Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Dunlarg Care Home

NIPSO Reference: 201916392

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

The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

TABLE OF CONTENTS

Page

Case Reference: 201916392
Listed Authority: Dunlarg Care Home

SUMMARY

I received a complaint about the actions of Dunlarg Care Home (the Home). The complainant raised concerns about the care and treatment the Home provided to her father, (the resident). Four Seasons Health Care managed the Home during the time her father was resident there. The Home is currently managed by Healthcare Ireland.

The complaint said that the Home failed to provide the resident with adequate personal and oral hygiene. The complainant also said that the Home failed to follow the advice of health care professionals in how it managed the resident's pressure wounds and leg contractures. The complainant believed that the Home falsified records in relation to the resident's weight and that staff cut and paste entries into records of the resident's daily nursing care. She also believed that the Home failed to call an ambulance when the resident was showing possible stroke symptoms.

In order to assist with the consideration of the issues the complainant raised, I obtained independent professional advice (IPA) from a Consultant Nurse for older people with over 30 years of relevant experience.

My investigation found that it was reasonable for the Home not to provide the resident with regular showers due to the risk of causing further skin damage. However, I found failures in the care and treatment in relation to the following matters:

- failure to document the resident's refusal to have a shower,
- failure to assess or document oral thrush
- failure to update the resident's care plan to reduce the risk of pressure sores.
- failure to follow advice on managing pressure sores and leg contractures.

- failure to keep accurate records in respect of wound care, weight measurement and daily nursing notes. In addition,
- failure to call an ambulance in a timely manner when the resident was showing possible stroke symptoms.

I concluded that these failures in care and treatment caused the complainant and the resident to experience the injustice of uncertainty, distress, upset and the loss of opportunity.

I also found failures in the Home's handling of the complaint. In particular, I found that the Home was unable to provide records detailing the care it provided to the resident, having lost or misplaced them. This, in addition to the inaccuracies in the Home's records led me to question the credibility of the Home's responses to the complainant and the investigation.

I recommended that the Home provide the complainant with a written apology for the injustice caused as a result of the maladministration and failure in care and treatment I identified. Regarding failures in record-keeping and in care and treatment provided to the patient, I made eight further recommendations for the Home to address under an evidence-supported action plan to instigate service improvement and to prevent future reoccurrence of the failings identified.

THE COMPLAINT

1. The complainant raised concerns about the actions of Dunlarg Care Home[1] (the Home) in relation to the care and treatment provided to her father (the resident) at the Home between March 2017 and January 2018.

Background

2. The resident was a 65 year old man with advanced Multiple Sclerosis. He went into full-time residential care at the Home in March 2017. The resident was admitted to the Emergency Department (ED) of Craigavon Area Hospital (CAH) on 23 January 2018 with a suspected stroke and oral thrush. The resident sadly passed away in CAH on 15 February 2018.

3. The complainant believed that the resident's deterioration during his stay at the Home was due to the failure of care staff to follow his care plan and the relevant medical guidance.

Issues of complaint

4. The issues of complaint accepted for investigation were:

Issue 1: **Whether the care and treatment provided to the resident by Dunlarg Nursing Home between 20 March 2017 and 23 January 2018 was reasonable and in accordance with relevant standards?**

In particular, this will examine:

- Showering of the resident
- Treatment of oral thrush
- Treatment of pressure wounds
- Prevention of limb contracture
- Weight management.
- Request for an ambulance at the appropriate time

[1] At the time of the complaint, Dunlarg Care Home was managed by Four Seasons Healthcare. This organisation dealt with the original complaint and subsequent investigation enquiries. The Southern Health and Social Care Trust also provided a response to the original complaint. For the purpose of continuity however, the body under investigation will be referred to as the Home throughout the report. The Home is now managed by Healthcare Ireland.

- Record keeping

Issue 2: **Whether the complaints handling by the Home was appropriate?**

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Home all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Home's handling the complaint.

Independent Professional Advice Sought

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

    - **Consultant Nurse for older people RN, BA(Hons), MSc, PGCert (HE) (N IPA)**. with over 30 years' experience across acute care, community and care homes

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

Relevant Standards and Guidance

8. 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[2]:

    - The Principles of Good Administration

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

- The Principles of Good Complaints Handling

9. 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.

   The specific standards and guidance relevant to this complaint are:

   - Nursing and Midwifery Council (NMC), The Code (the NMC Code), (January 2015);
   - Department of Health, Social Services and Public Safety's Nursing Homes, Standards, (April 2015) (Nursing Home Standards);
   - Four Seasons Health Care (FSHC) Management of Feedback Policy (Complaints, Concerns and Compliments) (August 2017) (FSHC Complaints Procedure);
   - Guidelines for Audit and Implementation Network (GAIN) Guidelines for the Oral Healthcare for Older People Living in Nursing and Residential Homes in Northern Ireland (2012) (Guidelines for Oral Healthcare);
   - National Institute for Health and Care Excellence (NICE) Guidelines: CG32 Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition (updated August 2017) (NICE CG32);
   - National Institute for Health and Care Excellence (NICE) Quality Standard: QS24 Nutrition Support in adults (November 2012) (NICE QS24);
   - National Institute for Health and Care Excellence (NICE) Guidelines: NG48 Oral Health for Adults in Care Homes (July 2016) (NICE NG48);
   - National Institute for Health and Care Excellence (NICE) Guidelines: CG68 Stroke and transient ischaemic attack in over 16s: diagnosis and initial management (updated March 2017) (NICE CG68);
   - NHS Website Stroke: -

https://www.nhs.uk/conditions/stroke/; and

- The Nursing Homes Regulations (Northern Ireland) 2005.

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

11. A draft copy of this report was shared with the complainant and the Home for comment on factual accuracy and the reasonableness of the findings and recommendations.

12. This investigation found numerous examples of failures in record keeping by the Home. There is information contained in the records that is demonstrably inaccurate, or untrue. Additionally, the Home's practice of cutting and pasting existing entries into the resident's electronic care record led me to question the reliability of the information contained within it. Overall, the poor standard of record keeping has caused me significant concern throughout this investigation.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the resident by Dunlarg Nursing Home between 20 March 2017 and 23 January 2018 was reasonable and in accordance with relevant standards?-

Detail of Complaint

Showering the resident

13. The complainant said that during his stay in the Home, staff neglected the resident's hygiene. She believed that staff failed to shower the resident regularly, despite instructions in his care plan to do so. The complainant questioned why the Home failed to record the resident's refusal to have a shower, when it stated that this was the reason why staff did not shower him regularly.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - The NMC Code
    - Nursing Home Standards

The Home's response

15. During a meeting with the resident's family in September 2017, the Home stated that it offered the patient a shower twice a week, but sometimes he refused. In a response to a written enquiry from the complainant, the Home stated that the resident '*did not receive a shower in the home during his time with us. This was due to a risk of pressure on his body and it would have been unsafe to shower him.'* The Home stated that it provided the resident with daily body washes as a safe means of delivering personal care.

