriate for the Consultant Psychiatrist to have decided to continue the patient's Quetiapine on 8 February 2016.

47. From the available evidence, I have found no evidence to substantiate any contact between the complainant and the Consultant in Rehabilitative Medicine on 19 January 2016. I am therefore unable to conclude that he failed to respond on this particular occasion. I also note that the prescription and concern regarding Quetiapine was the responsibility of the Consultant Psychiatrist and the CPN. However I have established that the complainant did contact the Consultant in

Rehabilitative Medicine's secretary on 28 January 2016 and despite a reminder from his secretary on 11 February 2016, he did not return the call. I note he has reflected on this and apologised that he did not respond to the complainant due to work pressures at the time.

48. In considering this issue, I note Standard 33 of the GMC Guidelines, which states that *'you must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'*. The First Principle of Good Administration requires public bodies to *'take proper account of established good practice'*. I consider that by not responding to the complainant's concerns about his mother's condition, the Consultant in Rehabilitative Medicine failed to act in accordance with the First Principle. I am satisfied that this constitutes maladministration. As a consequence of this maladministration, the complainant experienced the injustice of frustration and uncertainty from his attempts to communicate his concerns regarding his mother.

49. I have considered the complainant's view that he disagreed with the Consultant Psychiatrist's decision to continue the Quetiapine on 9 February 2016. The Consultant Psychiatrist has stated that this decision was based on information provided by the complainant, the CPN and Home staff. It is clearly documented in the CPN records that the Consultant Psychiatrist weighed the risks and benefits to the patient from Quetiapine and ultimately it was finely balanced clinical decision. I accept the advice of the Psychiatrist IPA that the Consultant Psychiatrist's actions were reasonable and appropriate. I also accept the advice of the IPA that at the dosages used, it is unlikely that there would have been a significant interaction between the alcohol and quetiapine. I consider no adjustments to her medication were necessary and the primary focus ought to have been to reduce her alcohol consumption. I am satisfied there is no evidence of a failure in care and treatment of the patient provided by the Consultant Psychiatrist in relation to the decision taken to continue her Quetiapine.

50. In relation to the action taken by the CPN to address the complainant's concerns, I acknowledge the CPN kept comprehensive notes of her interactions with the Home and the complainant regarding his concerns. It is clear that the complainant's views

were appropriately referred for discussion at a MDT meeting on 9 February 2016 where the decision was taken by the Consultant Psychiatrist to continue the Quetiapine. I accept the advice of the CPN IPA that the CPN did take enough time and action to address the complainant's concerns regarding his mother's drowsiness. Although I have identified maladministration in relation to the lack of contact from the Consultant in Rehabilitative Medicine, overall I am satisfied that the Trust did take sufficient action in addressing the complainant's concerns. I conclude the actions of the Trust's mental health team were reasonable and appropriate in addressing the complainant's concerns. I therefore do not uphold this issue of complaint.

51. However, the CPN IPA has identified a number of areas where relevant guidelines were not followed by the patient's CPN. The CPN IPA has highlighted the lack of a fundamental care plan that would detail the frequency of visits to the patient. The CPN IPA also advised that the risk assessment was not updated to include the management of her medication, which was not in accordance with the NMC Code. I therefore accept the advice of the CPN IPA that NICE guidelines 76 have not been complied with as there is a lack of a recorded discussion about the patient's medication and side effects with her. Although I am satisfied that the CPN did take timely action to address the complainant's concerns, I consider this points to a reactive instead of proactive approach to the patient's care and treatment. I conclude the lack of a care plan and updated risk assessment constitutes a failure in the care and treatment provided to the patient. I have not identified an injustice to the patient as a result of this failure.

Issue 3: Whether the Trust's investigation of the complaint was reasonable and in accordance with relevant standards?

