Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Homecare Independent Living

NIPSO Reference: 17919

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The Role of the Ombudsman

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

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

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

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

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

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

Reporting in the Public Interest

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

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

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EXECUTIVE SUMMARY

I received a complaint about the care provided to the complainant's late mother by Homecare Independent Living (HCIL).

Issues of Complaint

I accepted the following issues of complaint for investigation:

1. Whether the care planning, risk assessments and HCIL staff training were in accordance with relevant standards?
2. Whether the care provided by HCIL was appropriate, reasonable and in accordance with relevant standards, specifically on the 22 February 2015 to 25 February 2015?
3. Whether HCIL's communication with the family was appropriate and reasonable?

Findings and Conclusion

The investigation of the complaint identified failures in the care and treatment of the complainant's mother in respect of the following matters:

i. Failure to arrange suitable staff training

ii. Failure to document and record care plans, risk assessments and reviews

iii. Failure to comply with Minimum Standards and HCIL policies

The investigation also identified maladministration in respect of the following matters:

i. Failure to secure client records

ii. Failure to consider and address matters as a complaint

I am satisfied that the failures and maladministration I have identified caused the complainant to experience the injustice of distress, frustration and anxiety at the HCIL failures identified above. She also experienced the injustice of the lost opportunity to have her concerns dealt with as complaints and investigated.

Recommendations

I recommended:

- The complainant should receive a written apology from the HCIL Chief Executive for the failures identified in this report and a payment of £500 by way of solatium for the injustices I have identified. The apology should reflect my guidance on issuing an apology available at www.nipso.org.uk.

In order to improve the service delivery of the HCIL:

- I recommended that:

(i) HCIL conduct a review of its all its policies and procedures related to 'falls' and service failures, with a particular focus on clarity of policy and procedure, training of staff and record keeping. This relates to policies: Assessment, Care planning and review; Assessment of Risk in the client's home; Manual Handling Policy; Management of risks associated with care of individual clients; Reporting adverse incidents; Complaints and Training and Development. The review should specifically address the human rights of service users in all relevant aspects.

(ii) HCIL should provide this office with a report of the outcome of the review within three months from the date of my final report. The report should include an action plan indicating responsibility for implementing recommendations and timescales.

(iii) HCIL should provide me with an update on implementing the action plan within six months of the date of my final report.

HCIL accepted the findings and recommendations of my report.

THE COMPLAINT

1. The care provided to the complainant's late mother (the patient) was commissioned by the Northern Health and Social Care Trust (NHSCT) from HCIL, an independent healthcare provider. There was a separate complaint relating to the actions of the NHSCT in carrying out its investigation of events following the care provided. In order to fully investigate the matter, HCIL was informed in July 2017 that I wished to consider its role in the provision of domiciliary care to the patient. During care assistant visits to provide personal care, she had sustained two episodes of 'falls[1]', on 22 and 24 February 2015, while being raised to a standing position with a stand aid device. She was admitted to hospital on 25 February 2015 with a dislocated shoulder and died just over a week later from a heart condition.

Background

2. The patient was 81 years old and had a number of pre-existing medical conditions. She is noted as having a history of heart disease, stroke and diabetes. It is noted that she had plates inserted in both arms from old injuries and while unable to walk any distances, was able to weight bear with assistance for a short time. She had a wide family circle who regularly visited and stayed with her but she made clear she wanted to retain a level of independence by continuing to live in her own home. Some of her family lived in the immediate vicinity of her home. Her package of domiciliary care had been in place for a number of years and had been increased as assessed needs increased. By February 2015 the domiciliary care package was by way of four visits each/every day to assist with getting out of bed, personal hygiene, toileting, dressing, meals, sitting in a chair and returning to bed. The visits can generally be broken down as breakfast, lunch, tea and night visit. Each visit was carried out by two domiciliary health care assistants from HCIL who were to carry out designated tasks.

[1] The term fall is widely used in the documentation of this complaint as here. A more careful exposition of the mechanics of each incident will be detailed later in the report.

3. The NHSCT provided the patient with a number of community services including occupational therapy, community nursing and, centrally for the purposes of this investigation, domiciliary care[2]. The provision of domiciliary care is contracted by the NHSCT to an independent provider, in this case HCIL. It is important to understand the complex overlay of responsibilities of each of the parties in the provision of domiciliary care. The NHSCT is responsible for assessing and reviewing the need for domiciliary care. This is usually coordinated by a Trust social worker as the designated key worker. The key worker would involve other specialist services, such as occupational therapy or community nursing, as necessary in conducting the assessment of what aspects of domiciliary care are required. The assessment leads to a care plan being written and provided by the Trust to the care provider. The care provider is contracted by the Trust to provide the care according to the care plan. The contract between the Trust and care provider deals with issues such as staff training, care agency regulation and standards, referral arrangements, service requirements and untoward events/Serious Adverse Incidents. There is a substantial body of standard paperwork and forms routinely generated in the course of the arrangement and recording of domiciliary care both by the Trust and the care provider. A copy of the 'Home File' is retained at a patient's home and should contain a copy of the relevant care plan, risk assessments and daily report sheets where care assistants record details of their care and other relevant information including any patient health issues.