Relevant Independent Professional Advice

16. The N IPA advised that typically nursing homes do not regularly shower residents and that a full bed bath would be adequate to maintain the resident's personal hygiene. The N IPA also advised that given the condition of the resident's skin, it was reasonable for staff not to offer a shower, as moving the resident to the shower and placing him on a shower chair could increase the risk of further skin damage.

Analysis and Findings

17. It is evident from the complaint that the resident's personal hygiene during his time in the Home was an ongoing concern for his family. I note the resident's care plan documents that staff must ensure that the resident has *'a shower or bath once weekly or as necessary'.* I note that the records indicate the last time the resident received a shower in the Home was on 15 August 2017. In total, the records indicate that the Home provided him with a shower five times during his stay there. Nevertheless, I accept the N IPA's advice that when the resident had pressure sores it was reasonable to give him a full body wash as an alternative to a shower in order to avoid further damage to his skin. I also note

and accept the IPA's advice that a body wash would have provided the resident with an adequate level of cleanliness.

18. I note that the Home gave the resident's family two different reasons why it did not provide him with a weekly shower in line with his care plan. It initially stated that the resident sometimes refused showers, but stated on another occasion that it was unsafe to shower him due to the increased pressure to his skin. I examined the resident's records, which show that the first indication of possible tissue damage was identified on 6 June 2017. Before this, the only shower the resident received was on 24 March 2017, several days after he moved in to the Home. It is therefore reasonable to assume that as there were no issues with potential tissue damage until 6 June, the resident refused the weekly offer of a shower prior to this date and that the Trust's explanation about tissue damage does not apply. There is an entry in the resident's notes dated 22 June, which records that he refused a shower on that day. This is the only record of the resident refusing the offer of a shower and was after skin damage had first been identified. The NMC Code states that nurses are required to: '*2.5- respect, support and document* (my emphasis) *a person's right to accept or refuse care and treatment*'. I note that Standard 4, Criterion 9 of the Nursing Home Standards also applies. I am critical that the resident's records do not reflect the Home's statement that the resident sometimes refused the offer of a shower and I consider the Home's failure to document the resident's wishes a failure in his care and treatment. I consider that as a result of these failings the complainant experienced the injustice of uncertainty as the Home could not provide her with a consistent answer supported by records as to why the resident did not receive regular showers.

19. I note that in addition to the Home's failure to document what it stated were the resident's refusals to have a shower; the complainant said that she repeatedly raised the issue with the Home that the resident was not receiving showers during his stay there. I note further that she said the resident asked family members why the Home was not providing him with a shower. In investigating health and social care complaints, the contemporaneous records created by Care Homes can provide a helpful insight into what occurred. However, I note

the complainant's concern raised in response to a draft of this report that the resident's records were not an accurate reflection of the daily personal hygiene he received during his time in the Home. I note the complainant said that she personally witnessed occasions when her father had not been washed. Furthermore, I note the complainant refers to the issue on several occasions in her original complaint and I sympathise with her and acknowledge the depths of her feelings on the matter.

20. Given the concerns raised about the standard of records created by the Home and the complainant's personal recollections, I remain concerned about the standard of personal hygiene care provided to the resident. While, I cannot conclude that the Home failed to provide the resident with a shower when he requested one, or neglected his personal hygiene, I can not be entirely confident that the care notes are an accurate reflection of the personal hygiene provided to him.

21. I note that in its response to the complainant the Home also stated that the resident '*did not receive a shower in the home during his time with us.'* This statement is not supported by the Home's records. I will address the Home's response to the complainant in relation to this issue under the section on complaint handling.

Detail of Complaint

Oral hygiene

22. The complainant said that the family constantly had to ask the Home to clean the resident's dentures. She said that when the patient was admitted to CAH on 23 January 2018 he was suffering from oral thrush. The complainant provided a photograph of the resident's mouth, taken upon his arrival at CAH and date stamped 23 January 2018, which she believed demonstrates that the resident was suffering from oral thrush at the time he was admitted.

Evidence Considered

Legislation/Policies/Guidance

23. I considered the following guidance:

- The NMC Code

- NICE NG 48
- Nursing Home Standards

The Home's response

24. The Home stated an oral care plan was in place and that there was '*nothing recorded in relation to any issues with [the resident's] oral care'.* It added that as the resident wore dentures and was taking antibiotics, he was at increased risk of developing oral thrush. The Home stated that on occasion, the resident did not wish to engage with his oral hygiene plan, or have his dentures removed. In addition, the Home stated that prior to his admission to CAH, staff did not report any signs of thrush and that '*thrush plaques may not have been apparent when he left the home'.* Further, the Home stated that the Home Manager was with the nurse assisting with the resident's care on the morning of 23 January 2018. The Home manager stated that she was '*up close to [the resident] and did not get any smell from his mouth'.*

Relevant Independent Professional Advice

25. The N IPA advised that the Home did not follow up on its own oral care plan for the resident, which specified that staff must '*ensure oral health assessment is kept up to date and changes documented appropriately*'. The N IPA further advised that there was no record of the condition of the resident's dentures, or provision of oral hygiene '*either of which would have increased the risk of developing oral thrush'.* The N IPA advised that the resident was also taking antibiotics, which further increased the risk. In relation to the Home's statement that there was no smell from the resident's mouth on the morning of the day that he was admitted to hospital, the N IPA advised that the care notes made no reference to the condition of the resident's mouth and whether it smelled or not.

26. In relation to the photograph of the resident's mouth taken by the complainant, the N IPA advised that it was strongly suggestive of oral thrush. In response to the Home's statement that '*thrush plaques may not have been apparent when he left the home',* the N IPA advised that it was not reasonable to conclude that

the thrush plaques developed in the time between the resident leaving the Home and arriving at CAH, which was approximately 40 minutes. The N IPA advised that she considered the care and treatment the resident received in respect of his oral hygiene was not of a reasonable standard.

Analysis and Findings

27. I note that there was no record in the resident's care notes that Home staff attended to his daily oral hygiene. I note further the lack of evidence in the records to substantiate the Home's statement that the resident occasionally refused oral care or declined to remove his dentures. While I acknowledge that there was a care plan in place in respect of the resident's oral hygiene, I also accept the N IPA's advice that the Home failed to follow up on the plan by not documenting the oral care provided to the resident, or his refusal to remove his dentures. I find this especially concerning as the Home was aware that the resident was at increased risk of oral thrush due to a number of factors. Standard 10 of the NMC Code states that nurses are required to: '*keep clear and accurate records relevant to your practice*' and Standard 2.5 requires nurses to *'respect, support and* ***document*** (my emphasis) *a person's right to accept or refuse care and treatment*'. I note that Standard 4, Criterion 9 of the Nursing Home Standards also applies.

