Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 201915573 & 201916339

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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

Case References: 201915573 and 201916339

Listed Authorities: Independent HSC Provider - Private Nursing Home and The Western Health and Social Care Trust

I received a complaint concerning the actions of the Trust and a Home in relation to the care and treatment received by a care home resident.

I determined to issue a composite report of the investigation of this complaint to allow for a comprehensive investigation of the totality of the complaint and to provide a maximum opportunity for learning for both the Home and the Trust. I found a failure in the care and treatment received in relation to the following matters:

In respect of the Home

1. a failure to adequately involve the family in the preparation of pre admission assessments and care plans
2. a failure to notify the GP of weight loss and to consider a referral to a dietitian
3. a failure to maintain a satisfactory standard of record keeping with regard to the resident
4. a failure in the completion of a falls diary
5. a failure to request external specialist advice in relation to the level of falls experienced
6. a failure, following discharge from hospital on 30 January 2017, to update risk assessments or the care plan or to document other safeguards to minimise injury caused by falls.
7. a failure to respond to a triggered resident's alarm
8. a failure following a fall on 6 February 2017 to carry out appropriate observations, including using the Glasgow Coma Scale, for a period of 24 hours or of seeking medical advice following a head injury.

In respect of the Trust

9. a failure to initiate a care review or to take action to address the relationship with social work involvement, following the meetings of 10 February 2017 and 2 March 2017

Following my investigation I made a number of recommendations to both the Home and the Trust which are detailed at the conclusion of this report.

THE COMPLAINT

1. The complaint concerns the actions of both a private nursing home (the Home) and the Western Health and Social Care Trust (the Trust) when providing care and treatment to the complainant's late husband (the resident), during his residency in the Home between 12 October 2016 and 20 March 2017, when he sadly passed away.

2. The complaint against the Trust relates to how the Trust dealt with a complaint regarding the care and treatment received by the complainant from the Home.

3. As the issues of complaint are interlinked I decided to produce a composite report so the resident's journey could be fully understood and the maximum potential for learning highlighted. Consequently, this report sets out my investigation of the involvement of each body in the care of the resident and includes my consideration of the action taken by the Trust in dealing with the subsequent complaint.

Issues of complaint

4. The issues of complaint which I accepted for investigation in relation to the Home were :

Issue 1: Communication between the Home and the family, both on discharge from Hospital and when formulating the resident's care plan;
Issue 2: Monitoring of the resident's weight loss:
Issue 3: Record keeping;
Issue 4: Management of falls; and
Issue 5: Heating of the resident's room.

In relation to the Trust the issues I accepted for investigation were
Issue 6: The Trust's management and investigation of the complainant's concerns; and
Issue 7: the actions of the Trust's social worker

INVESTIGATION METHODOLOGY

5. In order to investigate the complaints, the Investigating Officer obtained from the Trust and the Home documentation on the relevant guidance and policies relating to the care received by the resident, together with the Trust and the Home's comments on the issues raised by the complainant. The Investigating Officer also obtained a copy of the Trust's complaints file, the Home's assessment and care records and a copy of the medical GP records.

Independent Professional Advice Sought

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

- Independent Nursing Advice (N IPA) from a Practising Consultant Nurse specialising in care for frail older people across, Community and Care Home settings;
- Independent Social Work Advice (ISWA) from a former Executive Director of social work with 40 years operational experience delivering health and social care services across all programmes of care in Northern Ireland HSC Trusts.

The clinical advice I received is enclosed in Appendix four to this report.

The information and advice which informed my findings and conclusions are included within the body of my report. The IPAs provided me with 'advice'; however how I 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. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[1]:

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

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

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

8. The specific guidance relevant to this complaint are:

- DHSSPS-" Quality ,Improvement and Regulation (NI)Order 2003;
- HSC Complaints Procedure –Regional Guidance-"Complaints in HSC ;Standards and guidelines for resolution and learning (April 2004) updated Oct 2013;
- "Best Practice Best Care"-2002;

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

- Quality Standards for HSC-Supporting good governance and best practice in HPSS(2006);
- HPSS (NI)Order 1994;
- The Mental Health (NI)Order 1986 –;
- The HPSSs(NI) Order 1972;
- The Chronically Sick and Disabled Persons (NI)Act 1978;
- The Disabled Persons (NI)Act 1989;
- The Carers and Direct Payments (NI)Order 2002;
- Mental Capacity Act (NI)2016-Deprivation of liberty safeguards(2019);
- Care Management Provision of Care and Services DOH Circular 2006 / 2010;
- People First –Community Care in NI 1995;
- Guidance on Discharge Protocol;
- Care standards for nursing homes;
- "Home Truths" Commissioner for Older People NI report –June 2018;
- Safeguarding Vulnerable Adults –Regional Adult Protection Policy and Procedural Guidance (Sept 2006);
- Safeguarding Vulnerable Groups (NI)Order 2007;
- Adult Safeguarding "Prevention and Protection in Partnership"(July 2015);
- Department of Health (DoH) Audit of Safeguarding referrals in care homes;
- 10,000 Voices" Experience of Adult Safeguarding"(4.12.18)PHA;
- "Power to the People"-Expert panel recommendations;
- Reform of Adult Care and Support;
- HSCB policy on Self Directed Support;
- Northern Ireland Social Care Council(NISCC) Standards of practice; and
- SCIE Building the evidence base for adult social care – Nov 2014
- The Nursing Care Home Minimum Standards 2011 (the minimum standards 2011)
- NICE Clinical guideline [CG161] (Published date: 12 June 2013) *Falls in older people: assessing risk and prevention.*

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

INVESTIGATION

Issue 1: Formation of the care plan and communication with the complainant on her husband's discharge from Hospital

Detail of Complaint

10. The family complained of poor communication between anyone involved in the care of the resident and the family about both his discharge from hospital and in the formulation of care plans for his continued care. The family said that contrary to responses received indicating that preferences were discussed, the resident did not have the capacity to communicate on any matter.