4. I note the dates of relevant key events as:

28 July 2014:	completion by the Trust of the patient's manual handling risk assessments and care plan
4 December 2014:	completion of HCIL client review form
6 January 2015:	Trust domiciliary nursing care review
22 February 2015:	1st 'fall' incident: night care call approx. 7.45pm

[2] Domiciliary care is defined in the legal contract as the provision of personal care and associated domestic services…necessary to maintain…measure of health, hygiene, safety and ease.

24 February 2015:	2nd 'fall' incident: tea care call approx. 2.15pm
24 February 2015:	No record of night care visit
25 February 2015:	Meeting: Complainant with HCIL Managers and Trust Occupational Therapist (OT) to discuss events, with patient in bed.
25 February 2015:	Patient admitted to hospital
27 February 2015:	Complainant informs Trust of hospitalisation after 'falls'
27 February 2015:	Trust communicates with HCIL regarding 'service failure'
27 February 2015:	HCIL open Quality Improvement Form
6 March 2015:	Patient dies in hospital
13 March 2015:	HCIL closes Quality Improvement Form

Issues of complaint

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

   i. Whether the care planning, risk assessments and HCIL staff training were in accordance with relevant standards?

   ii. Whether the care provided by HCIL was appropriate, reasonable and in accordance with relevant standards, specifically on the 22 February 2015 to 25 February 2015?

   iii. Whether HCIL's communication with the patient's family was appropriate and reasonable?

INVESTIGATION METHODOLOGY

6. This complaint raises issues of maladministration and failings in professional judgment. By virtue of section 15(2)(b) of the Public Services Ombudsman Act (NI) 2016, I can investigate the merits of a decision of a body to the extent that it was taken in consequence of the exercise of professional judgment on social care. The Investigating Officer obtained from HCIL all relevant documentation together with the HCIL's comments on the issues raised by the complaint.

7. The Investigating Officer obtained the documentation generated in the course

of the NHSCT investigation of this matter under its serious adverse incident procedure. The records of the Northern Ireland Ambulance Service Trust, regarding the two attendances with the patient on 22 and 24 February 2015 and the audio recordings of the calls, were also obtained. The Investigating Officer also obtained the patient's home file from the complainant.

8. The Investigating Officer arranged to interview three care assistants who had provided domiciliary care on 22 and 24 February 2015 when the 'falls' occurred. One of those interviewed was no longer employed by HCIL. The fourth care assistant who attended and was no longer employed could not be located. He also interviewed the HCIL Area Manager, the HCIL Quality and Training Manager and he visited the HCIL Head office to look at its computer records system. The Investigating Officer spoke with the complainant, and her three sisters, all of whom lived close to their mother, to obtain details of their interactions with HCIL staff and ambulance staff on 22, 24 and 25 February 2015. He also attended a demonstration of the Sabina II Model 'sit to stand aid' type device[3] and the Delta Hoist[4] of the types used in the patient's home, and a number of photographs were taken of the devices to assist in the investigation.

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

   A Nurse Practitioner, (Dip Asthma, Dip COPD, Dip Advanced Diabetes Care) – the 'Care IPA'.

   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.

10. A copy of the draft of this investigation report was shared with the complainant,

[3] Sabina II Model type 2020003 Manufactured by Liko-AB Sweden used with a compatible Liko Safety Vest.
[4] A mobile, electric hoist used to lift and transfer persons from a seated or lying position, or to and from the floor

HCIL and named persons for comment.

11. 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.

12. The general standards are the Ombudsman's Principles[5]:
    (i) The Principles of Good Administration
    (ii) The Principles of Good Complaints Handling
    (iii) The Public Services Ombudsmen Principles for Remedy

13. The specific standards are those which applied at the time the events occurred and which governed the exercise of the professional judgment of the individuals whose actions are the subject of this complaint and the administrative policies of HCIL. The specific professional and regulatory standards relevant to this complaint are:
    (i) The Domiciliary Care Agencies Regulations (Northern Ireland) 2007[6] - ('2007 Regulations')
    (ii) RQIA Domiciliary Care Agencies – Minimum Standards[7] - ('Minimum Standards')
    (iii) DHSSPS NI Guidance for complaints in Regulated Agencies 2009[8]
    (iv) Medicines and Healthcare products Regulatory Agency Alerts[9] (MHRA Alert)
    (v) Liko Sabina II Instruction Guide[10]
    (vi) Operational Protocol for Service/Quality Failures – NHSCT/14/844

[5] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[6] http://www.legislation.gov.uk/nisr/2007/235/pdfs/nisr_20070235_en.pdf
[7] https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Standards/domiciliary_care_standards-Aug-11.pdf not 2007 as noted in the Trust contract.
[8] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20Complaints%20-%20Guidance%20on%20Complaints%20Handling%20in%20Regulated%20Establishments%20Agencies.pdf
[9] http://webarchive.nationalarchives.gov.uk/20080609151118/http://www.mhra.gov.uk/PrintPreview/PublicationSP/CON017981
[10] http://www.liko.com/Documents/na/raising/Sabina/Sabina_II/SabinaII_InstrG_EN.pdf

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

MY INVESTIGATION

Issue 1: Whether the care planning, risk assessments and HCIL staff training were in accordance with relevant standards?

