Investigation of a complaint against the South Eastern Health & Social Care Trust

Report Reference: 202001708 and 202002322

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

SUMMARY ………………………………………………………… 4

THE COMPLAINT ………………………………………………. 9

INVESTIGATION METHODOLOGY …………………………. 11

THE INVESTIGATION ………………………………………….. 14

CONCLUSION …………………………………………………... 76

APPENDICES ……………………………………………………. 84

Appendix 1 – The Principles of Good Administration
Appendix 2 – The Principles of Good Complaints Handling

Case References: 202001708 and 202002322

Listed Authorities: South Eastern Health and Social Care Trust and Blair House Care Home

SUMMARY

I received a complaint about the actions of the South Eastern Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant's late mother (Resident A) from March 2015 to September 2018 in Blair House Care Home (the Home). In exercise of the statutory discretion, this office also opened a complaint against the Home. During this period Priory Adult Care managed the Home. Healthcare Ireland currently manage the Home. This report examines the actions of both the Home and the Trust.

The complainant raised concerns about:

- safeguarding in-relation to the development of an intimate relationship between Resident A and Resident B;
- Resident A's transfer from residential care to nursing care;
- the care and treatment provided to Resident A while in the Home's nursing unit;
- the monitoring the Trust provided (March 2015 to November 2017)
- and the Trust's handling of her complaint.

The investigation identified serious failures, particularly in relation to the safeguarding issues. When relative/cares make the difficult decision to place loved ones into care they expect a certain level of care to be provided, alongside measures to protect their loved ones from any harm. I consider that both the Trust and Home failed to provide such care to Resident A.

My investigation found failures in care and treatment provided by both the Trust and the Home.

I identified the Trust failed:-

- to thoroughly investigate the Home's safeguarding referral of 8 and 9 March 2015 incidents;

- to assess the Home's safeguarding referral of 1 April 2015 incident under its safeguarding procedures.
- to carry out a care review for Resident A in an appropriate timescale.

In the course of my investigation information emerged which suggested that Resident B did not fully fit the profile of the stated purpose of the home and had a number of additional risk factors which should have led to consideration of the appropriateness of the placement or at least a more detailed risk assessment.
My investigation found no evidence of such a risk assessment, and I consider this a failing on behalf of the Trust.

I concluded that these failures caused Resident A the loss of opportunity to ensure any potential vulnerabilities were thoroughly assessed and if necessary ensure she was protected, and that the effectiveness of strategies implemented following the safeguarding incidents were appropriate and robust.

My investigation did not establish failures in relation to:-

- the Trust Staff's response to the complainant's concerns about bruising on Resident A's arm.
- the Trust's assessments regarding Resident A's transfer to and from the nursing unit;
- The Trust's communication with the complainant about Residents A's transfer to the nursing home in December 2017; and
- The appropriateness of the Trust's actions when investigating the concerns the complainant raised about the Home in 2018.

I identified that the Home failed to:-

- update Resident A's 'expressing sexuality' care plan;
- assess the capacity of both residents to consent to forming an intimate relationship;
- record and act on the complainant's concerns about bruising on Resident A's arm;

- provide information to the complainant and the Trust in relation to Resident A's transfer date;
- provide adequate staffing for the period 2 July 2018 to 29 July 2018;
- update and maintain an accurate record of Resident A's Breathing and Circulation' care plan;
- offer sufficient meaningful activities and events to Resident A while in the nursing unit; and
- maintain Resident's A's dignity and respect while in the nursing unit, particularly in relation to the provision of chiropody services and wearing of appropriate clothing.

I concluded that these failures in care and treatment caused Resident A the loss of opportunity to;

- have her capacity in relation to forming intimate relationships assessed;
- to have the complainant present during the transfer to the nursing unit; to ensure her care needs were adequately met;
- to be provided with a possible alternative form of medication;
- to experience the potential benefits from activities for a person with dementia; and
- to have the presence of bruising investigated fully.

I also concluded both Resident A and, the complainant experienced upset and distress.