28. I note the N IPA's advice that the photograph of the resident's mouth taken on 23 January was suggestive of oral thrush. I examined the resident's hospital records which confirmed that the resident received treatment for oral thrush in CAH. I note the Home's statement that thrush plaques may not have been apparent when the resident left the Home. I note that on 23 January the resident left the Home in an ambulance at approximately 21.00 and arrived at CAH at 21.41. I agree with the N IPA's advice that it was not reasonable to conclude that the resident developed thrush plaques during a 40 minute journey to CAH. Therefore, on balance I am satisfied that the resident developed oral thrush prior to his admission to CAH and that Home staff failed to assess, or document his condition contrary to his care plan. I consider this a failure in the resident's care and treatment.

29. I am satisfied that as a result of the failures identified the resident experienced the injustice of the loss of opportunity to have his condition fully assessed and treated at an earlier time. I also consider these failings caused the complainant the injustice of upset and uncertainty regarding the level of the care and treatment that the resident received. I therefore uphold this element of the complaint.

Detail of Complaint

Treatment of pressure wounds

30. The complainant said that the home failed to follow the Tissue Viability Nurse's[3] (TVN) instructions to change the resident's position every two hours when he was on bed rest due to pressure wounds. The complainant believed that the Home's failure to follow these instructions prevented the resident's pressure sores from healing.

Evidence Considered

Legislation/Policies/Guidance

31. I considered the following guidance:
    - Nursing Home Standards
    - The NMC Code

The Home's response

32. The Home stated that no pressure wounds were recorded upon the resident's admission to the Home. It stated '*records provided sufficient evidence that there was effective wound care being provided to [the resident].*' The Home stated that the resident '*was nursed on an airflow mattress[4] and repositioned every two hours*.' The Home stated that the resident developed pressure sores after stays in hospital and that his existing wounds worsened after a day out with his family.

Discussion with the complainant

[3] A nurse that provides a specialist service to patients with a wide variety of complex wounds including pressure ulcer prevention and management

[4] A mattress designed for people with limited mobility, who spend a lot of time in bed and are consequently more prone to developing pressure ulcers

33. As part of the investigation, the Investigating Officer spoke by telephone with the complainant. She said that the resident never complained that he suffered any pain as a result of his pressure sores. She said that even if he had been feeling any pain, he was not the kind of the man who would say anything about it. She said '*I guess he was the perfect patient*'.

Relevant Independent Professional Advice

34. The N IPA advised that the resident's care plan for wound care on his admission to the Home was adequate in terms of assessment and prevention. The N IPA advised that Home staff identified oedema[5] to the resident's sacral area[6] and lower limbs on 6 June 2017. The N IPA advised this increased the risk of the resident developing pressure sores. The N IPA advised that upon discovering the swelling, Home staff ought to have reassessed the patient's risk of skin damage and updated his care plan to reflect the appropriate preventative care. The N IPA advised that this did not happen. Furthermore, the N IPA advised that Home staff did not increase the frequency of checks for skin damage, or reduce the amount of time the patient spent sitting in his wheelchair. Because of this, the N IPA advised that the resident '*did not receive appropriate treatment following the discovery of the sacral oedema*'. The N IPA advised that it was likely that this had led to skin damage and caused the resident detriment.

35. The N IPA advised that when the resident first developed a pressure sore in the Home on 14 June 2017, the TVN provided staff with advice on how to treat and manage the wound. The TVN instructed staff to reposition the resident at two-hour intervals to relieve pressure on his sores. The TVN also provided detailed instructions on the procedure and frequency for dressing the resident's wound.

36. The N IPA advised that the records available indicated that while staff followed TVN guidance on wound dressing, '*the frequency of records of wound treatment is inadequate and does not provide a satisfactory progress record*.' The N IPA also advised that repositioning charts were not available before

[5] Swelling caused due to excess fluid accumulation in the body tissues
[6] Sacrum: a concave bone that sits at the bottom of the spinal column

October 2017 and that prior to this, the only positioning records were the daily entries in the care notes, which the N IPA advised were inadequate. In addition, the N IPA advised that Home staff did not consistently follow the TVN's guidance to reposition the resident every two hours. The records often show turning frequencies of two to three hours and three to four hours. The N IPA also highlighted that when Home staff recorded the resident's skin condition on the repositioning charts, it was referred to as '*good*', or '*wound-on-going*', which the N IPA said was inadequate as it was '*ambiguous information*'.

37. The N IPA advised that Home records were unclear regarding the site of the pressure sores. The site of the pressure sore identified by staff on 14 June 2017 was variously referred to as the sacrum, the inner left thigh, the inner right thigh and the inner right buttock. The N IPA advised that the inconsistency of the record keeping '*could have led to errors in care and wound reassessment*'.

38. The N IPA considered that the care and treatment provided in respect of wound care was not reasonable and appropriate. This was due to the lack of preventative care, the failure of Home staff to follow TVN guidance on the frequency of repositioning the resident, the poor record keeping in respect of wound dressing and the failure to accurately record the site and type of pressure damage throughout the period. The N IPA advised that it was likely that the resident's first pressure wound resulted from the Home's failure to take appropriate preventative measures following the identification of oedema in his lower limbs and sacrum. However, there was insufficient evidence to conclude that the failures identified in the subsequent care and treatment of his pressure sores caused detriment to the resident. In addition, the N IPA also advised that it appeared that the resident might have also developed pressure wounds during his stays in hospital.

Analysis and Findings

39. I note the complainant's concern that the resident developed pressure sores in the Home, which did not heal because Home staff failed to follow the TVN's advice to turn the resident every two hours. I addressed this issue in terms of development of sores and treatment of existing sores. In addition, the Home

was unable to provide the resident's repositioning charts prior to 20 October 2017; I also considered how this issue impacted on the investigation and the complainant.

Development

40. I note the N IPA's advice that the resident's Skin Care plan was adequate to his needs on his admission to the Home. I note further the N IPA's advice that when the resident developed oedema of the sacral area and lower limbs it increased his risk of subsequently developing pressure sores. The N IPA advised that when it identified the oedema, the Home ought to have updated the resident's care plan to reflect the change in preventative care he needed. The Home did not do this; nor is there any evidence that it took additional preventative measures, such as increasing the frequency of skin checks, or reducing the amount of time the resident spent in his wheelchair. I note and accept the N IPA's advice that it was probable the resident developed a pressure sore on 14 June 2017 as a result of the Home's failure to take appropriate preventative measures after the discovery of the oedema. I consider these actions to represent a failure in the resident's care and treatment in that care plans and risk assessments were not updated to represent an evolving situation and that the resident developed a pressure sore as a result.

41. While I note the complainant said that the resident was not the type of person to complain when he was in pain, I do not doubt that developing pressure sores would have been a distressing experience for him. Therefore, as a result of the failures identified, I am satisfied the resident experienced the injustice of distress and the loss of opportunity to receive appropriate care to prevent pressure sores developing. I therefore uphold this element of the complaint.

Treatment of existing sores

42. I note the N IPA's advice that where records exist, there is evidence that Home staff followed TVN guidance on wound dressing. However, the overall inadequacy of record keeping in relation to wound dressing did not provide a satisfactory progress record.