The Home and Trust response

11.The Trust response to the complainant of 19 October 2018 stated that the resident's *'formulation which noted family preferences was used to form the basis of [his] care plans, however it has been accepted that family should have been involved in the formation of care plans.'.* Following the Trust's investigation, the Home stated that it developed a new care prescription policy, which *'began a project to encourage consultation with all families on the care of their loved ones within (the Home).'* It stated that *'leaflets were designed and printed to encourage engagement and nursing staff were educated in the consent and consultation process. Supporting documentation was devised to enable and empower relatives to acknowledge their consultation with the care prescribing process and further to direct them to channels available including advocacy services if they require additional support in understanding best interests decisions in prescribing of care by nursing staff.'*

Relevant Independent Professional Advice

Nursing IPA

12.The N IPA provided me with details of the relevant guidance issued by NICE and RQIA which outline that a Home has a '*clear responsibility make a pre-assessment to identify needs, to identify whether the resident has capacity to make decisions specific to discharge or to communicate regarding discharge with the resident and when appropriate their family or carer.'* The N IPA did not find any entry in the Home records or in the pre-assessment document that a discussion with the resident or relatives had been held. '*There is no direct evidence that that the Home discussed any aspects of the transfer (*from hospital to the Home on admission) *with relatives*…' The N IPA advised that there should have been a recorded discussion with the Home manager and the resident /family regarding his long term needs and preferences. While the pre assessment document evidences that some information was obtained, its source was not recorded. The N IPA also advised that she would have expected to see some record of mental capacity assessment, even if only from the Home manager.

13. In relation to the formulation of care plans, the N IPA advised that overall care plans were developed in a timely way, however she stated that they should have recorded evidence of the involvement of the resident/family in the development and review of care plans, incorporating decisions made. The N IPA advised that she did not see evidence of this, the implication of which was that the resident's needs and preferences may not have been understood in detail by the Home.

Social Work Advice

14. The ISWA advice largely mirrored the N IPA advice. She advised that ' *At the core of the divergence between the care home and the perception of the resident's family of the care provided and how risks were to be managed, was the lack of family involvement in the care plan formulation following the resident's admission to the care home. An effective care planning process at commencement of the placement would have acknowledged the family as experts in the resident's care having experience of directly providing care and support to the resident prior to and during his admission to hospital. In addition, effective care planning would have provided a*

shared narrative in regards to needs, risks and how the personalised care plan agreed for the resident would mitigate any risks. As the resident's care needs changed there should have been active review and amendment of the care plan as required which again should have had the involvement of the resident's NOK and family carers. The care home should routinely involve family in the admissions and care plan process.'

Analysis and findings

15. I agree with and accept the independent professional advice which I received in connection with this issue of complaint. This advice has revealed a lack of appreciation on the part of the Home of the necessity, contained within all of the relevant guidance, of securing the involvement and participation of family members or carers in the preparation of pre admission assessments and care plans for residents. It is evident throughout the whole complaints process of how this issue of the family feeling excluded from the care planning process spilled over into dissatisfaction and disgruntlement over the overall care and treatment a much loved family member was receiving while resident in the Home. I consider that the optimum care and treatment of residents in care home settings is best achieved when family members can feel that they are working in partnership with the facility providing the care, rather than a feeling being allowed to develop whereby they feel that they are outsiders looking in, with limited input. After all, the development of a partnership spirit in the provision of care assists all involved. The Home benefits from tapping into the knowledge of the family/carers, often built up over years providing the care that the Home is now taking over, of the residents' needs and preferences. The family experiences the benefit of feeling that their input to the care of their loved one is of value and that they continue to play an important role in the care provided, following the often difficult and emotional decision to relinquish their hands of the day to day caring role when placing a family member into a Home.

16. The disconnect the family felt in this case, and the level of their non-involvement in the making of decisions regarding their husband and father, is best summed up for me in the fact that the family felt compelled to ask the Trust to investigate who was consulted regarding the resident's preferences in such mundane matters as

shaving and choice of footwear. The Trust response acknowledged that the family preference to bring shaving equipment with them and to shave the resident nightly themselves was not adhered to and that while the Home assessment was that the resident preferred to wear shoes, the footwear provided by the family was trainers, which the resident then wore. The Trust investigation also revealed that the Home did not issue a written invitation to the family to consult in the care plans as this was not then common practice. The Home apologised for this and stated that learning would be taken from this and an action plan generated.

17. I consider that the failure to adequately involve the family in the preparation of pre admission assessments and care plans, which also included a failure to complete any form of mental health assessment as highlighted by the N IPA, to represent a failure in the care and treatment received by the resident. As a result, I consider this failure caused the resident the injustice of loss of opportunity regarding his care and treatment. I further consider this failing to have caused the complainant the injustice of upset, distress and uncertainty regarding the level of the care and treatment which the resident received.

18. I deal with the remedy and my recommendation in the conclusion of this report.

Issue 2: Monitoring of the resident's weight loss:

Detail of Complaint

19. The complainant said that the Home did not record the resident's weight regularly or accurately.

The Home and Trust response

20. The Trust stated that the Home's new manager, *'has implemented more stringent managerial audits to ensure that weight loss monitoring amongst other areas of care are regularly audited against their standard of monthly completion.*' The Home stated that it subsequently has developed a policy on the management of nutrition and weight loss.

Relevant Independent Professional Advice

21. The N IPA advised that the Care Home monitored the resident's *'nutritional status and weight appropriately up to December 2016.'* As per the Care Standards, she advised that the Care Home applied '*the MUST tool (Malnutrition Universal Screening Tool)'* monthly, *'following measurement of [the resident's] weight and calculation of his Body Mass Index (BMI).'*

22. The N IPA advised that the resident was weighed on:

- *13 October 2016 (63kg, BMI = 24, MUST = 0)*
- *29 October 2016 (61.8kg, weight loss 1.2kg, MUST = 0)*
- *26 November 2016 (62.5kg, weight gain 0.7kg, MUST = 0)*
- *[Unclear date] December 2016 (60.8kg, weight loss 2.2kg (cumulative total), MUST = 0)*
- *[Unclear date] 2017 (57.35kg, weight loss 3.45kg), MUST = 1)*

23. As per the MUST score guidance, the N IPA advised that there *'was a significant weight loss of 3.45kg (5.4%) since December 2016'.* She advised that the resident's *'total weight loss during the above period from admission to the home was 5.65kg, which is just under 9% weight loss.'* As per Standard 12.12 of the Care Standards, the N IPA advised that she would *'expect to see a referral to the [resident's] GP following identification of the weight drop to 57.35kg.'*