My investigation did not establish failures in the Home's care and treatment in relation to:-

- The recording and reporting of safeguarding incidents that occurred in the Home on 8 and 9 March 2015;
- The recording of reporting of the incident that occurred in the Home on 1 April 2015;
- The appropriateness of Home staff to request the Trust to review Resident A's care needs;

- The appropriateness of the Home's treatment of Resident A's chest infection.

My investigation also identified maladministration by both the Trust and the Home.

I identified the Trust failed to:-

- Record the rationale for the decision not to proceed to further investigation and exploration for the safeguarding incidents that occurred on 8 and March 2015;
- provide the complainant with full information about the safeguarding incident on 9 March 2015;
- inform the complainant she had an opportunity to view the nursing unit in the Home;
- keep the complainant updated as to the contact details of Resident A's monitoring officer; and
- provide an adequate complaint response on 23 May 2019, 19 August 2019, 24 January 2020 and 18 June 2020.

I concluded the maladministration identified caused the complainant the loss of opportunity to;

- fully consider the protection strategies the Trust and Home implemented and to decide if she was content with them;
- to make an informed decision about the suitability of Resident A's new placement; for a thorough and complete response to her initial concerns as well as her safeguarding concerns.

I also concluded that this caused the complainant to experience the injustice of uncertainty; frustration and time and trouble by bringing a complaint to this office.

I identified the Home failed to:-

- provide Resident A's visual observation records for the period 9 March to 8 June 2015;

- notify the Trust of the concerns staff documented on 5, 12 and 18 April 2015 in line with the Home's Safeguarding January 2015;
- provide accurate information, to the complainant, about the possible transfer of Resident A to nursing care in June 2017; and
- provide daily progress notes for the period of 6 December 2017 to 31 December 2017.

I concluded the maladministration identified caused Resident A the loss of opportunity to have Home staff concerns considered by the Trust under its Safeguarding Policy and Safeguarding Good Practice Guide. I also concluded the complainant experienced the loss of opportunity for a more thorough investigation about the safeguarding incidents loss and to support her mother during the transfer.

I recommended that the Trust and Home provided the complainant with a written apology for the injustice caused as a result of the failures in care and treatment and maladministration I identified. I also made recommendations for both the Trust and Home to address under an action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

THE COMPLAINT

1. I received a complaint about the actions of the South Eastern Health and Social Care Trust (the Trust) in relation to the care and treatment provided to the complainant's late mother (Resident A) from March 2015 to September 2018 in Blair House Care Home[1] (the Home). As the complainant raised issues of complaint relating directly to the actions of Home staff, in exercise of the statutory discretion, this office considered it necessary to also open a complaint against the Home. I determined to produce one composite investigation report to provide maximum learning opportunities for both the Trust and the Home.

Background

2. On 22 September 2014, Resident A was placed in the residential EMI[2] unit (residential unit) of the Home as result of a diagnosis of dementia.[3] Initially Resident A was independent with daily tasks. In 2017 residential unit staff recommended, due to increased supervision needs, decreased mobility and higher risks associated with increased confusion, that Resident A be moved to the EMI nursing care unit (nursing unit) within the Home. Resident A subsequently moved to the nursing unit in December 2017.

3. In July 2018 the complainant raised a number of concerns about the quality of care the nursing unit provided to Resident A as well as concerns about the appropriateness of the placement. As a result of these concerns the Trust commissioned General Practitioner (GP) and District Nursing assessments to obtain updated assessments and recommendations in respect of Resident A's future care arrangements. The outcome of these assessments determined that Resident A required EMI residential care rather than nursing care. However, due to difficulties in sourcing and securing a residential care placement, in any setting, the Trust agreed that Resident A could remain under nursing care

---

[1] At the time of the complaint, Priory Adult Care (previously known as Amore Care) operated Blair House Care Home. This organisation dealt with the original complaint, along with the Trust and subsequent investigation enquiries. For continuity, the body under investigation will be referred to as the Home throughout the report. Healthcare Ireland now manage the Home.
[2] EMI stands for Elderly Mentally Infirm and refers to care home residents who have Alzheimer's and other types of dementia.
[3] An umbrella term for a range of progressive conditions that affect the brain. Each type of dementia stops a person's brain cells (neurones) working properly in specific areas, affecting their ability to remember, think and speak. The word ''dementia'' describes common symptoms such as memory loss, confusion, and problems with speech and understanding which get worse over time.

however in an alternative setting from the Home. On 17 September 2018 Resident A moved to another nursing unit in a different Home. A chronology detailing the events leading to the complaint is set out at Appendix six to this report. The complainant also raised concerns about the Trust's handling of her complaint. A chronology detailing the complaint handling process is set out at Appendix seven to this report.