43. I note with concern the N IPA's advice that Home staff did not consistently follow TVN advice to reposition the resident every two hours in order to relieve pressure on his sores. The resident's notes show that staff repositioned him two to three hourly, or sometimes three to four hourly. In addition I note the N IPA's advice that on the occasions that when staff recorded the resident's skin condition on his repositioning records, the descriptions were ambiguous and therefore inadequate.

44. These failures were compounded by Home staff's additional failure to consistently and accurately record the site and type of pressure damage sustained by the resident during his stay in the Home. I note and accept the N IPA's advice that such errors could lead to further errors in wound care and assessment.

45. Standard 23 of the Nursing Home Standards, states '*There are clear and documented processes for the prevention, detection and treatment of pressure damage or ulcers which are based on best practice guidelines.'* Standard 10 of the NMC Code states that nurses are required to: '*keep clear and accurate records relevant to your practice*'. I consider that the Home's failure to consistently follow the TVN's advice to reposition the resident every two hours and its failure to keep accurate records in respect of wound care constitutes a failure in the resident's care and treatment.

46. I note that the issue of wound care and the development of pressure sores while the resident was in the Home is of particular concern to the complainant. She believed that the pressure sores he developed, their deterioration during his time at the Home and the failure of those sores to heal, is directly attributable to the care and treatment provided to him by the Home. I note and accept the N IPA's advice that aside from the first pressure sore the resident developed, there is insufficient evidence to conclude that the failures identified above caused the resident detriment. However, there is also a lack of evidence to indicate that the resident's care was sufficient to prevent further breakdowns and provide the best opportunity for healing. I consider that the Home's record keeping was poor in this respect and I will address this below. While I cannot

determine how the failures in care and treatment affected the resident. I consider that the complainant experienced the injustice of uncertainty and distress. This is because her father's pressure sores did not appear to be improving despite the fact that he was on constant bed rest. I therefore uphold this element of the complaint

Missing records

47. In addition to and compounding the failings identified above in respect of pressure wounds, the resident's repositioning records prior to 20 October 2017 were not provided to this investigation when requested, on the basis that the Home could not find them.

48. The complainant requested the resident's records when making her complaint. She advised the Home that she only received the repositioning records after October 2017 and asked for the missing records. The Home advised that it had supplied her with all the records that it held; it did not provide her with an explanation of what happened to the records. This Office asked the Home for these records – both at the outset of this investigation under a general request for all records and under an additional request made by the Investigating Officer.

49. When these could not be located, this Office encouraged the Home to make additional searches to locate the lost or misplaced documentation. The Home were unable to locate the records, or explain how they had been lost.

50. Where records are missing, it adversely impacts not only the Home's ability to investigate and respond to complaints directly, but also this Office's ability to investigate complaints. This includes the ability of the independent professional advisor engaged by this Office to provide complete and fully accurate advice. Missing records also have the potential to cause a complainant to feel that openness, transparency, fairness and justice is being denied to them. These are barriers to both Good Administration and Good Complaints handling. I consider it is a fundamental principle of information governance that bodies, especially those providing health and social care services, can easily identify,

locate and retrieve information relating to their service users

51. In this specific investigation, the N IPA set out in her responses to this Office that she made her findings based on the records which were available – primarily daily care notes and wound care records. On this basis, I was able to rely on the independent professional advice she provided in making my findings on this complaint

52. The First Principle of Good Administration, 'getting it right' requires bodies to act in accordance with 'relevant guidance and with regard to the rights of those concerned'. The Third Principle of Good Administration 'being open and accountable' requires bodies to 'handle information properly and appropriately' and to 'keep proper and appropriate records'. I consider the Home failed to act in accordance with these principles when it lost or mislaid parts of the resident's repositioning records. I further consider that the Home failed to act in accordance with these principles when it failed to provide an explanation for the missing records, on foot of a documented investigation, or inform the complainant that the records were missing when she requested them. I am satisfied that these failures constitute maladministration on the Home's part.

53. While this is not a matter for the Information Commissioner's Office (ICO), on the basis that the resident is deceased, this maladministration impeded my ability to provide full answers on all elements of the care and treatment provided by the Home to the resident in respect of this issue.

54. I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration and upset as a result of not being able to receive full answers to all elements of her complaint in a timely manner, upset at the loss of personal information relating to her father, as well as mistrust towards the Home regarding its record handling processes. I uphold this element of the complaint

Detail of Complaint

Prevention of limb contracture

55. The complainant said that the Home did not follow the physiotherapist's advice to stretch the resident's lower limbs every day, in order to avoid contracture. The complainant said that this led to the resident's legs contracting so severely that it became difficult to move him. The complainant said that in its response to her complaint, the Home appeared to suggest that the responsibility to stretch the patient's legs lay with the physiotherapist rather than the Home.

Evidence Considered

Legislation/Policies/Guidance

56. I considered the following guidance:

- The NMC Code

The Home's response

57. In its response to the complainant, the Home stated that it had it had been unable to find entries of physiotherapy input. It stated that a physiotherapist visited the Home on 10 January 2018, '*but unfortunately they did appear* (sic) *to have recorded detail in any notes provided by staff'.* In its response to Investigation enquiries, the Home did not address the issue.

Relevant Independent Professional Advice

58. The N IPA advised that the resident's care plan included physiotherapist's instructions detailing exercises to prevent limb contracture. The N IPA further advised that an entry in the care record on 19 November 2017 from the community physiotherapist, instructed staff to continue with lower limb stretches as previously prescribed, to avoid further contracture. In addition, the N IPA advised that the resident's care plan included instructions to staff to monitor his wheelchair to make sure that it fitted and positioned his body correctly. She advised that '*[p]oor positioning can contribute to contracture development*'. The N IPA added that she would expect to find evidence in the care record that staff had followed the instructions for limb stretches and positioning to prevent further contractures

59. The N IPA advised that she could find no such evidence in the records and

concluded that Home staff did not follow the guidance. She advised that the record keeping was inadequate and that there was no evidence that the care was of an appropriate and reasonable standard.

Analysis and findings

60. I examined the resident's medical records and I note the reference to his '*significant contractures'* upon his admission to CAH in November 2017. I note further the photograph taken in CAH by the complainant that appears to show the extent of the contractures.

61. I agree with the N IPA's advice that there is no evidence in the records that the Home followed the physiotherapist's advice to carry out daily stretches on the resident's legs to avoid further contractures. Furthermore, I note that the resident's family and representatives from the Home discussed the issue in a meeting on 7 August 2019. The minutes of the meeting record that *'[f]amily state that when they asked nursing staff* (about the leg exercises) *they were told it was too sore on him*'. I note that there is no evidence in the resident's notes that Home staff tried to stretch the resident's legs, or that he found it too painful. I note further, there is no indication from the records that staff advised the physiotherapist of the situation. Standard 10.1 of the NMC Code states that nurses are required to: '*complete records at the time or as soon as possible after an event*' and Standard 10.2 requires nurses to '*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*'

62. I am satisfied that on the balance of probabilities Home staff did not follow the physiotherapist's instructions to carry out daily stretches on the resident's legs to prevent any further contractures. I consider this a failure in the resident's care and treatment. In considering any potential impact and injustice to the resident on this issue, I am mindful that there is no record of the extent of the resident's contractures when he went into the Home in March 2017. In addition, there are no contemporaneous records of any changes in his condition during his time there. I am therefore unable to conclude how the failures in care and treatment in relation to this issue affected the resident. However it is evident

that the issue was an ongoing concern for the complainant, who raised it with nursing staff, representatives from the Home and felt compelled to take photographs showing the extent of her father's contractures when he was admitted to hospital. Therefore, I am satisfied that the complainant experienced the injustice of frustration and upset in relation to this issue. I therefore uphold this element of the complaint.