24. The N IPA advised that the resident had two hospital admissions between 31 December 2016 and 30 January 2017, and again in February 2017. The N IPA advised that *'it is likely a monthly weight in January might have been missed.'* However, she advised that the Care Home '*should still have taken action as soon as weight loss was identified. This includes notifying the GP and considering a referral to the dietician for advice. I did not find any evidence from the care home or GP records that a dietician referral had been prepared.'*

25. The N IPA also advised that the resident's *'nutrition care plan was drawn up on 12 October [2016]. It is regularly evaluated on a monthly basis, with a gap for January 2017, during the time that [the resident] was in in hospital.'* She advised that the subsequent entry for 4 February 2017 notes *'weight loss ? due to hospital*

admission' and advised that on 13 February 2017 '*the care plan is updated to "thickened fluids".'*

Analysis and Findings

26. The advice which I have received is clear that the Home's monitoring of the resident's nutritional status and weight was generally appropriate from admission on 13 October 2016 until December 2016 and that the correct validated tool (MUST) was used. The Trust response to the complainant stated that the resident spent considerable periods of time during January and February 2017 in hospital. The Trust also advised that it was *'unacceptable'* that the resident's weight was not taken on a more regular basis and that there were missed opportunities for obtaining his weight when he was a resident of the Home and not a hospital inpatient.

27. The N IPA advised that between the period December 2016 and January 2017 when the resident was weighed he had lost 3.45kg (5.4%). When measured against the weight the resident recorded on admission on 13 October 2016 this represented a weight loss 5.65kg, just under a 9% overall weight loss. While I accept that some weight loss might be experienced during periods of illness or hospital admission, using the MUST score guidance any unplanned weight loss over 5% in the previous 6 months is significant. Care Standard 12.12 requires care home staff to report any significant weight loss to a medical practitioner. I accept the advice of the N IPA that the Home, in January 2017, once the weight loss was identified should have notified the GP and should have considered a referral to a dietitian. This did not happen. I accept the statement in the Trust response that there is no evidence that the resident suffered malnutrition or dehydration as a result, however this does not take away from the fact that it should have been recognised by the Home that the resident had experienced a significant weight loss from admission to the Home which should have been actioned. I consider the failure to notify the GP of this weight loss and to consider a referral to a dietitian to represent a failure in the care and treatment received by the resident which caused an injustice of loss of opportunity regarding his care and treatment. I further consider this failing to have caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment which the resident received.

28. I deal with the remedy and my recommendation in the conclusion of this report.

Issue 3: Record keeping:

Detail of Complaint

29. The complainant said that poor practice in record keeping is evident by the Home throughout this complaint and is referred to in the response from the Trust. However the complainant believed that the tone of the Trust's response and the remedies proposed are inadequate. For example, on the issue of failure to monitor and keep records of weight loss, the Trust states merely that this has been communicated to the Home's management. However, the complainant also noted on several occasions records of observations were made for the resident when he was not in the home. The complainant therefore disagreed with the Trust recommendation that is only necessary to remind staff that records should be completed only when the resident is present.

The Home and Trust response

30. The Trust response to the complainant of 19 October 2018 contains several admissions from the Home and apologies for instances of poor record keeping regarding the falls diary, weight monitoring, dietary preferences, podiatry, the failure to update care plans and the updating of records and care plans while the resident was in hospital. In response to the observations made of the resident when he was not present in the Home, the Trust stated that there was an *'internal review of the staff nurse responsible'.* It was also accepted that there was no record of the resident trying to leave the building on 28 October 2016. The Trust recommendations in response to its investigation of the complaint included that staff receive training in record keeping through a formal supervision with the Home manager.

Relevant Independent Professional Advice

31. The ISWA advised that '*There are a number of individual incidents of poor recording practice and lack of robust auditing procedures by the care home which the Trust's complaint response acknowledges. In regards to the issue that care home observations were recorded when the resident was not in the home, the care*

home and Trust response focused on the staff nurse responsible for updating the resident's care records rather than the need to seek assurance about wider practice and leadership in the home…..There is no recognition in the Trust's response of the accumulative impact of the range of shortcomings acknowledged or any analysis about whether this was common practice in the home rather than isolated to this resident…..'

32. Concerning entries being made in Home records when the resident was in hospital, the N IPA advised that these entries '*are irrelevant, because the resident was in hospital at the time. In fact the records should have been updated once he was transferred back to the care home so that appropriate and up to date care could be delivered. Although the entries state that he "remains in hospital" there is no indication about the source of information or other evidence to support it. It is extremely unlikely that the nurse had been to the hospital to make a personal assessment, but they have not indicated whether they contacted the hospital or who provided the information. This is poor record keeping.'* Such entries are contrary to the NMC Code of Conduct in that Nurses are required to:

6.1 - make sure that any information or advice given is evidence-based, including information relating to using any health and care products or services

10.1 - complete all records at the time or as soon as possible after an event, recording if the notes are written sometime 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

Such record keeping is also contrary to the RQIA Standard on management of records which requires homes to ensure that:

1. The information held on record is accurate, up-to-date and necessary

33. The N IPA advised that any entries made when the resident is not there fail to meet these standards as they cannot be verified as accurate or up to date. They are also '*not necessary*.'

Analysis and findings

34. The complainant said that adequate and accurate record keeping should be an essential and fundamental requisite of providing care. I totally agree with the complainant's view. If a situation develops whereby confidence is lost that the records maintained in a care home or hospital are accurate, reliable or up to date, then the provision of the requisite standard of care becomes infinitely more difficult. In a care home setting, with multiple members of staff working in shifts, there is a clear need to have accurate and reliable information recorded concerning incidents and procedures carried out previously so that continuity of care can be maintained.