Detail of Complaint

15. The complainant alleged that there were failures in care by HCIL and its staff in relation to two 'falls' which her mother sustained in her home on 22 and 24 February 2015. In particular, she complained that the HCIL failed to complete care plans, risk assessments and to retain same within the 'Home File' records retained in her mother's home. She also complained about the adequacy of domiciliary care staff training relevant to the specific Sabina device used to raise her mother to a standing position [Sabina II].

16. I note that in relation to contractual and HCIL policy requirements, the Care IPA advised:

'Summary:

- *Client reviews were not monthly*
- *The moving and handling risk assessment was out of date*
- *Daily evaluations did not clearly identify the type of equipment used [for transfer].'*

In relation to the care planning and risk assessment provided to the patient, the Care IPA advised:

'*The moving and handling risk assessment and associated care plan dated 28.07.2014 lacks clarity.*

… If the care plan was explicitly clear, care staff would have been more likely to use the hoist in this situation

In regard to the training of staff and training standards. The Care IPA advised:

'…it is noted that there was uncertainty expressed within the staff statements with regards to the training that carers received on the use of the Standaid. Furthermore, there is no documented evidence that staff were taught how to use the Standaid prior to use.

…There is thus an emphasis on the individual carer identifying their own training needs rather than HCIL anticipating such training needs. RQIA guidance implies that it is the organisation that should identify their staffs' training needs and arrange to meet them.

… HCIL have in-house trainers that can cascade the training down to staff on specific pieces of equipment. This refers to 'train the trainer' whereby a senior member of staff will be taught how to use a piece of equipment rather than it being included in mandatory training. This would sufficiently address individual training needs provided that HCIL have a system in place to identify individual staff training needs rather than relying on staff to 'report to the office'. HCIL should have documented evidence that the training took place.'

17. I note in the contract between the Trust and HCIL:

'1.6.2 …[HCIL] must employ for the purposes of this contract only such persons as are careful, skilled and experienced in the duties required of them and must ensure that every such person is properly and sufficiently trained and instructed…'

'[Special Conditions]…[HCIL] will comply with the 2007 Regulations and Minimum Standards'

'3.2.1…[HCIL] should ensure that staff have appropriate understanding/received training in respect of clients who have specific needs.'

'3.6.1A member of …staff employed in a supervisory capacity is required to make contact with the service user on a monthly basis and receive updates to review the delivery of domiciliary services as part of their quality assurance system.'

'3.8 …[HCIL] must have procedures for reporting untoward events/serious

adverse incidents and matters in accordance with Trust Policy.'

18. I have considered the RQIA Minimum Standards referred to at paragraph 13, and in particular Standards 6, 8, 9, 10 and 12. I also note the content of the HCIL policies on: Assessment, Care planning and review; Assessment of Risk in the client's home; Manual Handling Policy; Management of risks associated with care of individual clients; Reporting adverse incidents; and Training and Development.

19. In response to investigation enquiries, HCIL commented on its care planning and staff training stating:

> *…[patient's] care plans were up to date... had been reviewed twice yearly. …Although we would not routinely attend reviews…(refer to contract)…we therefore consider it to be the Trust's responsibility to conduct reviews. …there is no requirement to provide training for each specific type of hoist that is or could be used in the provision of our services. We have therefore complied with our statutory obligations in this regard.*

20. The Investigating Officer interviewed relevant HCIL staff. During the investigation, interviews were conducted with three staff caring for the patient. It was confirmed that they had each received induction training. This training included practical manual handling using hoists. However care assistant staff could not confirm they had been provided with any formal training on the Sabina device in the patient's home. The staff confirmed they were familiar with the Sabina device from previous visits to the patient and other clients. The Area Manager and Quality Manager when interviewed also confirmed that specific training on the Sabina device was not routinely provided to staff. I have considered the specific instruction manual for the Sabina device which states:

21.

> ***'Important***
> ***Read the instruction guide for both the patient lift and lifting accessories before use. Lifting and transferring a person always involves a certain level of risk. It is important to completely understand the contents of the***

instruction guide. The equipment should be used by trained personnel only.' [Emphasis within document]

22. I refer to the history of Medical and Healthcare Products Regulatory Agency Alerts which states in respect of a 2008 alert:

'Action:
•Ensure that all posture/safety belts for seating, stair lifts, hoists and wheelchairs are fitted, adjusted, ***used,*** *cleaned, checked and maintained* ***in accordance with the manufacturer's instructions.***
•Ensure that guidance on how to check, adjust, clean and maintain each posture/safety belt is passed on to the user or carer.
•Before each use, ensure that the posture/safety belt is in a satisfactory condition, is appropriate for the user, and is adjusted correctly.
•Ensure that reviews of an individual's needs includes consideration of the appropriateness of the posture/safety belt for the user and carers.
•Report any inadequacies in the manufacturer's instructions to the MHRA'
[Emphasis Added]

23. I note with concern that the original home file held in the patient's home which would have contained daily sheets, care plans, risk assessments and daily contact sheets was not secured or retained by HCIL. However, copies of some of the documentation which would have been held within the home file have been provided. There was no audit by HCIL of the home file contents conducted at any stage after the falls in February 2015. The home file was the property of HCIL and contained records of the care and interactions of HCIL staff with the patient.