Detail of Complaint

Weight management

63. The complainant said that the Home falsified the resident's weight over a period of months. She said that according to the resident's records, his weight remained constant, however when nurses weighed him in CAH on 27 January he weighed 66.6kg, 17.7kg less than his last measurement taken at the Home. She also said that his records showed that the Home claimed to have weighed the resident on 27 January 2018 when he was actually in hospital.

Evidence Considered

Legislation/Policies/Guidance

64. I considered the following guidance:
    - The NMC Code
    - Nursing Home Standards
    - NICE CG32

The Home's response

65. The Home acknowledged that staff entered the resident's weight in his records on a date that he was in hospital. The Home further acknowledged its records showed that the resident's weight remained unchanged over a six-month period. It stated that the '*stability of [the resident's weight] seems unlikely and…that the results may not have been a true reflection. For this I offer my sincere apologies'.* The Home stated that it had introduced supervisions to ensure that staff recorded residents' weight measurements in a timely and accurate fashion.

Relevant Independent Professional Advice

66. The N IPA advised that the Malnutrition Universal Screening Tool (MUST[7]) includes the assessment principle that a person may need nutritional support if there is unintentional weight loss greater than 10% within the previous three to six months. The N IPA advised that the resident's weight as recorded in CAH on 27 January 2018 was 66.6kg; a weight loss of 21% from his previous measurement in the Home on 22 November 2017. The N IPA advised that if accurate, the hospital records show that the resident may have been at risk of malnutrition. The N IPA listed some of the potential consequences of malnutrition as fatigue and lethargy, increased risk of chest infection, anxiety and depression and reduced ability to fight infection.

67. The N IPA was asked if the failure to accurately record the resident's weight could have increased his risk of pressure sores. The N IPA advised that a pressure mattress used to nurse a person at risk of pressure sores, is calibrated to the person's weight to in order provide the maximum amount of support. If a person's weight is not measured accurately and the mattress is underinflated, this may increase the person's risk of developing pressure sores. The N IPA advised that as the resident lost weight, he was unlikely to have developed additional pressure sores, though he may have experienced discomfort.

68. The N IPA advised that '*there is a strong indication that the entries have been cut and pasted, as it would be impossible for a person's weight to remain exactly the same to one decimal point as that recorded across the period of time in the records'*. She advised that the record keeping in respect of weight measurement was inadequate and that the care and treatment in respect of this issue was not of a reasonable standard.

Analysis and Findings

69. I note the complainant's concern that the Home 'falsified' the resident's weight over a period of months. I examined the resident's records which show that the

[7] A five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese.

Home recorded the resident's weight approximately once a month. For the period 29 June 2017 to 27 January 2018 the resident's weight was recorded as 84.30kg. I note that when staff at CAH weighed the resident on 27 January 2018 his weight was recorded as 66.6kg. I note and accept the N IPA's advice that the Home appears to have taken a single measurement of the resident's weight and copied it across multiple entries, rather than taking regular, accurate measurements. I find this highly concerning.

70. I note that the TVN reviewed the resident on 9 August 2017 and advised that his diet was '*poor*' and that he had lost weight. A staff nurse recorded this advice in the resident's care notes, along with a recommendation from the TVN to refer the resident to a dietician. I note the entry was marked as '*priority'.* I note that the nurse who made this entry also recorded the patient's weight as 84.30kg on 3 September 2017. In addition, I note that the patient did not see a dietician until 3 January 2018.

71. The complainant said that recording accurate body weight is a fundamental part of patient assessment and I completely agree. I note the N IPA's advice that as the Home nursed the resident on a pressure mattress that was calibrated to his weight, failing to accurately weigh him could increase his risk of developing pressure sores. However, I accept the N IPA's advice that in this case, the resident was unlikely to have developed additional sores due to his weight loss.

72. I note the N IPA's advice that unintentional weight loss of more than 10% over a three to six month period can put a person at risk of malnutrition. I note further that the N IPA advised that if CAH's measurements were accurate, the resident lost approximately 21% of his body weight over a seven-month period.

73. Standard 10.3 of the NMC Code requires nurses to '*complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*'. I consider that the Home failed to keep an accurate record of the resident's weight between June 2017 and January 2018. This was despite the advice from the TVN on 9 August 2017, noted as a priority by Home staff, that the

resident had lost weight and needed to see a dietician. I am also satisfied that the Home falsely recorded that it had carried out an assessment of the resident's weight on 27 January 2018, as the resident was in hospital at the time. I will refer to the standard of record keeping below. I am satisfied that the failings identified above constitute a significant failure in the resident's care and treatment.

74. I note the N IPA's advice that the resident's undocumented weight loss put him at risk of malnutrition. However, from the records available I am unable to determine what impact, if any, the failure of the Home to accurately record the resident's weight had on his health. However, I am satisfied that this failure caused the resident to suffer the injustice of the loss of opportunity to have an accurate assessment made of his overall care and treatment. I also consider that the failures identified caused the resident's family to experience the injustice of uncertainty and distress over the appropriateness of his care and treatment.

75. I welcome the Home's acknowledgement to the complainant that it failed to accurately record the resident's weight between June 2017 and January 2018. I note that it stated that it provided staff with supervision sessions to ensure that weight measurements are taken in a timely and accurate manner. However, I am concerned that the Home felt it was necessary to take remedial action in relation to this issue, given how fundamental accurate weight measurements can be to the wellbeing of the elderly and vulnerable residents in its care. I uphold this element of the complaint.

Detail of complaint

Request for an ambulance at the appropriate time

76. The complainant said that the Home failed to call an ambulance when the resident was showing stroke symptoms on 23 January 2018.

Evidence Considered

Legislation/Policies/Guidance

77. I considered the following guidance:

- NICE CG68;

- NHS Website Stroke

The Home's response

78. In its response to the complainant, the Home stated that the resident was not displaying stroke symptoms. It stated that it would have called an ambulance immediately if stroke symptoms were evident. It also stated that on 23 January 2018 as the resident could not swallow properly and his speech was slurred it called the resident's GP at 09.05. The GP arrived at 18.10 and decided that the resident needed hospital care. He was taken to hospital by ambulance at 21.00. In response to Investigation enquiries the Home stated '*when the GP seen [the resident] at 18.10 'a non-urgent ambulance was ordered. Taking this into consideration the GP also did not query the possibility of a stroke'.*

Relevant Independent Professional Advice

79. The N IPA advised that with the onset of possible symptoms, Home staff ought to have screened the resident using a validated tool such as FAST[8], and to test for hypoglycaemia[9] to exclude it as a potential cause of the symptoms. The N IPA advised that there was no evidence that the Home took these actions.