Detail of Complaint

52. The complainant stated he met with the Trust on 8 June 2016 to discuss his concerns and it agreed to conduct an investigation. He stated the results were shared with him at a meeting held on 27 September 2016 with a written copy and

final letter received on 13 October 2016. He complained that he remains dissatisfied with the Trust's response as he believes it to be a 'complete farce' with no impartial investigation conducted. Instead, he believes the records have been 'simply regurgitated' and 'taken as the truth'. he complained that given his mother died from aspiration pneumonia, the investigation conducted should have been more conclusive and thorough and significant learning and improvements should have been taken forward. He also complained that the investigation report is littered with personal defamatory references to him and other visitors regarding alcohol, which had no relevance to the investigation and were simply included to shift blame.

Evidence Considered

The Complaints Policy

53. I have reviewed the complaints policy which provides an Investigation template for Investigating Officers *'to assist with the audit trail and drafting the response'.* The template outlines what should be included in the findings/analysis and conclusions of the response as follows:

'Findings/Analysis
Check statement/s and reports received for accuracy. Any conflicting information should be identified
Set out the findings in the order they appear in the complaint. Make sure all points are addressed

There is no need to include background information, or past medical history or dates seen or reviewed unless specifically relevant to the complaint
If through contact with the person making the complaint further issues have been raised, please include these in the response being issued.

Conclusions

Set out the conclusions from the findings. You should identify what went wrong, if anything, and why?

You must be able to satisfy yourself that the investigation process was robust and you have gained all the facts necessary to enable you to draft the response

When preparing the draft response:
- Be non-defensive and apologetic, where appropriate
- Do not include any opinions
- Make sure technical language, medical/clinical terms and abbreviations are explained.

Identify recommendations that are to be made as a result of the investigation. Some possible actions have been detailed:

- *No action required*
- *Apologise and offer a remedy*
- *Are there lessons to be learned from the complaint and if so, what action is to be taken*
- *Does the complaint identify a gap in services*
- *Does the complaint identify that policies/procedures need to be tightened/revised*
- *Do staff need training/re-training.*

Complete Summary of Action Form regardless of whether action is taken or not.'

The complaint to the Western Health and Social Care Trust

54. The complainant submitted a complaint to the Trust on 7 March 2016 and outlined the dates via a timeline in which he raised concerns about his mother's sedation and when she was found to be drowsy. According to the complainant, he raised concerns with the Consultant in Rehabilitative Medicine's secretary on 19 January 2016 and with Home staff on 19 and 20 January 2016. He also spoke to his mother's GP on 29 January 2016. On the 31 January 2016, the complainant stated he raised concerns again with Home staff and queried the name of the drug (Quetiapine) and its dosage. He was subsequently contacted on 5 February 2016 by his mother's CPN.

Review of Trust's investigation of the complaint

55. I note from the Trust's timeline of the investigation, it met with the complainant on 8 June 2016. As the Home completed an initial investigation into the complaint, the complainant outlined the issue which he remained dissatisfied with. It was agreed to conduct an investigation into the period from 19 January 2016 to 20 February 2016. I note the investigation team made enquiries of the patient's GP on 28 June 2016 in relation to whether Home staff or the patient's family had raised concerns with the GP between 19 January 2016 and 20 February 2016. The GP replied that he could not see any documentation in her medical records of such concerns being raised. The Trust made further enquiries of the GP on 4 August 2016 seeking clarification on the prescription of Quetiapine and its recommencement on 18 January 2016. The GP replied that the Home contacted the Practice on 29 December 2015 to say the patient *'was drowsy and sleeping constantly-not sure if there is any need for so much medication.'* As a result her Diazepam and Quetiapine was withheld and were subsequently on hold during her stay in hospital with a respiratory tract infection. On 18 January 2016 her Quetiapine was recommenced as he was informed her respiratory symptoms had resolved.

56. I note the Trust's investigation team conducted interviews with Trust staff and Home staff. From the detailed notes of these interviews, I have established the patient's CPN was interviewed on 5 July 2016 and provided an account of her involvement with the complainant's concerns. The CPN stated the patient was unwell in December with a chest infection which may have caused drowsiness and alcohol remained a major issue as the patient still had access to alcohol. The CPN did not believe the dose of Quetiapine she was on would cause drowsiness but noted Baclofen[7] could have a worse effect if alcohol is taken.