Analysis and Findings

24. In considering the adequacy of the care planning risk assessments I am seeking to determine HCIL compliance with its own policies and the Minimum Standards. This is of significance with regard to the conduct of reviews of care, reviews of risk assessments and staff training. The HCIL policy on Assessment and Reviews states:

'*Review*
Homecare will agree a review schedule with the client upon completion of the initial Care Plan and complete at least two reviews per year however the

client is entitled to request a review at any time. The Trust/HSE will be invited to attend the Review. The review will take into account the manner in which care has been delivered, whether it is meeting the objectives which were set at the beginning, and any changes which have taken place in the client's overall needs assessment.
The client and/or their representative will also be able to share their views on the service and formulate recommendations for improvement to the service.

Reviews with the referring Commissioner
Homecare Management will also participate in review meetings with Trust /HSE personnel or provide a written report on any matters regarding the current care plan; general changes in the client's situation and details of important events including incidents or accidents occurring during the review period.'

25. I refer to HCIL records which do not provide evidence that HCIL carried out an assessment of the risks in the provision of the patient's care package in accordance with its policy on 'Assessment of Risk in the Client's Home' with regard to the frequency of checking and reviews. As I have noted, the patient's home file was not secured or retained by HCIL. There are no records available of a risk assessment review for 2010, 2011 and 2013. A risk assessment review was undertaken on 28 July 2014. However, subsequently, there is no further review after the January 2015 NHSCT nursing review. I consider this is a failure in the care and treatment. The regular updating of risk assessments is part of the continuous provision of safe care to the patient. I also must consider the failure to comply with the HCIL policy on 'Assessment of Risk in the Client's Home' and the first principle of the Principles of Good Administration 'Getting it Right': which requires a public body to follow internal policy guidance. **I consider this failing also amounts to maladministration and I uphold this element of the complaint.**

26. I consider that the available HCIL records do not establish that HCIL carried out care package reviews in accordance with its 'Assessment, care planning &

review' policy. There are no records provided of a care package review in 2013, 2014 or after the NHSCT nursing review on 6 January 2015. As reviews and monitoring of care plans play a crucial role in ensuring a patient or service user gets the appropriately adjusted care which meets the required standard I consider that the failure to evidence such a practice with the patient amounts to a failure in care and treatment. I also consider this is a failure to comply with the HCIL policy on 'Assessment, care planning & review'. The first Principle of the Principles of Good Administration 'Getting it Right' requires a public service provider to follow its own internal policies and guidance. I consider this failing by HCIL to follow its own policy amounts to maladministration. **I uphold this element of the complaint.**

27. I note that HCIL confirmed in response to investigation enquiries that the patient's home file had not been retained by HCIL. The HCIL policy on Recording and Recording Care Practices Records states:

'Transfer of records

Client's records remain the property of Homecare even though they are kept in the client's home. The Community Manager/Client Manager will be responsible for removing these records periodically during assessments. The records will be transferred to head office for safekeeping in accordance with Data Protection. When a client's package ceases the Community Manager will collect the records and these will then be transferred to head office.'

28. I consider that the failure to retain the patient's home file raises serious concerns. Since she is deceased the Data Protection Act 1998 legislation did not apply. However, the care records of a deceased person are and remain confidential. The failure to secure and retain confidential records by HCIL is a matter for my Office. This failure to secure and retain confidential records means there is no possibility of definitively reviewing its contents. This is a significant failure to maintain records in compliance with the HCIL policy on 'Recording and Reporting Care Practices'. The third Principle of Good Administration 'Being open and accountable': requires a public service provider

to protect information and records. The patient's return from hospital was unknown following her admission on 25 February 2015. However, appropriate steps ought to have been taken to secure and retain her home file and its contents. I consider this failing to amount to maladministration. **I uphold this element of the complaint.**

29. I note the responses of the care assistant staff regarding informal or undocumented training and HCIL managers that staff are not trained in specific equipment including the Sabina device at induction but may acquire training or familiarity with the equipment over time with other patients. I have also considered the HCIL response to investigation enquiries that specific training is not required by the Minimum Standards. I consider that the information provided by HCIL in relation to staff training and the responses of the care staff involved with the patient clarifies that HCIL failed to comply with the HCIL policy on 'Manual Handling', which states:

'Equipment
Care assistants are not permitted to use a piece of equipment they have not received training in how to use. They are advised to contact the office to arrange training.'