35. The Trust's response to the complainant details a number of incidents of poor record keeping about the resident which the Home has acknowledged and apologised for. The independent professional advice which I received confirmed this. The N IPA, in commenting on the fact that records were maintained at a time when the resident was not physically present in the Home while in hospital, stated that these records were *'irrelevant'* and *'not of a reasonable standard'.*

36. I accept this advice and consider that the failure to maintain a satisfactory standard of record keeping with regard to the resident to represent a failure in the care and treatment received. I consider this failure to constitute a threat to the provision of continuity of care to the resident, thus causing him the injustice of uncertainty. I also consider this failing to have caused the complainant the injustice of upset, distress and uncertainty regarding the level of the care and treatment which the resident received.

37. I deal with the remedy and my recommendation in the conclusion of this report.

Issue 4: Management of falls:

Detail of Complaint

38. The complainant said that the resident suffered a number of falls while in the Home and was concerned that more was not done to prevent such occurrences happening so regularly. The complainant is particularly concerned regarding the

Home's actions following a fall on 6 February 2016.

The Home and Trust response

39. At the time of the resident's residency, the Home stated that *'there was no access to a community "falls team" in the [Trust]. Staff reported that that they did not have any prior deals with nor contact access to the "Trusts Falls Occupational Therapist".'* The Trust stated that its Falls Occupation Therapist *'did not have input into private nursing homes at this time'.* However, it stated that a *'Falls Co-ordinator has [since] been appointed and work is ongoing with the newly established Nursing Home In-reach Team to provide training and awareness in falls prevention.'* As part of this training, the Trust advised that evidence of monitoring following a fall is required.

40. In addition, the Home stated that *'its falls management policy in respect of the Home was updated after the complaint was investigated… and it was acknowledged that this was an identified area for improvement.'* It stated that *'this policy has since been tested by the Trust and found to be robust.'*

41. The Trust's response to the complainant acknowledged that a Glasgow Coma Scale assessment was not completed and stated that it had recommended that all Home staff received updated training on falls.

Relevant Independent Professional Advice

42. Regarding the fall on 6 February 2016 the N IPA advised that the Home records includes a body map which identifies a red mark to the resident's right temple. *A Falls Diary in the Care Home Records records that at 19:30 "Found on floor in fellow residents room…small red mark on front right side of head". The Daily communication Record for that date records that "fell in a residents room. He was found lying half on ground and upper half of body on floor. Small red mark noted on front R side of head. Please monitor. Obs BP 116/60, SpO2 97%, HR 68, Temp 36. Walking fine following this. Please continue to monitor". There is no further record of monitoring or observations taken.*

43. Subsequently on 07 February 2016 the entry at 02:56 states "At approximately 21:00 hours last night, the resident's wife approached me and said she was not happy about how he looked. On examination he was very lethargic and twitching various body parts", the entry outlines the subsequent actions which included taking vital and neurological signs, calling 999.

44. The N IPA advised that the actions of the Home following this fall were not appropriate. *Following a suspected head injury, NICE guidance[3] recommends using the Glasgow Coma Scale (GCS) to assess for signs of altered state of consciousness or other neurological signs and that immediate medical advice should be sought. The care home did not follow this guidance. The Resident had signs of potential head injury (red mark on temple) but there is no record of full examination, or of ongoing observations following the set of obs that were taken at the time. There is no record of Glasgow Coma Scale (GCS) or NEWS. There is no record that the care home contacted the GP or out of hours service for advice on further management until the next day. They should also have informed the resident's family at the first opportunity.*

45. In addition the N IPA advised that the resident was not appropriately monitored following this fall. '*Although an initial set of observations were taken these did not included standard neurological observations using the GCS. The observations should have been repeated during the period that the care team were awaiting medical advice. The care team did not follow published guidance that was available at the time'.*

46. This guidance consisted of

I. RQIA Care Standard 9 which requires a post-falls review to be carried out within 24 hours of a resident sustaining a fall to determine reason for falling and any preventative action to be taken. There is no record that this was done.

[3] Head injury: assessment and early management

II. NICE Clinical guideline [CG161] (Published date: 12 June 2013) *Falls in older people: assessing risk and prevention.* This recommends multifactorial risk assessments to prevent falls for people living in the community and in hospital.

III. The associated Quality statement 4: *Checks for injury after a fall* specifies application of a post-fall protocol which includes reference to the frequency and duration of neurological observations for all residents where head injury has occurred but cannot be excluded. There is no record of a post-falls protocol being applied.

47. The N IPA advised that the Home had developed a care plan for the resident "is at risk of injury due to high falls" dated 14 November 2016. This gave a broad management plan including "appropriate footwear" and other nonspecific safety statements. The resident's falls risk assessment score was recalculated monthly and was consistently assessed at 'medium risk'. These basic measures would have been sufficient to flag up falls risk to the care team but do not give detailed advice on preventative interventions. There is no record of expert advice being sought or provided. The N IPA did not find evidence of falls prevention strategies or resources to support staff in resident falls prevention.

48. The ISWA commenting on the Home's management of falls and its policies advised that '*The home's care Policy on the prevention of falls and policy on the management and treatment of falls do not appear to have been effectively integrated at operational level. The policy states "All falls must be documented on an incident form, daily evaluation notes, risk assessments, monthly care prescription evaluation, falls diary and next of kin and key worker must be informed as soon as practicable. Unwitnessed falls must be treated as suspected head injuries. A Glasgow coma assessment score must be included If head injury suspected and the resident not transferred to hospital; observations must be completed." When a risk of falling is identified, a detailed care plan must be drawn up to include; involvement of resident and family in the care planning process including education about hazards and risks. Consider involvement of HSCT healthcare professionals where appropriate. Consider referral to a local falls prevention team (where it exists) The care home*

policy does provide appropriate guidance and prompts the care home staff to seek external expertise to assist in the management of falls'.

Analysis and findings

49. It is evident from an examination of the resident's medical history that he had vascular dementia, had a history of wandering within the Home and a significant history of falls. I note that the Home records document that he suffered three falls in December 2016 and three in February 2017. The resident had also spent much of January 2017 in hospital following a fall in the Home on 30 December 2016. I note the advice of the N IPA who advised that the resident's care plan, completed in November 2016, stated that he was at risk of injury due to falls and that his falls risk assessments had been completed monthly during his residency. The resident had been consistently assessed as being at 'medium risk'. I accept that assessments were properly carried out on a regular basis giving consideration to the resident's risk of falling up to at least January 2017 and from these assessments the Home was aware of the potential of the resident to experience a fall.