57. I also note interviews were conducted with the Home's nursing staff on 5 July and 23 August 2016. A member of staff stated the patient was drowsy at times due to recurrent chest infections and some medications were held back due to sedatives. The family had been advised not to give alcohol which caused issues in the

[7] **Baclofen** is a muscle relaxer and an antispasmodic agent. **Baclofen** is used to treat muscle symptoms; such as spasm, pain and stiffness; caused by multiple sclerosis, spinal cord injuries, or other spinal cord disorders

relationship with the complainant when this issue was discussed. In relation to whether any family member reported concerns to staff that they found the patient drowsy and over-sedated during the stated period, one staff member replied *'Probably so. Would have done observations and contact would be made with GP. If over-sedated, GP called. They would make a decision to change medication.'* One staff member stated she could not recollect and if so would have documented this. Another stated that she *'would have followed it up or taken any action required if Gareth had expressed concerns….Times was drowsy, then not. Not able to highlight reasons. On one occasion she has drowsy, had a chest infection.'* Another member of staff stated *'There was occasions she was sleepy but could be due to a bad night. There was no reason given for this.'*

58. The Trust's investigation team received a report from the Consultant Psychiatrist. He outlined the patient's relevant medical background and his involvement in her care, including an explanation of the rationale for Quetiapine and the changes made to her dosages. The investigation team also received a response from the Consultant in Rehabilitative Medicine on 13 April 2016 acknowledging that the complainant did make contact with him in January and that he apologised in his response for not returning his call. I note an email contained in the Trust's investigation file dated 11 April 2017 entitled 'learning from investigation'. This email from the investigation team noted that ambulance records from the patient's transfer to hospital on 20 February 2016 could not be located from the ambulance service. The email also stated *'A communication to Culmore Manor Nursing home is required following on from the investigation in relation to appropriate recording and filing of documentation. Some information could not be provided to the investigating team in relation to the patient's medication. These issues will be raised at the Reflective Practice Event – twice yearly. The next event is currently being timetabled and the above will be discussed to ensure that the learning is dissmeninated.'*

Trust Investigation Report

59. I note the report outlined the complaint as arising from the meeting on 8 June 2016 in which the complainant requested a further investigation from the 19 January to 20 February 2016 regarding the patient's drowsiness, over sedation, the lack of response from the Home and the MDT in addressing his concerns. The investigation

process involved structured meetings with the social worker, Home staff, and the CPN. Correspondence was also received from the Consultant Psychiatrist and the patient's GP. Available documentary evidence was also examined such as care management records and medical records. The report notes it gathered evidence in response to the complainant's email of 7 March 2016.

60. The report used the timeline provided by the complainant to ascertain whether there was any evidence that he raised concerns in the Home's daily records. The content of these records were summarised in the report. The report also contained references to several instances in the notes where it was recorded that staff were concerned that the patient was being supplied with alcohol by the complainant and other visitors. The report concluded *'Following our investigation we are unable to substantiate the concerns raised in the complaint during 19th January 2016 until 20th February 2016 surrounding the patient's drowsiness, over sedation and lack of response from Culmore Manor staff and the Multi-disciplinary Team.'*

Trust's response to investigation enquiries

61. The Trust explained that the Home Manager had initially provided a report as a response to some of the issues raised by the family, which was undertaken independently of the Trust. The Home Manager and the Trust then jointly met with the family on 8 June 2016 to respond to the issues raised by the family in their initial letter to the Trust's Complaints Department. In relation to the Trust's investigation, it confirmed this was a 'fresh' investigation as the complainant requested a further investigation at the meeting on 8 June 2016, with particular focus on the dates from 19 January 2016 to 20 February 2016. The Trust stated this investigation was to focus on his allegations about the patient's drowsiness, over sedation and the lack of response from the Home staff and the MDT to his concerns. The Trust added this investigation was completed in accordance with the Trust's formal complaints procedure.