80. The N IPA advised that it was not appropriate for the Home to wait for the resident's GP to arrive, or to delay calling an ambulance. She said that '*[p]ossible symptoms of stroke should be responded to as quickly as possible. NHS guidance is that a stroke is a medical emergency and urgent treatment is essential*'. The N IPA concluded that the Home did not respond to the resident's symptoms in an appropriate or timely way.

Analysis and findings

81. I note the complainant said that she was alarmed when the resident's GP told her that her father would probably be admitted to a stroke rehabilitation ward on 23 January 2018 as he was showing symptoms of a stroke. The complainant believed that despite the obvious symptoms, the Home did not call for an

[8] (face, arm, speech test) is used to assess stroke-like symptoms in a patient..
[9] A condition resulting when the blood glucose levels drop below the specified limits. It causes irregular or rapid heartbeat, pale skin, numbness of lips, tongue or cheek, and sweating

ambulance for the resident in a timely manner.

82. I note the Home stated that the resident did not show any signs of stroke symptoms. I examined the resident's care notes, which record that on 23 January, he was slurring his speech and he was unable to lift objects with his right arm. According to the NHS FAST assessment tool, both of these symptoms are indicative of a possible stroke. I also examined the resident's medical notes following his admission to CAH on 23 January 2018. The resident's triage notes made at 22.49 indicate that he had been displaying possible stroke symptoms over 30 hours previously. I note that in its response to the complainant, the Home stated that it contacted the resident's GP after staff noted that the resident's speech was slurred and that he was unable to swallow properly. I am therefore satisfied that when the Home called the GP at 09.05 the resident was showing possible stroke symptoms.

83. I note and accept the N IPA's advice that it would have been appropriate for the Home to assess the resident using the FAST screening tool and call for an ambulance as soon as staff noted the onset of possible stroke systems. I note that the NHS Website Stroke advises that if a person is suspected of having a stroke '*phone 999 immediately and ask for an ambulance*'. I consider that the Home's failure to appropriately assess the patient for stroke symptoms and to call for an ambulance in a timely manner constitutes a failure in care and treatment.

84. I note that on 24 January 2018, medical staff in CAH diagnosed the resident as suffering from flu. Therefore, I am able to conclude that the failure of the Home to screen the resident for stroke symptoms and to call an ambulance in a timely manner was not ultimately detrimental to his health. However, I am satisfied that as a result of the failures identified the resident experienced the injustice of the loss of opportunity to have his condition assessed in a timely manner. I am also satisfied that the complainant suffered the injustice of upset and distress because of the failures in her father's care and treatment. I therefore uphold this element of the complaint.

Detail of complaint

Record keeping

85. The complainant said that the resident's nursing notes were not accurate. She believed that Home staff copied and pasted notes across multiple entries, therefore providing potentially false information about the care and treatment the resident received on a daily basis.

Evidence Considered

Legislation/Policies/Guidance

86. I considered the following guidance:
    - The NMC Code;
    - Nursing Home Standards

The Home's response

87. The Home did not address the issue of the nursing notes in its response to the complainant. In its response to Investigation enquiries, the Home stated '*On review…it was recognised that there had appeared to be an entry copy and pasted. Further training had taken place with staff with regards to their responsibility and accountability.'*

Relevant Independent Professional Advice

88. The N IPA identified numerous examples where entries in the records were cut and pasted from previous entries. The N IPA advised that the repetitive nature of the resident's notes indicated that it was common practice at the Home to cut and paste entries. She further advised that the '*sheer amount of repetition reduces the validity of these records which include qualitative statements about what he enjoyed…and in other places led to inconsistency regarding wound information and pressure area care.'*

89. The N IPA advised that the continual cutting and pasting by staff meant that the records were not person centred and were likely to lead to errors. She advised that the records in the nursing notes were inadequate.

Analysis and findings

90. I note the complainant's concern that Home staff appeared to have cut and

pasted entries throughout the resident's daily care records. She asked in her complaint if this sort of activity was acceptable in a modern nursing home. She also understandably asked '*if notes were being copied and pasted what really happened on these days?*' The complainant questioned how this practice affected not just her father's care and treatment, but all the residents in the Home.

91. I note the Home's response that it found that '*an entry*' in the notes had been copied and pasted. I will address this response under the issue of complaint handling. I note the N IPA's advice that numerous entries in the resident's notes are exact copies of previous entries. I note and accept with dismay, the N IPA's advice that the quantity of repetition of the same entries in the resident's records indicates that cutting and pasting of records was common practice in the Home. I note further her advice that this practice '*reduces the validity of these records*'

92. I examined the resident's records and found numerous examples where staff had cut and pasted existing entries into the resident's daily nursing notes. This included entries relating to daily activities, food and drink, repositioning and wound care. I note that there are examples when the entries detail care provided to people with a different name to that of the resident.

93. Standard 10 of the NMC Code requires nurses to '*Keep clear and accurate records relevant to your practice*'. Standard 10.3 of the NMC Code requires nurses to '*complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*'. Nursing Homes Standards Standard 4 Individualised Care and Support, requires Homes to provide evidence that '*All entries in case records are meaningful; contemporaneous; dated; timed; signed; and accompanied with the name and designation of the signatory. The language used is reflective of person-centred principles'.*

94. I consider that due to the Home's practice of cutting and pasting existing notes across multiple entries, the resident's records cannot be regarded as accurate, true, or meaningful. This clearly indicates that the potentially inaccurate

records created by the Home were not person centred and were likely to lead to errors in the resident's care and treatment. I am satisfied that the Home's practice of cutting and pasting entries into the resident's records constitutes a failure in his care and treatment. I will address this issue below.

95. The complainant said that it was impossible to know from her father's records if the Home gave him the level of care and attention he required during his time there. My sympathies go out to the complainant and her family, who will always wonder if the resident's deterioration could have been slowed, or prevented if his daily records were a true reflection of the care he received. While I cannot gauge the impact that such poor record keeping had on the resident's health, I am satisfied that the failings identified caused the resident to experience the injustice of the loss of opportunity to receive person centred care. I also consider that the complainant experienced the injustice of uncertainty that the Home provided the resident with the care he required on a daily basis. I therefore uphold this element of the complaint.

Communication with the resident's family

96. The complainant was concerned that the Home failed to inform the resident's family that he received treatment for sepsis[10] while in hospital in September 2017. The complainant believed that the Home was obliged to inform the resident's family about his diagnosis and treatment in accordance with his care plan. I note that the complainant did not raise the raise issue with the Home and it did not have an opportunity to provide an explanation.

97. I note that Step 7 of the Communication section of the resident's care plan requires staff to '*Keep the family informed'.* I examined the resident's nursing records and note that staff made an entry on 29 September 2017, recording that the resident returned from hospital after receiving treatment for wound associated sepsis. The complainant said that she was unaware of this until she obtained the resident's records in March 2019.