Issues of complaint

4. I accepted the issues of complaint below for investigation.

The following issues relate to the actions of the Trust and the Home:

Issue One: Whether safeguarding incidents involving Resident A were dealt with appropriately and in accordance with relevant policies and standards.

Issue Two: Whether Resident A's transfer from residential care to nursing care in 2017 was handled appropriately and in accordance with relevant policies and standards.

Issue Three: Whether the care and treatment provided to Resident A from 6 December 2017 to 17 September 2018 was appropriate and in accordance with relevant policies and standards.

The following issues relate to the actions of the Trust:

Issue Four: Whether the level of care monitoring, provided by the Trust, from March 2015 to November 2017 was suitable and in accordance with relevant policies and standards.

Issue Five: Whether the Trust responses to the complainant from May 2019 to May 2021 were appropriate and in line with relevant policies and standards.

INVESTIGATION METHODOLOGY

5. I determined to issue a composite report of the investigation of the complaint to provide a clear and complete explanation of the issues raised. I informed the Trust and the Home of my determination in this regard. This report therefore encompasses the issues of complaint against both bodies and will be set out under the headings stated in paragraph four.

6. To investigate this complaint, the Investigating Officer obtained from the Trust and the Home all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust and the Home's complaints process. The complainant provided extracts of her journal which she kept throughout Resident's A time in the Home. The Investigating officer also obtained documentation from the Regulation and Quality Improvement Authority[4] (RQIA) in relation to an unannounced care inspection of the Home on 23 July 2018.

Independent Professional Advice Sought

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

- A Social worker with 33 years' experience including in services related to elderly care and safeguarding adults. (SW IPA); and
- A Consultant Nurse for older people RGN, BA(Hons), MSc, PGCert (HE) with over 20 years' experience across acute care, community and care homes. (N IPA)

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPAs provided 'advice'. However,

[4] An independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and, encouraging improvements in the quality of those services.

how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

   The general standards are the Ombudsman's Principles[5]:
   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

10. 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:
    - The Department of Health, Social Services and Public Safety, Regional Adult Protection Policy and Procedural Guidance - Safeguarding Vulnerable Adults, September 2006 (the Department's Safeguarding Guidance);
    - The South Eastern Health and Social Care Trust's Policy on Safeguarding Vulnerable Adults, December 2013 (the Trust's Safeguarding policy);
    - The South Eastern Health and Social Care Trust's Safeguarding Vulnerable Adults, Good Practice Guide, January 2012 (the Trust's Safeguarding Good Practice Guide);
    - The Priory Group of Companies Safeguarding Adults (Anyone aged 18 or over) Policy, January 2015; (the Home's Safeguarding January 2015 Policy);

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

- The Priory Group of Companies Safeguarding Adults (Anyone aged 18 or over) Policy, July 2015; (the Home's Safeguarding July 2015 Policy);
- The Department of Health, Social Services and Public Safety, Residential Care Homes Minimum Standards, August 2011 (the Department's Residential Homes Standards);
- The Department of Health, Social Services and Public Safety, Care Management, Provision of Services and charging Guidance, Circular HSC (ECCU) 1/2010, March 2010 (the Department's Care Management Guidance);
- The Priory Group of Companies Admission, Transfer and Discharge Policy, July 2016 (the Home's Transfer Policy);
- The Department of Health, Social Services and Public Safety, Care Management, Care Standards for Nursing Homes, April 2015 (the Department's Care Standards);
- The Nursing and Midwifery Council's (NMC) Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (the NMC Code);
- The Northern Ireland Social Care Council's Standards of conduct and Practice for social care workers, November 2015 (The Social Care Workers Standards);
- The Northern Ireland Social Care Council's Standards of conduct and Practice for Social Workers, November 2015 (The Social Worker Care Standards);
- The South Eastern Health and Social Care Trust's Guidance on the Management of Incidents and Complaints for Independent Sector Providers, December 2017, (the Trust's Independent Sector Provider Complaints Guidance);
- The Department of Health's Guidance in relation to the Health and Social Care Complaints Procedure, April 2019 (the Department's Complaints guidance);
- The South Eastern Health and Social Care Trust's Policy on the Management and Handling of Complaint's, April 2019 (the Trust's

Complaints Policy).

11. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

12. A draft copy of this report was shared with the complainant, the Trust, Priory Adult Care and Healthcare Ireland (as the previous and current owners of the Home) for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue One: Whether safeguarding incidents involving Resident A were dealt with appropriately and in accordance with relevant policies and standards. In particular this considered:

- **Safeguarding incidents in 2015; and**
- **Presence of unexplained bruising in May 2018.**

Detail of Complaint

13. The complainant raised concerns about how the Trust and the Home dealt with incidents involving the development of an intimate relationship between Resident A and another resident (Resident B), in March and April 2015. She believed both bodies mishandled the incidents and as a result did not protect Resident A's vulnerability. She said the Home did not inform Resident A's Key worker[6] of the second incident in April 2015 and believes there was a lack of transparency in the notes recorded. She also said the bodies did not keep her informed during the investigation process.

14. The complainant also raised concerns about bruising on Resident A's wrist. She queried the presence of bruising, on 13 May 2018, with Home staff who

[6] A person who coordinates all aspects of care and communication for the person, their family members and carers, and the services that when they have been placed in a care setting.

told her it was from the resident getting washed as her skin was very delicate. The complainant said the Home did not follow-up with her about her concerns. She said on 23 July 2018 an RQIA inspector saw the bruising on Resident A's wrist, and he said it was not as result of medication but contact bruising.

Evidence Considered

Policies/Guidance

15. I considered the following policies/guidance:
    - the Department's Safeguarding Guidance;
    - the Trust's Safeguarding Policy;
    - the Trust's Safeguarding Good Practice Guide;
    - the Department's Residential Homes Standards;
    - the Home's Safeguarding January 2015 policy;
    - the Home's Safeguarding July 2015 policy; and
    - the Social Care Workers Standards.

The Bodies' response to investigation enquiries

The Trust

i. Safeguarding

16. The Trust explained, in its response of 19 January 2022, that *'…these concerns were initially raised by [the complainant] on 21 April 2020 and responded to by the Trust on 18 June 2020…[Resident A's] records have been audited in respect of the incidents raised…and records would evidence that the Trust investigated the concerns at the time under Vulnerable Adult Procedures… Staff from [the Home] contacted [Key worker A] on 9 March 2015 to advise of two incidents involving [Resident A] and [Resident B], one occurring on 8 March 2015 and the second on 9 March 2015…The Trust can confirm that Vulnerable Adult Procedures were implemented and a protection plan agreed with the home. RQIA was also informed of the incidents, as were family relatives and appropriate medical staff in respect of both individuals. The Vulnerable Adult investigation was completed with recommendations for ongoing monitoring and liaison with relevant professional alongside appropriate Dementia Management*

strategies…The incidents were discussed… at [Resident A's] Care Review on 27 March 2015…both [Resident A] and [the complainant] confirmed their satisfaction at the quality of care provided by staff in the residential unit and no concerns or issues were identified.'

17. The Trust further explained, in its response dated 19 May 2022, that in relation to Resident A *'… that there is no other documentation or recording in the case file regarding any further safeguarding incident in and around the…beginning of April 2015…'* However, on 12 September 2022, in response to further enquires by this office, the Trust explained it had *'…reported previously that there was no evidence in relation to [Resident A] of any other documentation or recording in the case file regarding further safeguarding incidents in and around the…beginning of April 2015, that remains the case… The Trust apologises that, on review of [Resident B's] records there was evidence that an incident occurred between [Resident A] and [Resident B] on 1 April 2015…'*