30. I have also considered the Sabina device manufacturer instructions and MHRA Alert. The Care IPA advised:

'Staff training on all moving and handling equipment should be documented. HCIL should identify any equipment used by their clients that is not covered in mandatory training and ensure that individual staff members are trained in its use.'

The first Principle of Good Administration 'Getting it Right': requires a public service provider to follow internal policy guidance. **I consider this failing in evidencing training to amount to maladministration and I uphold this element of the complaint.** It is apparent that there is confusion on the part of HCIL regarding the overlap of its contractual obligations with the Minimum

Standards and its own documented internal training policy. I will refer to this issue in my recommendations at the conclusion of this report.

31. In respect of the failures in care and treatment and maladministration identified above regarding care planning, risk assessment and training I consider that the patient has suffered the injustice of distress, frustration and anxiety at the HCIL failures to provide appropriate training to staff and document care planning and risk assessment reviews in accordance with its internal guidance. Had this documentation been available it would have been possible for the complainant to see that up-to-date assessment and monitoring of her mother's care had taken place. I will deal with the remedy in the conclusion of my report.

32. **Issue 2: Whether the care provided by HCIL was appropriate, reasonable and in accordance with relevant standards, specifically on the 22 February 2015 to 25 February 2015?**

Detail of Complaint

33. The complainant believes that the falls experienced by her mother were related to the failures in care provided by HCIL. After considering the documents that she had obtained from the NHSCT and HCIL she believes that there are deficiencies in the accounts given by care staff of what happened to her mother, how those matters were documented and the actions that were taken by HCIL.

34. In the course of the investigation HCIL provided copies of the following:

<u>22 February 2015 fall incident</u>
two Notification of Accident/Incident forms: one from each care assistant present
(one marked received 26 February 2015; other undated)
two handwritten statements: one from each care assistant present
(one marked received 9 March 2015; other undated)

24 February 2015 fall incident:

two Notification of Accident/Incident forms: one from each care assistant present

(one marked received 26 February 2015; other undated)

two handwritten statements: one from each care assistant present

(Both undated)

Subsequently one care assistant from each of the above visits was interviewed by staff involved in the NHSCT serious adverse incident investigation. I obtained summary notes of those interviews.

35. I note that the care assistants completed Notification of Accident/Incident forms after the incidents. These were not retained in the patient's home file. It appears from interviews with staff they were forwarded to the HCIL Area Manager at her request in the days following the requests.

36. From the documentation provided by HCIL there are four handwritten statements, one from each of the care assistants present at the two incidents. The statements are basically a narrative of the recollection of each person. They were completed on request by HCIL management and provided up to two weeks after the incidents based on the date of receipt marked on some them, as they are not dated with the date of completion. Each visit is also recorded in summary form in the daily Report Sheet that is intended as a continuous record of care. The Daily Report Sheets for the two visits on 22 and 24 February 2015 have been provided, as well as the records for the surrounding days. I note that the Daily Report Sheet with the entry for the final call on 24 February 2015 is not available from HCIL. I refer to my finding at paragraph 27 regarding securing and retaining these records.

37. As part of the investigation three of the four care assistants were interviewed individually for the purposes of establishing their actions, HCIL training, knowledge of HCIL policies, and recollections of the incidents. The Investigating Officer also sought to establish involvement with HCIL

management and any discrepancies within and between staff accounts.

38. From the two staff involved in the fall on 22 February 2015 only one care assistant was interviewed as the other, had left HCIL employment and could not be traced. One account was consistent of the patient weakening while in a standing position raised with the Sabina. The care assistant was using her knee to attempt to support her and she 'broke her fall' to the ground. Her accounts make clear that procedures were followed of contacting HCIL's office, seeking medical assistance from the Ambulance service and subsequently assisting with getting the patient into bed using the Delta hoist that was in her home. One care assistant recorded that the patient may not have been fully aware of events during the period of the fall as she was unable to remember how she got onto the floor.

39. In relation to the 24 February 2015 incident which occurred at the second call that day, the first care assistant provided consistent descriptions of the patient complaining of a sore shoulder and arm before being hoisted and during the handling to hoist her out of the chair the patient again complained about her shoulder. The care assistant states she appeared to lose her grip and slipped out of the hoist (vest) onto the floor, in an upright seated position. The HCIL office was informed by the care assistant and medical assistance summoned from the Ambulance service. The care assistants helped ambulance staff to lift the patient into her chair before she was hoisted to bed using the Delta hoist.

40. The second care assistant's account of the fall on 24 February 2015 was consistent that the patient 'slid through the sling' used to circle around her torso and lever against the Sabina device.

41. I have noted the number of relevant HCIL policies which deal with the issues associated with the task of manual handling (hoisting by equipment) of a patient as referred to at paragraph 18

42. I also note that the NHSCT introduced an 'Independent Sector Provision of Domiciliary Care Services – Operational Protocol for Service/Quality Failure' Protocol in December 2014.

43. I have obtained the documentation generated in accordance with the NHSCT and HCIL contractual relationship. The falls on 22 and 24 February 2015 were considered to be service failures within the terms of the contract and procedures under the contract determined that a Quality Improvement Form[11] was generated to record events and actions taken to deal with matters.