98. The N IPA advised that while the Home had an obligation to inform the family of

[10] An infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever.

the resident's return from hospital, the release of any information on the resident's condition and care and treatment needs, depended on his wishes for information sharing. The N IPA advised that the Home's records '*do not include adequate information in relation to what information…should be shared with his family*.' I agree with the N IPA that the requirement to '*Keep the family informed'* is vague and as such, it was unclear what the Home ought to have told the family. In my view, the Home ought to have recorded what information the resident consented to share with his family. Considering the involvement of the family in the care of the resident, I see no reason to doubt that he would have consented to information about his treatment being shared with family members and would therefore have consented to information about his treatment for sepsis being shared. I accept the N IPA's advice that the care plan was not of an adequate standard in regard to this issue.

Issue 2: Whether the complaints handling by the Home was appropriate?

Detail of Complaint

99. The complainant questioned the honesty of the Home's responses to the issues raised in her original complaint. In addition, while not specifically raised as an issue of complaint, the complainant detailed the delays she experienced in waiting for a response to her complaint.

Evidence Considered

Legislation/Policies/Guidance

100. I considered the following policies:
    - FSHC Complaints Procedure.

The Home's response

101. The Home stated it believed that there '*have in some instances, been a difference in perception in respect of people's intentions and actions and how these intentions and actions have been received by the other party.'* It stated that the manner in which it investigated the complaint ensured '*that we are impartial and always act fairly towards residents, family and staff.*' The Home

apologised for the long delays in responding to the complaint and acknowledged the upset it caused the complainant. It stated that the '*complaint raised a number of issues which…have taken time to investigate.'*

The Home's records

102. I carefully considered the Home's records relating to the complaint.

Analysis and Findings

103. For the purposes of clarity, where applicable, I addressed the Home's responses to each of the sub-issues separately.

Showering the resident

104. I note that in its response to the complainant, the Home stated that the resident '*did not receive a shower in the home during his time with us. This was due to a risk of pressure on his body and it would have been unsafe to shower him.'* I examined the resident's nursing records and I note that on five separate occasions Home staff provided him with a shower. I consider that in preparing its response to the complainant, the Home evidently failed to make a thorough check of its own records.

Pressure wounds

105. I note that in its response to the complainant's concern that the Home was not following the TVN's advice about wound care, the Home stated that the resident was '*repositioned every two hours*.' I examined the patient's records and I note there are frequent occasions when Home staff turned the resident after a period of three or sometimes four hours. I consider the Home's response that staff repositioned the resident every two hours is misleading.

Prevention of limb contracture

106. I note that in its response to the complainant's concern that Home staff failed to follow the physiotherapist's advice to stretch the resident's limbs to prevent further contractures, the Home stated that it had reviewed the resident's physiotherapy notes. It stated that it had been unable to ascertain if staff followed the physiotherapist's advice and found '*no further evidence of*

physiotherapy input.' It also stated that the physiotherapist visited the Home on 10 January 2018, '*but unfortunately they did appear* (sic) *to have recorded detail in any notes provided by staff".* I note the complainant's concern that in this response the Home appears to suggest that the physiotherapist was responsible for the resident's contractures. While I am unable to conclude that this was the Home's intent, I consider that the Home's response is incoherent and fails to address the complainant's concerns. I consider that the Home's response in this regard is wholly unsatisfactory.

Request for an ambulance

107. I note with great misgivings, in its response to Investigation enquiries the Home stated that when the GP saw the resident at 18.10 '*a non-urgent ambulance was ordered. Taking this into consideration the GP also did not query the possibility of a stroke'.* I examined the GP's notes for 23 January 2018. The notes show that the GP queried the possibility that the resident had suffered a stroke '*? CVA*[11]' and also that the resident required '*emergency hospital admission'.* I examined the resident's notes and can find no evidence to substantiate the Home's statement that the GP did not consider the possibility that the resident may have had a stroke, or that he did not consider the matter urgent. Indeed, the GP's notes suggest that the opposite is true. I consider that the responses provided to the complainant and to this Office in respect of this matter were misleading and sought in part to shift responsibility from the Home to the resident's GP. The complainant expressed a lack of confidence in the honesty of the Home's response to her complaint and it is evident from its response to this issue at least that her concerns are justified.

Record keeping

108. I note that in its response to Investigation enquiries, the Home stated '*it was recognised that there had appeared to be an entry copy and pasted*.' I examined the resident's nursing notes and it is evident that Home staff cut and pasted entries into the resident's nursing notes on numerous occasions. In its response, the Home represented a practice that was clearly endemic as an

[11] Cerebrovascular accident (CVA) is the medical term for a stroke.

isolated incident. I cannot conclude if this was due to dishonesty, or the lack of a thorough investigation; however, I consider that the response failed to acknowledge the extent of the issue and was inaccurate and inadequate.

109. The Third Principle of Good Administration 'Being open and accountable' requires public bodies to '*keep proper and appropriate records'.* The Third Principle of Good Complaint Handling 'Being open and accountable' requires public bodies to provide '*honest evidence-based explanations and giving reasons for decisions'.* In addition the Fourth Principle of Good Complaint Handling 'Acting fairly and proportionately' requires public bodies to ensure '*that complaints are investigated thoroughly and fairly to establish the facts of the case*'. In its response to the complainant regarding the care and treatment given to the resident in respect of the issues above, I do not consider that the Home meets these standards for the reasons outlined above. I consider that this failure to provide honest and evidence-based explanations and to conduct a thorough and accurate investigation constitutes maladministration. I therefore uphold this element of the complaint.

Delay

110. The complainant detailed the delays in the Trust's response to her complaint. I note that the FSHC Complaints Procedures states that *'a full investigation of a complaint should normally be completed within 20 working days'* I reviewed the Home's complaint file and I note that it received the original complaint on 30 May 2018. I note that the Home informed the complainant on 28 June 2018 that there would be a delay in its response due to a parallel investigation into the complaint by the Southern Health and Social Care Trust (the Trust). I note that the Home sent a response to the complainant on 23 July 2018 in which it offered to meet the resident's family to discuss the complaint. I note that the first proposed meeting date was 25 March 2019. I note that there was a delay of over eight months between the Home's offer of a meeting and the proposed meeting date. I note that the complainant requested the resident's records from the Home and the Trust respectively and the subsequent delay before she received all the records on 8 January 2019.

111. I note that the Home requested that the complainant provide it with a list of the issues she wished to discuss prior to the meeting. I note that when the complainant provided it with a list of her queries, the Home requested a deferment of the meeting so that it would be able to address all the issues raised. I note that the complainant agreed and the meeting was rescheduled for 20 June 2019. I note that the Home cancelled this meeting, as its lead investigator was unavailable. I note that the meeting eventually took place on 7 August with two representatives from the Home who had no prior involvement in the investigation.