18. The Trust also explained '…*Information from this report…states there was no evidence of which service user instigated the actions…As a result a VA1*[7] *was completed in respect of both individuals being alleged vulnerable individuals. It outlines that the couple had apparently developed a friendship and it had been agreed with [Resident A's] keyworker and relevant family members at the care review (27 March 2015…) that the couple had permission to spend time in the service user's bedroom, so long as the bedroom door was left open and 30 minute observations were put in place. Following the incident [on 1 April 2015] it was recorded that staff were advised to continue with 30 minute observations, but that the service users were to spend time with each other in the lounge rather than the bedroom. The VA1 states that RQIA and family were informed of incident. The report also states that the keyworker was to follow up on her return from annual leave. There is no record of this in the service user's [Resident A] file. The Trust apologises for this…'*

[7] Form used to report any safeguarding concerns to a Designated Officer.

19. The Trust provided information that, following a previous Ombudsman's investigation report, dated 15 September 2021, it had now implemented recommendations which included updating information within its Adult Protection documentation to reflect the need to record rationale for decisions when screening out safeguarding referrals.

ii. Bruising

20. The Trust provided contact records in relation to the follow up and decisions made in relation to the complainant's report of bruising noted on Resident A's arm.

The Home

Safeguarding and Bruising

21. The Home explained *'As a company we endeavour to operate an open and transparent culture and encourage all of our staff to report and escalate concerns within the care home environment. This forms an integral part of our training programme and we have very robust internal reporting systems in place as well as having systems to report such concerns externally. These are outlined in our 'in house' Safeguarding policies and procedures…These systems are complemented by our confidential Whistleblowing Helpline, an employee assistance helpline, safeguarding on line training via Priory academy as well as face to face training. In accordance with our own internal procedures we are bound by our contractual agreements with the host NHS Trust to report all concerns via the incident reporting systems and via the Regulation and Quality Improvement Authority to report via the web portal. In the event that an incident has reached the threshold for a safeguarding report to be made an APP1 form is completed, and forwarded to the named Care Manager for each individual resident. This identifies the nature of the matter, the level of risk and protection plan measures if required depending on the nature of the incident.'*

Relevant Trust, Home, and Complainant records

22. Resident A's Trust and Home records were considered as well as entries made within the complainant's journal and the RQIA's inspector's notes from the unannounced inspection on 23 July 2018. Relevant extracts from these records are enclosed at Appendix five (a) to this report.

Relevant Independent Professional Advice

i. Safeguarding incidents

8 and 9 March 2015

SW IPA

23. The SW IPA advised the Trust received a notification on 9 March 2015, from the Home, about incidents that had occurred on 8 and 9 March 2015, involving Residents A and B and '*The Designated Officer allocated an Investigating Officer and subsequently a strategy discussion was held between the two officers. A decision was taken for the matter to be closed under the Adult Protection process and for the matter to be addressed by the Key Worker under the processes for assessment of need*[8]*.'*

24. In relation to the Trust's actions following the reporting of the incidents the SW IPA advised that it appears *'…the matter did not proceed beyond a discussion between the Designated officer and the Key Worker/Investigating Officer. There is some confusion here because the Trust's response to the complainant of 21st May 2021 refers to all incidents as having been investigated under the procedures and in fact the 'Decision to Close an Adult Protection Investigation' also refers to 'the investigation' as having been completed. There is in fact no evidence on file of any investigatory activity as such and furthermore, the Trust's response to the Ombudsman of 19th May 2021 implies that in relation to the incidents of 8th and 9th March, a decision was actually taken not to investigate.'*

[8] Process used to determine the care needs of a service user.

25. The SW IPA went onto to advise *'…It is of course entirely within reason that upon occasions, a decision is taken at the 'screening' stage not to proceed to investigation. However, I could not identify a clear rationale for this decision in this case. I do not imply here that it was the wrong decision; it may be that the decision was taken because all appropriate actions had been put in place. But I am not able to ascertain why the decision was made and in particular why it was not deemed necessary to speak to ether of the residents involved…'*

26. She further advised that she did not agree with the Trust's response that under the policies in place at the time, there was no requirement for decisions made in relation to screening to be recorded. This is because both the Trust's Safeguarding Good Practice Guide and the Department's Safeguarding Guidance state, rationale for decisions should be recorded. The SW IPA also advised that *'…It is in any event established good practice within social work for key decisions of any kind to be recorded, along with their rationale. A decision not to proceed with a safeguarding investigation is clearly a key decision and the rationale for it should be able to be easily identified from the file.'*