44. I note that the response of HCIL to investigation enquires dated 18 August 2017, regarding the actions of care assistants in February 2015, stated:

'Our care assistants are acutely aware of their responsibility to service users and they would not have hoisted [the patient] if she was in any pain or discomfort as a result of using the hoist.

… We acknowledge that there were improvements that we could have made in relation to documenting our communication with the Trust…we have adopted the learning alert…'

Independent Professional Advice

45. I note that the Care IPA has advised:

'moving and handling plan dated 28.07.2014 (page 49 HCIL part 2) states under 'Summary of main tasks and action': If [patient] is feeling weak/tired Delta hoist with extra large full body sling to be used to transfer her onto bed for personal care and hygiene. Then on the same plan, under 'activity': Transfer from + to bed to chair using delta hoist; then under 'details of method and equipment': Delta Hoist and extra large sling (illegible word in brackets above this) to be used to transfer [patient] from bed to commode/ chair (when required).

Using terms such as 'when required' is open to interpretation and thus could be taken differently by different carers. This would increase the risk of harm being sustained during the transferring of [the patient] as the Standaid could be used when she was unwell instead of a hoist.

[11] The Quality Improvement Form procedure is provided for in the Trust/HCIL contract as a log of actions regarding a service failure. It also appears in the Trust operational protocol to report service failures. It also appears in the HCIL 'Reporting of Adverse and Serious Adverse Incident' policy. It therefore may have 3 possible iterations.

…

Care staff documented within their evaluations that prior to the falls [the patient] looked unwell. Despite this they persisted in using the Standaid. If the care plan was explicitly clear, care staff would have been more likely to use the hoist in this situation.'

Analysis and Findings

46. I have considered the issue of the care and treatment of the patient on 22 and 24 February through the assessment of the records generated and the steps taken to follow HCIL's own relevant policies. I note that the events of late February 2015 are now some 42 months old. In the intervening period the Trust dealt with a Serious Adverse Incident investigation which concluded in March 2017. I have dealt with a complaint arising from the NHSCT actions and do not wish to cover that aspect in any way in this report.

47. I consider that there is some confusion in this matter caused by the overlapping of the contractual relationship between the Trust and HCIL. The contract merely engages the legal relationship between the Trust and HCIL to provide services to patients. The terms and procedures of the contract are not a replacement for and do not supersede the fact that HCIL as a care provider has an independent responsibility to patients and should comply with its own documented policies.

48. Those responsibilities are outlined in the Domiciliary Care Regulations and the Minimum Standards. The Regulation and Quality Improvement Authority[12] (RQIA) has a statutory responsibility to ensure those Minimum Standards are met. As part of Minimum Standards requirements HCIL are required to have in place a range of policies to cover its work and operation. Some of those policies, in so far as relevant to this complaint, are as outlined at paragraph 18 above.

49. From my examination of the records of the Daily Report Sheets, Notifications of Accident forms, statement/interviews and Ambulance Service records it is not

[12] https://rqia.org.uk/who-we-are/about-rqia/

possible to determine exactly when and how the patient sustained a dislocated shoulder. The limited medical assessment conducted by the ambulance paramedics did not identify an injury and she declined to be taken to hospital after the two falls. I appreciate that is a cause of some frustration for the complainant and the wider family that the cause and timing of the injury cannot be confirmed with more clarity. I consider that the handling of this matter over the significant period of time that has elapsed has exacerbated their frustration.

50. It is clear from the HCIL internal guidance that several steps should have been taken prior to the first fall on 22 February 2015. In the Minimum Standards, Standard 6 outlines:

'6.1 The agency participates in review meetings organised by the referring HSC Trust…
6.2 Staff from the agency attend review meetings or contribute by submitting a report…'

The HCIL policy on assessment, care planning & review section on 'Reviews with referring Commissioner', relates to Standard 6 and I consider in this complaint there are no written records to establish that either the Minimum Standard or the HCIL policy was complied with in the months prior to the February 2015 incidents. There are no records of HCIL staff attending reviews conducted by the Trust in July 2014 and January 2015. There are also no records of HCIL preparing a report for either review. There are no records of HCIL initiating a review with the Trust, inviting the Trust and arranging the complainant or her mother to attend under the terms of the HCIL policy on reviews. I consider this contravenes the first Principle of Good Administration (Getting it right: acting in accordance with policy and guidance) and the third Principle of Good Administration (Being open and accountable: keeping proper and appropriate records). This is a failure of the management within HCIL. **I consider this failure amounts to maladministration and I uphold that element of the complaint.**

51. I consider that the complainant has suffered the injustice of distress, frustration and anxiety at the HCIL failures to follow the Minimum Standards and its internal policies.

52. Following the Trust reviews and assessments in July 2014 and January 2015, HCIL policies on Assessment Care Planning and Review dictate actions on the part of HCIL staff. I consider that the July 2014 care plans completed by the Trust and the Nursing review on 6 January 2015 ought to have alerted HCIL of the need to be aware of the patient's declining ability to weight-bear. The policies make clear that changes in health and physical condition necessitate action by HCIL. There are no records of adequate action by HCIL to address this issue.