62. The Trust stated it did initially consider the issues raised under the Adult Safeguarding procedures but following discussions with the Adult Safeguarding Team it was recommended that the case needed to be considered under the

Regional Serious Adverse Incident (SAI) procedure or via the Complaints process. However following discussion with the Primary Care and Older People (PCOP) staff and the Risk Management Team it was agreed that the concerns raised should be addressed under the Trust's complaints process. The Trust further stated a comprehensive investigation was undertaken by staff in PCOP to investigate the complainant's concerns. This involved a comprehensive review of available documentation in the Home, care management records, medical records and hospital admission records. The team also arranged structured interviews with nursing home staff, social work and CPN staff and received reports from the Consultant Psychiatrist and the patient's GP.

63. The Trust was asked to explain why despite mentioning Trust staff in his complaint, there was no reference to the actions of Trust staff in the investigation report. The Trust responded that under the Trust complaints procedure the concerns the complainant raised were investigated within the timeframe he had indicated in his outlined concerns. This involved a review of all the records of the Trust and also structured interviews with Trust staff and reports provided by Trust staff as part of this investigation. In relation to why the investigation report did not refer to a letter received from the patient's GP, the Trust stated the information was considered as part of the investigation as the GP was contacted directly to provide a response to some of the complainant's issues. The Trust added the GP's letter and his response formed part of the investigation process and the GP subsequently met with the complainant and Trust representatives when the final report was shared with the family.

64. In response to enquiries, the Trust stated during the course of the investigation the team was unable to secure some of the medication charts relating to the patient's time in the Home. The Home was unable to provide an explanation of what happened to these records and it was unable to locate them. The Trust stated the investigation team had visited the Home several times to interview the staff and had requested this information but Home staff were unable to locate these records. The Trust acknowledged that this information related directly to the medication prescribed during the time period and therefore would have been significant for the team to have reviewed as part of the investigation.

Analysis and Findings

65. The complainant raised concerns about the thoroughness, impartiality, conclusions and lack of learning identified by the Trust's investigation. He also complained about the references in the report to alcohol which he did not feel to be of relevance to the investigation. I consider the report clearly captured the complaint and outlined its intentions to investigate his specific concerns during the stated time period. The Trust's complaints policy indicates the standard expected from the response, including the completion of an investigation template. I have found no evidence that the Investigation Team completed this template. I acknowledge the Trust has provided evidence of its investigation in the form of detailed notes of interviews with staff and a review of the nursing home records. However following the template would have provided an audit trail of the Trust's investigation and ensured the response was drafted according to the necessary standards.

66. The complaints policy investigation template also outlines what should be contained in the findings and conclusions. I am critical that the report did not contain any analysis of the evidence presented and therefore contained no particular findings. In regards to the conclusions, the policy states *'You should identify what went wrong, if anything, and why? You must be able to satisfy yourself that the investigation process was robust and you have gained all the facts necessary to enable you to draft the response.'* However the report did not acknowledge that the investigation team were unable to locate the patient's full medication records. The Trust has accepted that these records would have been significant as they related to the time period under investigation. The report therefore does not state that its conclusions were limited due to these missing records.

67. In addition, the report does not refer to the patient's medication regime such as an explanation of her dosages of Quetiapine, which I consider was central to the complaint. the Consultant Psychiatrist provided this information to the investigation team in a detailed report and was acknowledged by the investigation, however the contents of the Consultant Psychiatrist's report is not referred to in the report. I consider this information would certainly have been useful in explaining the rationale

of the patient's prescription of Quetiapine and that the Consultant Psychiatrist did not believe the dosages would have caused her drowsiness. Furthermore, although the complainant specifically referred to raising concerns with the Consultant in Rehabilitative Medicine, there is no reference in the report that the Trust had sought information from the Consultant in Rehabilitative Medicine and that he apologised for not returning his call. This information was provided to the Trust in April 2016, which was before the meeting with the complainant on 8 June 2016. I am critical that the Trust failed to communicate this to the complainant at this meeting or include it in the investigation report. This should have also provided an opportunity for learning for both the Consultant in Rehabilitative Medicine and the Trust.

68. In relation to the references to alcohol in the report, I consider this reflected the evidence contained in the nursing notes and the concerns raised by staff regarding the impact of alcohol on the patient. It is clear this issue was a long standing issue between the Home and the complainant. The report cited examples in the nursing notes and did not seek to offer opinion on the issue. I therefore consider it had relevance to the issues under investigation and was appropriate to be included in the report.