50. Before giving consideration to this issue of complaint I should state that I recognise and accept that there is a high incidence of falls in hospital and nursing home settings with ill, elderly residents experiencing proportionately more falls than other age groups. I also accept that not all falls can be prevented, no matter what strategies are put in place and that residents can and do fall, even at times when a carer is present and by their side. Furthermore given the resident's diagnosis of vascular dementia which can decrease a resident's perception of risk, his physical condition and age, it is likely he was always at an elevated risk of falling.

51. Nonetheless while I accept that the policies regarding care plans and risk assessments regarding the potential of experiencing a fall were in place, I also accept the ISWA advice I received which concluded that these policies do not appear '*to have been effectively integrated at an operational level.*'. I comment on the management and treatment of a particular fall in following paragraphs, however prior to that I note examples of what I consider to be a failure of the Home in the care and treatment received by the resident concerning falls management and prevention.

1. The Home's care policy on the prevention of falls and its policy on the management of falls states that '*all falls must be documented on an 'incident form, daily evaluation notes, risk assessments, monthly care prescription evaluation, falls diary*….' The Home accepts that the falls diary did not accurately reflect all of the falls. I consider this to represent a failure in the care and treatment received in that if the totality of the falls experienced by a resident is not accurately recorded and recognised, this can impinge upon the evaluation of risk and the potential to put mitigating measures in place.
2. The ISWA advice and N IPA advice both noted that there was no record of expert external advice being sought by the Home on this issue, despite the fact that its falls management policy referenced the requirement to do so. Whilst the Trust confirmed that it did not have a specialist falls team in place at that time (it now does) I consider that given the high levels of falls experienced by the resident, that specialist advice could and should have been sought by the Home of Trust professionals such as an Occupational Therapist, to ascertain if strategies existed to minimise risk. This would have represented an opportunity to raise awareness of risk and to demonstrate to the family that their concerns were being taken seriously. I consider this failure to request external advice to represent a failure in the care and treatment afforded by the Home to the resident.
3. I note that the Trust investigation into the complainant's concerns discloses that upon discharge from hospital on 30 January 2017 the resident's care needs were evaluated, however there was no evidence of updated risk assessments or that the care plan was updated. Additionally while a crash mat was put in place, I note no other safeguards were documented to minimise injury caused by falls. I consider these to represent a failure in the care and treatment afforded by the Home to the resident in that care plans and risk assessments were not updated to represent an evolving situation. It is the case that at the end of January 2017 the resident had spent a month in hospital having experienced three falls in December 2016. A failure to update care plans or risk assessments reduces their effectiveness and currency.
4. The Trust response to the complainant acknowledges that on one occasion the Home staff did not respond to a triggered alarm mat, as they were aware

that the family were with the resident. The Trust response stated that it was '*unacceptable*' that staff did not follow the Home's alarm procedures and that the presence of a family member should not override alarm procedures. I agree with the Trust's assessment in this instance and consider a failure to respond to a triggered resident's alarm to represent a failure in the care and treatment afforded by the Home to the resident. This factor again would have diminished the confidence of the family in the care the resident was receiving in the Home.

52. The complainant raised concerns over the management of the resident's condition following falls while in the Home. In particular she remains concerned about the resident's fall on 6 February 2017, just over a month prior to his death. I note that the resident had suffered a number of falls prior to this occasion. In the record of this incident it was noted that the resident had been found on the floor in a fellow residents room with a '*small red mark on the R(ight) side of head*.' Observations were taken at the time and it was noted '*walking fine following this. Please continue to monitor.'* I note the N IPA advice that there is no further record of monitoring or observations taken.

53. Having considered all the circumstances relating to this issue of complaint including the independent professional advice received, I have come to the conclusion that the fall experienced by the resident on 6 February 2017 was an unfortunate incident for which I am unable to attribute a single cause. It is possible that the resident's physical condition and dementia were factors, or that his tendency to experience seizures from at least December 2016, if not earlier, played a part in this unwitnessed fall in which he experienced a head injury.

54. The central aspect in this issue of complaint is the care and treatment subsequently received by the resident. I note that observations were taken immediately after the fall and that a request was made that monitoring be continued. I consider that while initial assessment and recording of the resident's vital signs following the fall was carried out, the observations and monitoring did not go as far as the policy in place at the time dictated. I note that it was not until 21.00hrs the following night, and only upon concern being raised by the family and not by any

Home staff, that further vital and neurological signs were noted and an ambulance arranged.

55. I considered this matter carefully and having taken the N IPA advice on this issue of complaint into account, I am of the opinion that the failure to record further observations for a period of over 24 hours, represents a significant failure in the care and treatment afforded to the resident. I am concerned that following the fall, after which a head injury was noted, a decision was evidently taken not to immediately contact a GP or the out of hours service for advice. No ambulance was called for the resident, the family were not contacted and informed, rather it was decided that continued monitoring take place. However there is no record of any monitoring or observations whatsoever being carried out until the next night. More importantly there is no record of the Glasgow Coma Scale (GCS) or NEWS being used or of any of the standard neurological observations being utilised. In an elderly gentleman suffering from dementia, with a history of seizures and who had suffered a head injury these observations should have been repeated throughout the night and into the next day and medical advice sought. Additionally there is no evidence that the follow on daytime staff were aware of the situation and therefore due to the lack of data from observations, these staff would have had no reference points upon which to assess if the resident was presenting with a changing condition as time progressed. This is perhaps a moot point as the following shifts do not appear to have noted anything amiss until it was drawn to their attention by the family the next night. I consider this serious failure in the provision of care and treatment by the Home relating to observations to represent a loss of opportunity for the resident to have his injury fully assessed in hospital at an earlier time, thus causing him an injustice. I also consider this failing to have caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment which the resident received.