53. In response to the patient's fall on 22 February 2015, HCIL policies on Manual Handling, Assessment, care planning & review, Management of risks associated with care of individual clients required that matters ought to have been reported both internally and externally to the Trust. There are no records of adequate action by HCIL to address this issue to comply with the policy. This could have had an impact on whether the patient's daily regime was altered and she was only hoisted to/from bed or nursed in bed until further review. She was nursed in bed until further review was agreed when HCIL managers met with her and the family on the morning of 25 February before her hospitalisation. This decision ought to have been made earlier in accordance with HCIL policies.

54. There are records of reporting by care assistant staff to HCIL centrally. However, there is no evidence of, or records of actions taken, at that time by HCIL management. Although HCIL stated that the Trust was informed by its office of the first incident on 22 February 2015. I note that HCIL state both incidents individually were reported to the Trust when they had occurred, there are no records provided by HCIL to substantiate that reporting. In the log of communications obtained from the NHSCT there are no records of the reporting of the first fall on 22 February 2015 or the subsequent fall. At a later point, a process of raising a 'Quality Improvement Form' was begun by HCIL.

This was in response to a notification of a service failure by the Trust. This is a process within the contract with the Trust related to a service failure. It is also governed by the Trust Protocol referred to in paragraph 11. Completion of the form was begun after both falls had taken place and the patient had been admitted to hospital. Although the Quality Improvement Form is also referred to in the HCIL 'Reporting of Adverse & Serious incidents policy' it is clear from the timing of the opening of the form and actions recorded that it was generated as part of the contractual process and not in compliance with the HCIL policy. Other steps in the policy were not taken including raising such a form specifically after the first fall. The form was originated only after reporting by the complainant to the Trust on 27 February 2015.

55. I accept the Care IPA advice, outlined at paragraph 44, relative to the care plan. Specifically, the advice confirming that had the care plan been sufficiently clear that the care assistants would have been more likely to have used the hoist and not the Sabina, in one or both situations on 22 and 24 February 2015. It is not possible to determine the exact timing of the shoulder injury therefore I cannot connect that lack of clarity, on the balance of probabilities, as the key factor in causing the injury.

56. I consider that HCIL did not comply with Standard 8 of the Minimum Standards: 'Management systems and arrangements are in place that support and promote the delivery of quality care services' in respect of the failures outlined at paragraphs 45 and 46. Specifically I refer to Minimum Standard criteria 8.3 and 8.16 which state:

'8.2 The registered manager ensures that all staff are familiar with, and work in line with the agency's policies and procedures, and any revision thereof.
8.16 All accidents and any incidents occurring when an agency worker is delivering a service are reported as required to relevant organisations in accordance with legislation and procedures. A record of these is maintained for inspection.'

I also consider that HCIL failed to implement and record the relevant actions required by those parts of the policies referred to in paragraph 45 such as notification to the Trust or Northern Ireland Adverse Incident Centre of incidents involving equipment. There is no clarity in the HCIL policy on actions to be taken by HCIL staff following consideration of an incident as a 'serious adverse incident'. HCIL failed to follow and record actions taken in compliance with the Minimum Standards and its own policies. I consider this does not meet the first Principle of Good Administration: 'Getting it right' which requires a public body to act in accordance with policy and guidance. It also fails to meet the third Principle of Good Administration: 'Being open and accountable' by the failure of a public body to keep proper and appropriate records. I am satisfied that HCIL care assistant staff took initial action in accordance with its policy to ensure the patient's safety and to seek medical assistance. However, there are no records of action by HCIL management to subsequently fully follow their policies. **I consider this failure amounts to maladministration and I uphold that element of the complaint.**

57. As a result of the failings I have identified, I am satisfied that the complainant has suffered the injustice of distress, frustration and anxiety at the HCIL failures to follow the Minimum Standards and its internal policies. I will deal with the remedy in the conclusion of my report.

Issue 3: Whether HCIL's communication with the family was appropriate and reasonable?

58. The complainant stated that HCIL did not engage effectively with the family following her mother's falls. This relates in particular to knowledge of what had happened to her mother, what action were taken in response and the outcome. I have taken account of the fact that no formal complaint was made to HCIL by the complainant. I therefore exercised my discretion to investigate the complaint in July 2017, under section 24(2) of the 2016 Act.

59. I note the contents of the Minimum Standards state:

Quality care

Having a caring, open and responsive approach where the service user feels respected as an individual and his or her needs are being met is key to the delivery of quality services. These minimum standards for domiciliary care agencies promote the empowerment of service users and strongly encourage a proactive engagement and a listening partnership with each service user to ensure they feel involved in and can influence the operation of the agency. The use of both informal feedback mechanisms and more formal arrangements with service users and gaining carers' and relatives' views about the services provided, listening to and responding to compliments, comments and complaints will provide managers and staff with essential information about improvements that can be made.