27. The SW IPA advised that whilst she could not identify any investigation process *'...certain initial actions were agreed with the home…'* and '*These were, on the surface of it, appropriate initial actions, based on what was known at the outset and in so far as they went…'* The SW IPA was unable to establish if the two residents were spoken to *'…in order to establish their views about the incidents and about their relationship moving forward or to consider their respective capacities to make decisions about that relationship…'* She further advised that while she understood that there may have been *'…difficulty in establishing who might be the 'perpetrator', there was a situation here that, on the surface of it, might present some risk to one or the other of the residents and that also raised questions about the capacity of either one of them to enter into a relationship. I would have expected these to be explored via safeguarding processes, and analysed and specifically addressed in the decisions made moving forward.'*

28. The SW IPA further advised Home staff were not *'…interviewed to gather information about the ongoing relationship between the residents and the*

practicality or otherwise of managing this by the means suggested. It is not possible to say what the outcome of such enquires would have been, and therefore I am not able to say with certainty that the decision not to investigate had any particular impact upon Resident A. I can only say that the rationale for the decision not to proceed to further investigation and exploration of this quite complex situation is not available.'

29. In relation to communication with the complainant about the incidents on 8 and 9 March 2015 the SW IPA advised she *'…could not identify anything to support the view that the Designated Officer made contact with the complainant. But it appears that the care home staff and the Key Worker did so, and I would view this as sufficient…'* However, '*…it is very unclear exactly what was communicated to the complainant. She remains adamant that she was not informed of the second incident. Clearly, she should have been. There is nothing to tell me with absolute authority that she was informed, and it is feasible, but not provable either way, that the verbal discussions in the review of 27th March did not mention the second incident (although I acknowledge that it is difficult to understand why it would not have been mentioned at this point or by the care home staff when she was rung quite soon after the second incident took place.)'*

N IPA

30. The N IPA advised that the Home's recording and reporting of these incidents was appropriate. Following the incidents The N IPA advised, that the Home set *'…out a plan for 15 minute observations and behaviour record with aim of "staff to protect as far as possible for this not to happen again"…'* An entry in the Home's records on 11 March 2015 confirmed that Resident A '*…remained on "30 minute obs"...',* which was also confirmed with the complainant during the care review on 27 March 2015.

31. In relation to the maintaining of observations of both Residents the N IPA advised that initial records refer *'…to 15 minute observations, although subsequent references are to 30 minute observations. It was appropriate to maintain regular observations of the residents… Observation records… from 8*

June 2015 and continue intermittently up to October 2018. In view of the observations being a plan in response to a safeguarding concern, I would have expected to have seen a record of them during this earlier period…'

1 April 2015

SW IPA

32. The SW IPA advised that the Home notified the Trust of an incident, occurring on 2 April 2015, involving Residents A and B on the same day. She went on to advise '*The files states that the Designated Officer was made aware and that the matter was allocated to the Key Worker to address upon her return from leave. As far as I can see, the matter ended there. The complainant acknowledges that she was informed of the incident…The matter should have been considered under the safeguarding vulnerable adults procedures and a decision taken as to whether the matter would proceed to investigation, with a rationale being made out and recorded if this was not to happen. Furthermore, family members should have been involved in discussions about the next steps and an appropriate plan.'*

N IPA

33. The N IPA advised that the incident was *'…described in the progress notes and form VA1…was completed and signed on 02/04/2015 by the care manager and records that the RQIA and Resident A's daughter was informed…This is in line with the [Home's] safeguarding policy…*' The N IPA further advised the VA1 form documented that Home staff were *'…continuing with 30 minute observations but have asked that clients spend time together in the lounge rather than the bedrooms…*' However, she also advised *'…There are no 30 minute observation logs until 08/06/2015… These continue to October with exception of…22 July to 7 Aug and 8 August to 6 September…As specific documentation of the 30 minute checks is missing, it cannot be verified whether they were carried out on all dates as planned*…'

34. In relation to the appropriateness of the Home's actions the N IPA advised that *'…Whilst the care home staff demonstrated that they recognised situations that required intervention or escalation…and took action…'* it *'…could have adopted*

a more person-centred approach the issue of whether Resident A and Resident B had the capacity to make decisions about sexual / intimate relationships…Although there is a care plan for "expressing sexuality"…, it refers to [Resident A's] appearance and clothing but there is no mention of her interactions with Resident B. I did not see any specific references to whether either resident had mental capacity to consent to forming a sexual relationship. I recommend that this could be an area for staff development and organisational guidance.'