69. In relation to the complainant's view regarding the lack of learning identified in the report, as stated previously the report did not include the account provided by the Consultant in Rehabilitative Medicine. Furthermore, this investigation has established that the Trust did identify learning during its investigation as a result of missing information which had significance to the investigation. The Trust stated that communication was required to the Home and would be discussed at a learning event. Although this email dated 11 April 2017 postdates the investigation report, the investigation team were nonetheless aware of the missing information during the investigation. It is therefore unclear why this issue was not noted in the investigation report.

70. I consider there is evidence that the Trust conducted a thorough investigation by seeking information from the relevant sources. However the subsequent investigation report does not fully reflect the evidence obtained and contains a number of significant omissions. In relation to whether these failings amount to a lack

of impartiality or bias as suggested by the complainant, the Oxford Dictionary definition of bias describes it as an *"Inclination or prejudice against one person or group, especially in a way considered to be unfair."* I do not accept the complainant's view that the Trust's investigation was unfairly biased against him. It is important to consider the distinction between actual bias and perceived bias. Actual bias is rare and most cases are concerned with the appearance of bias. I have found no evidence of actual bias in this particular Trust investigation and I have found no evidence to doubt its impartiality. However I have found a number of areas where improvements could be made.

71. In terms of the conclusion reached by the report, I consider this lacks detail and does not provide sufficient reasons for the decision reached. Ultimately I conclude the report does not fully address the complainant's complaint and therefore lacks the necessary thoroughness as required under the Trust's complaints policy. It also contained a number of significant omissions. I consider that decisions taken within any procedure need to be reasonable, well-reasoned, fully evidenced and transparent. The third principle of Good Complaints Handling requires public bodies to be 'Open and Accountable' by providing honest evidence-based explanations and giving reasons for decisions. The fourth principle of Good Complaints Handling requires public bodies to 'act fairly and proportionately' by ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case. The fifth and sixth Principles of Good Complaints Handling requires public bodies to acknowledge mistakes and apologise where appropriate and to use all feedback and the lessons learnt from complaints to improve service design and delivery.

72. I conclude that the Trust conducted a thorough investigation however the report produced did not fully answer the patient's complaint. In light of these errors, I am satisfied that the Trust failed to meet the requirements of the third, fourth, fifth and sixth Principles of Good Complaints Handling, which constitutes maladministration. As a consequence, the complainant experienced the injustice of uncertainty and frustration regarding the Trust's investigation. I therefore uphold this issue of complaint.

CONCLUSION

73. I have investigated the complaint and I have not found a failure in care and treatment of the patient in relation to the dosage of Quetiapine. I have also found that the complainant's concerns about the level of sedation administered to his mother were adequately addressed by the Trust. However I consider it a failure that the Consultant in Rehabilitative Medicine did not respond to the complainant's concerns about his mother's condition. I am satisfied that the maladministration I found caused the complainant to experience the injustice of frustration and uncertainty from his attempts to communicate his concerns with the Consultant in Rehabilitative Medicine.

74. I have also found a failure in care and treatment in aspects of the planning of the patient's care namely; (1) the lack of a fundamental care plan that would detail the frequency of CPN visits to the patient (2) the risk assessment was not updated to include the management of her medication. I also found no evidence that the CPN routinely monitored her medication and side effects. I have not identified an injustice to the patient regarding these failures.

75. I have found the Trust appropriately investigated the complainant's complaint. However I found deficiencies in the reporting of the outcome of the complaint investigation which I consider constitutes maladministration. The complainant experienced the injustice of uncertainty and frustration regarding the Trust's investigation as the response to his complaint did not clearly set out the evidence and reasons for the Trust's decision.

Recommendations

76. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to him as a result of the maladministration identified (within **one month** of the date of this report).

77. In relation to service improvements, the CPN IPA had identified areas where she

considered the Trust could improve its practice. The Trust indicated its acceptance of these issues as learning from the complainant's complaint and its intention to implement these. I will follow up with the Trust regarding these recommendations to ensure they have been implemented (within **three months** of the date of this report).

PAUL McFADDEN
Acting Ombudsman **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.