I also note the contents of Standard 15 in the Minimum Standards which states:

'Standard 15: All complaints are taken seriously and dealt with promptly and effectively.

15.1 Agencies should operate a complaints procedure that meets the requirements of the HPSS Complaints Procedure and is in accordance with the relevant legislation and DHSSPS guidance.'

Analysis and Findings

60. I have considered the records of communication between the complainant's family and HCIL. I note that members were not asked to attend and were not present during the December 2014 review by HCIL. However HCIL have provided a review form indicating the review took place. It is clear from the available records that the family were informed in the immediate aftermath of both falls on 22 and 24 February 2015. This was communicated to them by telephone from HCIL's office and care assistant staff. It is also clear that there was some interaction with the complainant in relation to a meeting on 25 February 2015 to assess any changes needed in her mother's care.

61. Subsequent to the falls, HCIL were aware of the patient's hospitalisation from 25 February 2015, as a result of telephone calls with the Trust on 27 February

2015. The Trust document that they communicated the complainant's dissatisfaction with what had occurred. The Trust also contacted HCIL on 6 March 2015 to confirm the patient's sad death and the complainant's dissatisfaction with HCIL's care and treatment of her mother.

62. The records also evidence that the Trust had taken steps from 6 March 2015 to inform HCIL that an investigation under the Serious Adverse Incident process was to begin.

63. The Regional Guidance on Complaints Handling in Regulated Establishments and Agencies (2009)[13] clarifies that complaint information can come from next of kin or commissioners of services such as the Trust in this instance. There are no records of HCIL considering any issue that had been raised as a complaint or seeking guidance from NHSCT on raising a complaint. There was also no communication with the complainant to ascertain if she was making a complaint.

64. The HCIL policy on reporting adverse incidents includes guidance on reporting complaints, raising a QIF internally in response to an incident and management in reporting incidents to relevant bodies. However, the policy is unclear as to the nature of the investigation and the overlap with HCIL's complaints and serious incident policy.

65. Despite the sensitivity of the circumstances surrounding the death, HCIL surprisingly took the view that it had no obligation to engage with the complainant or the family. While HCIL was aware of significant issues that the complainant was raising about the care of her mother from as early as 27 February 2015 it is difficult to comprehend why it took no further action other than the QIF required under the Trust contract/protocol. These serious issues were not recorded as a complaint and no records exist of any consideration of this matter as a complaint. I am uncertain as to HCIL's consideration of this serious matter due to the absence of records. If there was consideration of the

[13] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20Complaints%20-%20Guidance%20on%20Complaints%20Handling%20in%20Regulated%20Establishments%20Agencies.pdf

family concerns and a decision not to treat them concern as a complaint there are no records of these considerations. This omission is a failure to apply the Minimum Standards at Standard 15 and the first Principle of Good Administration 'Getting it right' that requires a public body to act in accordance with policy and guidance and the third Principle of Good Administration 'Being open and accountable' that requires a public body to keep proper and appropriate records. I consider this failure amounts to maladministration and I uphold this issue of complaint.

66. As a result of this maladministration, I am satisfied that the complainant has suffered injustice. Injustice in this case is evidenced by the obvious distress, frustration and anxiety. The complainant also suffered the injustice of the lost opportunity to obtain answers by having a complaint investigated by HCIL. I will deal with the remedy in the conclusion of my report.

CONCLUSION

I have considered a complaint about the actions of HCIL in dealing with care provided to the complainant's late mother. The investigation identified failures in the care and treatment in respect of the following matters:

i. Failure to arrange suitable staff training
ii. Failure to document and record care plans, risk assessments and reviews
iii. Failure to comply with Minimum Standards and HCIL policies

The investigation also identified maladministration in respect of the following matters:

i. Failure to secure client records
ii. Failure to consider and address matters as a complaint

I am satisfied that the maladministration I have identified caused the complainant to experience the injustice of distress, frustration and anxiety at the HCIL failures identified above.

Recommendations

I recommended:

- The complainant should receive a written apology from the HCIL Chief Executive for the failures identified in this report and a payment of £500 by way of solatium for the injustices I have identified within **one** month from the date of my final report. The apology should reflect my guidance on issuing an apology available at www.nipso.org.uk.

In order to improve the service delivery of the HCIL:

- I recommended that:

(i) HCIL conduct a review of its all its policies and procedures related to 'falls' and service failures , with a particular focus on clarity of policy and procedure, training of staff and record keeping. This relates to policies: Assessment, Care planning and review; Assessment of Risk in the client's home; Manual Handling Policy; Management of risks associated with care of individual clients; Reporting adverse incidents; Complaints and Training and Development.

(ii) HCIL should provide this office with a report of the outcome of the review within **three** months from the date of my final report. The report should include an action plan indicating responsibility for implementing recommendations and timescales.

(iii) HCIL should provide me with an update on implementing the action plan within **six** months of the date of my final report.

I am pleased to record HCIL have accepted the findings and recommendations of this report.

Marie Anderson

MARIE ANDERSON
Ombudsman **February 2019**

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.