56. The complainant remains concerned about the subsequent effect of the falls experienced on her husband's health and the possibility that they contributed to his death over a month later. I note that following his admittance to hospital on 7 February 2017 the resident underwent a CT brain scan, the results of which were discussed with the neurosurgeons who determined that no surgical input was

required. The resident was declared medically fit for discharge and returned to the Home the next day. I also note that he was admitted to hospital again on 18 February 2017 not as a result of a fall but because of ongoing seizure activity and discharged back to the Home on 20 February 2017. I acknowledge the complainant's belief that the resident's hospital admissions were caused by the falls which led to seizure activity, rather than the possibility that it was seizure activity which contributed to the falls and hence hospital admission, which appears to have been the Home's position. I find that I am not in a position to make a judgement either way, however I would bring to the attention of the Home, as a learning point, the advice of the ISWA that the Home in addressing this issue with the family '*appeared to be defensive*'. The ISWA further advised that the Home did not frame its responses in the wider context of the falls occurring in the days before admission to hospital and that it would have been more appropriate to '*openly engage with the family about the falls that did occur and not make them the subject of dispute.*'

57. In summary regarding this issue of complaint I found a number of failings in the care and treatment received by the resident. Of most serious concerns the failure of the Home following the resident's fall on 6 February 2017 to carry out appropriate observations, including using the Glasgow Coma Scale, for a period of 24 hours or of seeking medical advice following a head injury. I also found a failure by the Home to accurately record all of the falls experienced by the resident, a failure to seek external advice in relation to falls management, and a failure to update care plans and risk assessments following hospital admission. I consider these failings to have caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment which the resident received.

58. I will deal with the remedy and my recommendations at the conclusion of this report.

Issue 5: Heating of the resident's room

Detail of Complaint

59. The complainant stated that for a period of three days there was no heating in the resident's room. She contended that a loss of heating for an older person should

be treated more seriously than it was done in this case.

The Home and Trust response

60. The Home confirmed that the heating in the room was not working on 9 November 2016 and that in response additional blankets were provided. A static heater was not provided due to the risk it would pose to a person with dementia. The Home requested that a contractor repair the heating on 10 November 2016 and this work was carried out on 12 November 2016. An alternative room became available for the resident on 11 November 2016. The Trust reported that while the heating in the resident's room was not working, the ambient heat in the Home was reported as being 21 degrees C.

Analysis and findings

61. I note that the Trust response to the complainant on this element of complaint incorrectly identifies the date of this incident to be in November 2017. The Home accepts that the heating in the resident's room was not working for three days during November 2016. While it did seek an external contractor to repair the heating and did provide extra blankets, I share the concern of the independent professional advisor that this was not expedited more quickly than 3 days, given the needs of nursing home residents. It is evident and understandable that the resident's family expected a more urgent move for him to another room or that the heating was fixed more promptly. However, I accept that such breakdowns can happen in any setting and that spare rooms are not always immediately available for transfers. While this does not take away from the family's perception that the resident received sub optimal care, during a winter period, prior to the heating being fixed, I have uncovered no evidence of a detrimental consequence being experienced by the resident as a result. I accept there is no evidence that the ambient temperature of the Home overall did not fall below acceptable temperatures. Although I do not uphold this issue of the complaint, I would recommend that the Home reviews arrangements for emergency repairs.

Issue 6: The Trust's management and investigation of the complainant's concerns

Detail of Complaint

62. The complainant considers that the Trust failed to adequately investigate her complaint and feels that the family's concerns were not taken sufficiently seriously. The complainant is not reassured that either the Trust or the Home have learned from this complaint.

The Home and Trust response

63. In response to investigation queries the Trust stated that it was sorry that the family feel the Trust had not listened or taken the complaint seriously, this was not its intent. The Trust stated that as a result of this complaint it had worked extensively with the Home, resulting in an action plan being agreed with changes to policies and auditing procedures being implemented.

64. The Home advised that it never received a complaint directly from the complainants, rather details of the complaint were received directly from the Trust. Following on from this, the Home carried out two detailed investigations, it met with the Trust resulting in new policies and an action plan being devised to ensure improvements in practice not only in the Home but in other facilities operated and managed by the management company. The new policies included a new falls management policy, a care prescription policy and a policy on the management of nutrition and weight loss.

Analysis and Findings.

65. In my consideration of this issue of the complaint, I considered the standards for complaints handling outlined in the HSC complaints procedure. I also considered detailed documentation from the Trust's complaints file and related correspondence with the family. I acknowledge that the Trust undertaking an investigation into such a complaint is appropriate and allowed for under the HSC Complaints Procedure.

66. I note that following receipt of the complaint the Trust determined that it consisted of 79 separate areas of concern. As part of its investigation the Trust

appointed two senior members of its Older Peoples Mental Health Team to liaise with the Operational Manager of the Home and to review its records. The relevant HSC standard of complaint handling states that a response must be sent to the complainant within 20 days of receipt of the complaint and where this is not possible the complainant must be advised of the delay. During the course of the investigation the complainant was advised of a delay in finalising the Trust's consideration of the complaint and updated on the complaint investigation. I fully accept that there may be circumstance when complaints handling timescales may need to be exceeded. In this case given the large number of issues raised, I consider it reasonable that the 20 day time limit for responding to a complaint was exceeded. The Trust appointed senior members of staff to investigate this complex complaint demonstrating that it took the complaint seriously. Although the responses were outside the timeframe outlined in the HSC complaints procedure, this was a complex and serious complaint which required detailed investigation by the Trust, given the nature of the concerns raised. I do not find maladministration in relation to the time taken by the Trust to respond to the complaint.

67. Having carefully examined the response from the Trust to the complaint, dated 19 October 2018, I am satisfied that the Trust responded with the necessary level of detail and that responses to the numerous clinical and care questions raised by the complainant were responded to. I am also satisfied that the complainant was properly signposted to this office at the conclusion of the Trust's complaints process.

68. Overall I agree with the independent professional advice which I received which stated '*it is my professional view that the Trust largely followed the appropriate policies and procedures in regards to investigation of complaints against the care home'.* Therefore I do not uphold this issue of the complaint and make no finding of maladministration in relation to how the complaint was handled by the Trust.