112. I note that the Home issued its final response letter on 18 December 2019, four months after the meeting. I reviewed the complaints file and I do not consider that those involved in the complaints process demonstrated sufficient urgency to respond to the complaint. I accept that it may not always be possible for the Home to fully respond to a complainant within the stated 20 working day timeframe. However, the complainant provided the Home with a copy of her queries in relation to the complaint on 12 March 2019, in advance of the proposed meeting of 25 March 2019. She then agreed to a deferment of the initial meeting to allow the Home time to fully respond to her questions. The meeting was subsequently delayed until 7 August 2019 and I note that the Home still did not address any of the complainant's queries during that meeting, despite having four months to investigate the issues raised. I note that it took the Home an additional four months to finally respond to the complaint. I consider that the Home's delay in responding to the complaint was significant and unacceptable.

113. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances*'. I consider that the failure to respond to the complainant in a timely manner constitutes maladministration.

114. I considered the complaints file and note that any correspondence with the complainant after the meeting with the resident's family on 7 August 2019 followed requests for updates from the complainant. I also note that in its

replies to the complainant, the Home stated that it could not give a timescale of when it expected to provide her with an outcome. I note that the Home's Complaints Procedure states that *'the Lead Investigator must keep the Complainant informed, as far as reasonably practicable, as to the progress of the investigation. The Lead Investigator must also ensure that the Complainant is informed if the agreed timescales cannot be complied with and provide an explanation. The new response date should be noted…and an action documented of the discussion with the complainant agreeing to the extension for the response date*'. I consider that the Home ought to have provided the complainant with a timescale in accordance with its Complaints Procedure.

115. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned'*. I consider that the failure to provide the complainant with anticipated timescales constitutes maladministration. I therefore uphold this element of the complaint.

116. Consequently, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office. Therefore, I uphold this issue of the complaint.

Additional comments on the standard of record keeping

117. My investigation into this complaint uncovered systemic failures in record keeping by the Home, which I find alarming and worrying. The failings include, but are not limited to, failure to keep records of the resident's wishes, failure to document a deterioration in the resident's oral health, repetitive cutting and pasting of entries in the daily care notes and creating false records. The Home was also responsible for losing, or mislaying records containing evidence of the nursing care provided to the resident.

118. The consequences of poor record keeping can have a devastating effect on services users[12], particularly the elderly and vulnerable. It can also lead to a

[12] See Records Matter by NIPSO, NIAO and ICO records-matter-january-2020-digital-edition.pdf (nipso.org.uk)

loss of confidence in those organisations charged with maintaining the wellbeing and quality of life of the people under their care. In addition, failings may be repeated with potentially significant outcomes. Incomplete, missing or inadequate records can lead to suspicions of wrongdoing or a sense that the body has something to hide. In this case, the complainant questioned the honesty of the Home's responses. I share the complainant's concern. In my view the Home's record keeping is of an extremely poor standard and I believe it calls into question the Home's integrity. I expect the Home and its staff to learn from the numerous failures identified in the report

CONCLUSION

119. I received a complaint about the actions of the Home. The complainant raised concerns about the care and treatment Home staff provided to her father, the resident. The complainant also had concerns about the Home's handling of her complaint.

Issue One

120. The investigation of the complaint found that it was reasonable for the Home not to provide the resident with regular showers due to the risk of causing further skin damage. The investigation established failures in the care and treatment in relation to the following matters*:*
    - Failure to document the resident's refusal to have a shower;
    - Failure to document, or assess the resident's oral thrush;
    - Failure to update the resident's care plan to prevent pressure sores;
    - Failure to follow the TVN's advice to reposition the resident every two hours;
    - Failure to keep accurate and consistent records in respect of wound care;
    - Failure to follow instructions to prevent limb contracture;
    - Failure to accurately record the resident's weight;
    - Failure to call an ambulance in a timely manner; and
    - Cutting and pasting multiple entries in the resident's daily care records.

Issue two

121. The investigation established maladministration in relation to the following matters:

- Failure to provide an explanation for the resident's missing records;
- Failure to provide the complainant with honest evidence-based explanations;
- Failure to conduct a thorough and accurate investigation;
- Failure to respond to the complainant in a timely manner; and
- Failure to provide the complainant with anticipated timescales in relation to her complaint.

122. I am satisfied that the failures in care and treatment identified caused the complainant to experience the injustice of distress the loss of opportunity. I also consider that these failures, in addition to the maladministration identified caused the complainant and her family the injustice of upset, distress, frustration, uncertainty and the time and trouble of bringing a complaint to this office. I note that the complainant described how the situation had a severe impact on her personal life and left her unable to grieve. I consider that the experience of watching the resident's health deteriorate during his time in the Home must have been extremely distressing for the complainant and her family and I extend my deepest sympathies to them.

Recommendations

123. I recommend that:

- The Home provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice identified in this report. The Home should provide the complainant with the apology within **one month** of the date of the final report;

124. I further recommend for service improvement and to prevent future recurrence that

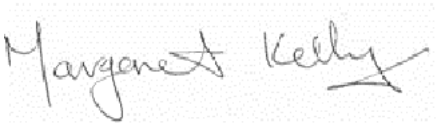
- The Home brings the failures identified in this report regarding the oral health care to the attention of the relevant staff, emphasising the importance of mouth and denture care;
- The Home undertakes an audit using a random sample of nursing records. The audit should assess if the records contain completed oral assessments and mouth care plans etc. Take action to address any identified trends or shortcomings. The Home ought to include any recommendations identified in its update to this office. The Home should report its findings to my office.
- The Home brings the failures identified in this report regarding the failure to follow the TVN's and physiotherapist's instructions to the attention of the relevant staff within three months of date of my final report;
- The Home provides training to relevant staff on the recognition of potential stroke symptoms and the steps to take when a stroke is suspected within three months of date of my final report;
- The Home provides staff with training in keeping relevant and accurate records in particular identifying good practice and legislative requirements; Home staff involved in this case should evidence a reasonable level of reflection of findings in the complaint including discussion of the matter in their next appraisal;
- The Home carries out a random sampling audit of residents' records with a particular emphasis on daily care notes to ensure all entries are accurately and clearly recorded and are not pasted copies of existing entries. Take action to address any identified trends or shortcomings. The Home ought to include any recommendations identified in its update to this office. The Home should report its findings to my office.
- The Home carries out a review of their record management policies and processes to ensure that resident notes and records can be tracked and located at all times, and to ensure a procedure for reporting mislaid or lost records forms part of that dossier;
- The Home reminds all staff involved in patient complaints handling of the importance of providing full, clear, and thorough responses to every element of a complaint raised by, or on behalf of a resident. Staff should

also be reminded of the importance of meeting response times and where this is not possible to update the complainant, provide reasons for the delay and indicate when they can expect a response; and

- The Home provides evidence that it has reviewed why its own investigation did not identify or acknowledge all the failings highlighted here.

125. I recommend that the Home implements an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

126. I am pleased to note that Healthcare Ireland, the Home's current owners have agreed to implement my recommendations. Unfortunately, I note with concern that Four Seasons Healthcare did not provide a response, to either my findings or my recommendations in respect of complaint handling.



March 2022

MARGARET KELLY
Ombudsman

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.