Ombudsman makes recommendations to healthcare provider after patient suffers falls at home

A healthcare provider has been asked to improve its staff training and carry out a review of its policies after an investigation by the Public Services Ombudsman.

The investigation began after a complaint about the standard of care provided to the complainant's elderly mother who had sustained two falls at home. The falls occurred while she was being raised by carers to a standing position using a special device. She was admitted to hospital with a dislocated shoulder and died just over a week later from a heart condition.

The complainant alleged that Homecare Independent Living (HCIL) had not trained their care staff to use the stand-aid device and that care plans and risk assessments for her mother had not been properly completed.

In response to investigation enquiries, HCIL commented that it believed there was no requirement to provide training for each specific type of hoist. The staff providing the care confirmed that although they were familiar with the device, they had not been given any formal training on how to use it.

The Investigating Officer consulted the device's instruction guide, which stated that '*lifting and transferring a person always involves a certain level of risk'*, and that the equipment '*should be used by trained personnel only'.*

The company's policy on Manual Handling also stated that care assistants should not use equipment if they have not previously received training.

The Ombudsman upheld this part of the complaint, and recommended that the company review all of its policies related to falls. She also recommended that the company look specifically at staff training and the use of risk assessments in client's homes.

However, after consulting Ambulance service and other medical records the Ombudsman concluded that it was not possible to determine exactly how and when the complainant's mother sustained her dislocated shoulder.

In relation to the other allegations, the Ombudsman agreed with an independent professional advisor who stated that the care assistants should have had a more detailed care plan to work from. If so they would have been more likely to have used another method of transfer on the day of the falls.

The Ombudsman also criticised the care provider for not telling the Northern Health and Social Care Trust about what happened, for not properly managing and securing the patient's file which contained records of her care, and for not engaging with the complainant despite the significant issues she was raising.

As well as asking HCIL to review its policies and procedures, the Ombudsman recommended that HCIL apologise to the complainant and pay £500 in acknowledgement of the injustice caused.