69. Having said that, I also note and accept the further comments of the independent professional SW advisor concerning the overall tenor and emphasis contained within the Trust's response to this complaint. I agree with the independent professional advice which stated '*The Trust's final response addresses each of the 79 issues individually, but in doing so, may not have demonstrated the impact of the*

accumulated complaints and shortcomings.' I acknowledge and accept that this was a complex and time consuming investigation which involved senior Trust staff reviewing voluminous care records and other documentation and responding to multiple issues of complaint. I also note that the Trust apologised to the complainant for the distress suffered as a result of the matters complained of. However I also accept the point made by the independent professional advisor that in responding to each issue of complaint individually, the overall accumulative impact and distress to the complainant in having to make such a large number of complaints on the care provided to a much loved family member may have been lost. *'The complaint investigation and response did not acknowledge the accountability of the Trust to provide assurance on the quality of care contracted through independent sector providers through effective monitoring and care management process.'* I consider that a learning point for the Trust, in responding to complaints of this nature would be to provide a response with increased emphasis on providing assurance to the complainant that implementation of improvements identified would be effectively monitored and that any actions recommended would be undertaken within a specific timescale and that evidence of improvement would be actively sought by the Trust.

Issue 7: the Actions of the Trust's social worker

Detail of Complaint

70. The complainant was concerned that there was poor communication between the Home and the family or between anyone with involvement in the care of the resident and the family. In particular the complainant remains concerned about the actions of the responsible social worker, who was appointed when the resident was admitted to the Home.

The Social Worker's response

71. During the course of investigation enquiries the Investigating Officer obtained a written statement from the Social Worker (SW), a member of the Trust's Mental Health Team. The SW explained that she first assumed case responsibility in June 2016, due to the complexities of the resident's dementia, while he was a resident in hospital. At that time the complainant did not want a change of social worker as she

was happy with the resident's current social worker. The SW explained that she understood the complainant's apprehension as she had a positive working relationship with the current Social Worker, however a multi-disciplinary decision was made that the resident now met the criteria for allocation to the Community Mental Health Team. It was for this reason that a new social worker was allocated.

72. The SW stated that the complainant confirmed in a meeting that she did not want any direct contact with the SW and that any contact should be through her children. The SW did meet the complainant at the Home on 10 January 2017 to discuss a fall. Prior to the meeting the SW was informed by the Home manager that the complainant did not wish her to attend as she did not see the SW as the resident's social worker. The SW contacted the complainant to highlight the importance of her attendance and that she would be attending. The SW stated that she met the complainant again on 10 February 2017 at the Home and at two discharge planning meetings on 2 March 2017 and 8 March 2017.

73. The SW explained she was aware that on 10 February 2017 after having met with the complainant, that she (the SW) would discuss the possibility of regular checks on the resident and a change of room with the Home manager. The Home manager did not agree to complete the checks. The SW stated that when she attempted to relay this information to the family, they had already left the premises. The SW accepted that the complainant was annoyed that she was not contacted to advise her that the request was refused or that any follow up telephone call was made to the family. The SW stated that she was not returning to work that day and assumed the family would be informed of the decision by the Home manager when they attended the Home that night. The SW sincerely apologised for any distress caused by her actions to the complainant and her family.

Relevant Independent Professional Advice

74. The ISWA placed the meeting with the SW on 10 February 2017 in context. She explained how the family had been raising concerns with the Home over the resident's care and treatment during November 2016 and that they became more concerned following a number of falls, particularly one which occurred on 6 February

2017. The outcome of this was a meeting held in the Home which the SW attended on 10 February 2017. The ISWA noted that the Home communication sheet records this meeting stating '*family met with care manager and feel some observations would be of benefit however same declined by home manager due to some observations not being able to prevent falls. Care manager to liaise back with family.'*

75. The ISWA advised that it was correct that the SW raised the family concerns with the Home as this is an appropriate social work role. However the ISWA went on to state that the SW '*should have taken further action to not only immediately update the complainant but also to consider what further actions were necessary to address the risks that had been identified and the concerns of the family. Given that the social worker had acted to make the request based on need, I would have expected the social worker to have engaged with multi-disciplinary team and arrange a care review to update care plan if required. The family's request for 15 minute observations may or not have been possible and may or may not have reduced risk, however, there was no action taken by the social worker/ care manager to coordinate discussion across all parties to agree a shared understanding and to agree updated care plan for the resident. The social worker had already reflected in supervision (8 December 2016) and in the social work statement that she had not been able to build an effective relationship with the complainant and this was a further missed opportunity to build trust and confidence that the social worker would advocate for the resident'*

76. When asked if the care provided by the SW on this occasion was of a reasonable standard the ISWA referred to legislation, regional policy, DOH circulars and guidance and NISCC standards (Appendix 3). The ISWA stated that in her professional opinion '*the social work actions fell short of the professional standards expected on this occasion*.'

77. The ISWA stated that a recurring issue from the resident's admission to the Home was the poor relationship between the complainant and the social worker. The Social Worker's statement acknowledges that the complainant did not want a change of social worker and subsequent events up to the meeting on 10 February 2017. '*There was no reflection in the documentation I reviewed on why family did not want*

the social worker to attend this meeting. The focus was on the view of the social worker that she would attend. This is significant and should have been addressed by the social worker with her manager to address how an effective relationship could be established. Consideration should have been given initially to a joint transfer visit between former and incoming social worker to ensure continuity and build confidence or a meeting should have been convened by the social worker in the complainant's home with her family to agree how the care management and review process could most effectively involve them'. The ISWA viewed the events of this time to represent '*a missed opportunity to address the underlying challenge engaging the resident's family. The social worker's manager should also have given consideration as to whether further steps were necessary to understand the perceptions of the resident's family and agree how more effective engagement and trust could be established*.'

78. 'The complainant and wider family held concerns about the risk of falls which was evidenced for them in the diagnosis of subarachnoid haemorrhage secondary to falls in January 2017. The SW acknowledges that the change of social worker occurred at a time when the family were facing significant crisis and the difficult decision about the resident's admission to care home, however I did not see evidence in the documentation provided from the care home or the Trust, that sufficient consideration had been given to the psychological impact of this decision on the family. The family concerns when raised were viewed as single episodes as were the incidents of falls and omission to involve the family effectively in the care plan process rather than analysed accumulatively'.

79. The ISWA also advised that '*It is the responsibility of every practitioner; every manager and leader in social care to ensure that social care governance is an integral part of practice and service provision so that there is shared ownership and accountability at every level for the standard of social care provided……
This was a missed opportunity for senior managers to step in to seek genuine engagement with a family struggling to come to terms with the rapid deterioration in the resident and a family whose experience of the quality of care provided had led them to plan resident's discharge to the family home rather than consider discharge to a care home placement……. I do not view the care provided by the social worker*

or her manager at this time as a reasonable standard although this was acknowledged by the social worker and the Trust.'

80. In relation to the minute of a discharge planning meeting on 2 March 2017, the ISWA advised that this communication *'was a missed opportunity for senior managers to step in to seek genuine engagement with a family struggling to come to terms with a rapid deterioration in the patient and a family whose experience of the quality of care provided had led them to plan the patient's discharge to the family home rather than consider discharge to a care home placement'.*

Analysis and Findings

81. I agree with and accept the ISWA advice which I received concerning this issue of complaint in that the social work actions were appropriate to some extent in that the SW did act in the role of a care manager in bringing the complainant's concerns to the attention of the Home. However in light of the Home's dismissal of the requests brought forward on behalf of the complainant, I agree with the advice that further action should then have been taken by the SW. I consider that there was a failure to recognise the depth of feeling being experienced by the complainant and the family and the growing concerns they had regarding the increasing falls being experienced by the resident, alongside the associated concerns generally over the care and supervision being provided by the Home. I accept the ISWA advice that this 'missed opportunity' also applied to the circumstances following the discharge planning meeting from hospital on 2 March 2017. The SW and senior managers should, in the light of these concerns being raised, have initiated a care review to involve the appropriate multi-disciplinary team, the Home and the complainant. I also agree with the advice received that this represented a missed opportunity to address the breakdown in confidence of the family with social work involvement, as evidenced by the initial reluctance by the complainant to have the SW in attendance at the meeting on 10 February 2017.

82. I consider this failure to initiate a care review or to take action to address the relationship with social work involvement, following the meetings of 10 February 2017 and 2 March 2017 to represent a failure in the care and treatment provided to the resident and to have caused him the injustice of a loss of opportunity. I consider

it to also have caused the complainant the injustice of upset, distress and uncertainty regarding the level of the care and treatment which the resident received.

CONCLUSION

83. I received a complaint concerning the actions of the Trust and a Home.

84. I determined to issue a composite report of the investigation to allow for a comprehensive investigation of the complaint and to provide a maximum opportunity for learning for both the Home and the Trust. I found a failure in the care and treatment received in relation to the following matters:

85. In respect of the Home

a) a failure to adequately involve the family in the preparation of pre admission assessments and care plans
b) a failure to notify the GP of weight loss and to consider a referral to a dietitian
c) a failure to maintain a satisfactory standard of record keeping with regard to the resident
d) a failure in the completion of a falls diary
e) a failure to request external specialist advice in relation to the level of falls
f) a failure, following discharge from hospital on 30 January 2017, to update risk assessments or the care plan or to document other safeguards to minimise injury caused by falls.
g) A failure to respond to a triggered resident's alarm
h) A failure following a fall on 6 February 2017 to carry out appropriate observations, for a period of 24 hours or to seek medical advice following a head injury.

In respect of the Trust

a) a failure to initiate a care review or to take action to address the relationship with social work involvement, following the meetings of 10 February 2017 and 2 March 2017

I recommend in respect of the Home:

- The Home should consider introducing an audit process that targets the key areas of practice relating to recording and resident safety as a means of providing independent evidence that practice has been implemented in adherence with policy and best practice.
- The Home should ensure that pre-admission care planning and risk assessments include the family input and should ensure that all staff have received relevant training in the appropriate NICE nursing home standards and professional guidelines.
- The Home should consider requesting that the Trust convene a care review meeting if communication from the family indicates rising concerns.
- The Home should provide me with evidence of its consideration of these recommendations and of evidence of learning having been derived from its response to the Trust's investigation and to the content of this report, to include details of changes in policy, guidance and approach or any staff training carried out within three months of receipt of this report in final form

I recommend in respect of the Trust

- In responding to complaints when drafting recommendations for improvement the Trust I would remind the Trust that it should ensure that they are time bound and have clear metrics/ measures to assess and track sustainable improvement.
- The Trust should ensure that relevant complaint issues and investigation findings are notified to RQIA.
- I would remind the Trust that it should ensure that care management process is implemented effectively and that a case review is convened when the needs of the resident change or there are rising concerns expressed by family.
- The Trust should review care management processes to ensure effective service user and carer/family involvement in care planning including pre-admission to care home placement.

- The Trust should ensure effective monitoring of improvements through the care management process at an individual care level but also through contract monitoring and regular audits
- The Trust should ensure that any learning derived from this report and its investigation of the complaint is embedded in training provided to staff

In addition

i. In accordance with NIPSO guidance on issuing an apology that the Chief Executive of the Trust and the head of the management company of the Home provides a written apology to the complainant for the failures in the care and treatment received by the resident identified in this report. The Trust and Home should provide the apology to the complainant within one month of the date of my final report;
ii. The Trust bring the failures identified in this report to the management of the Home to ensure that it has the opportunity to consider the findings and reflect how practices can be improved in the future and highlighting any learning outcomes identified; and
iii. The Trust and the Home share the outcome of this investigation with relevant staff highlighting any learning outcomes identified.

Finally, I wish to pass on my condolences to the complainant and her family on the death of a much loved husband and father. Throughout my examination of this complaint I fully recognise the distress experienced by the complainant and the family over the care and treatment he received and the evident care and devotion shown to ensure that he received the appropriate care and attention. I hope that my report has gone some way to address the complainant's concerns. I recognise that the complainant may not totally agree with all of my conclusions but I wish to assure her that I have reached them only after the fullest consideration of all the facts of this case.

MARGARET KELLY
OMBUDSMAN **August 2021**

Appendix 1

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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. **Getting it right**

    - Acting in accordance with the law 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 learned from complaints.

    - Including complaint management as an integral part of service design.

    - Ensuring staff are equipped and empowered to act decisively to resolve complaints.

    - Focusing the outcomes for the complainant and the public body.

    - Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. **Being customer focused**

    - Having clear and simple procedures.

    - Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.

    - Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.

    - Listening to complainants to understand the complaint and the outcome they are seeking.

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

3. **Being open and accountable**

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

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.