Additional concerns

SW IPA

35. The SW IPA highlighted additional concerns recorded within the Home's daily progress on 5, 12 and 18 April 2015. She advised that these concerns *'…should have been relayed to the Trust and should also have been considered under the safeguarding process. While the home did put useful strategies in place, and these do appear to have been effective, it was the Trust that had responsibility for the safeguarding process and the concerns ought to have been formally considered via that process, with appropriate involvement of family members.'*

36. The SW IPA further advised that after 18 April 2015 *'…the situation does seem to have settled down, with both residents responding to staff re-direction when told that they could not be alone together. This, plus the strategy of 30 minute checks, appear to have been effective on the home's part in avoiding another incident.'*

N IPA

37. The N IPA advised the additional events *'…were recorded in the progress record but not specifically reported to the Trust at the time that they occurred…the care home did not carry out a documented assessment of sexuality/relationships that covered consent issues – consequently they were not specific about what behaviours between the residents, such as kissing, were to be considered consensual or within an acceptable risk for both residents…In view of the recent history and absence of specific action planning,*

I think that this should therefore by default have been a report to the Trust, but there is no record that this was done at the time…'

ii. Bruising

SW IPA

38. The SW IPA advised the Trust shared the information, it received from the complainant about bruising on Resident A's arm, with the Adult Gateway Protection Team[9] (AGPT). Following deliberations *'…the decision was taken to process the concerns via the complaints procedure, and via a review to consider the placement…'* The SW IPA further advised at the care review *'…no further concerns came to light about the matter of the bruising…the complainant indicated her willingness to accept the complaint being closed but wanted her mother to move placement. This was in effect therefore a resolution of her concerns…'* The SW also advised that the Home responded as part of the complaints process and *'…could find no record of the bruising and that they apologised that the bruising had not been noted.'*

39. The SW IPA commented on the RQIA inspector's report and advised that the inspector did not record any reference to the bruising being 'rough handling' or make *'…any mention of bruising at all, and neither did he make a safeguarding referral, which I would have expected him to do if he had concerns of 'rough handling…'* The SW IPA further advised that the actions of the Trust *'…were reasonable…'* and taking everything into account, including the historic nature of the bruising, *'…it made sense for the Trust to consider the issue as part of the overall picture of concern about standards in the home as presented by the complainant and to act further if it recurred.'*

N IPA

40. The N IPA advised that in and around 13 May 2018 she did not find any entry within the Home's records that the complainant raised the presence of a bruise on Resident A's arm to Home staff. She also advised that she could not find *'…any record or [sic] bruising on the resident's arm during this period…'* or any

---

[9] Team within the Trust that helps people who are being abused, exploited, or neglected.

record of incidents that may have explained any bruising, although staff documented skin checks for other periods.

41. The N IPA also advised that the *'Risk of skin damage (such as bruising) increases with age, health conditions and other factors such immobility, circulation problems, smoking and can present as skin tears, bruising and discolouration. It is important to recognise that skin damage of the type described can appear 'seemingly unprovoked'…'* She went on to advise that the Home had completed a skin damage assessment for Resident A and due to specific risk factors, that *'…Resident A would therefore be at risk of bruising or other damage…'* although *'…it is not possible to conclude whether washing could have caused skin damage as there is lack of evidence…'* The N IPA further advised that it was unlikely that the medications prescribed to Resident A *'…would contribute to the appearance of bruising as described.'*

42. As the N IPA did not identify any records of bruising around 13 May 2018, she was not able to comment on whether any incidents should have been referred to the Trust.

Complainant's response to draft report

43. The complainant raised concerns whether the implementation of dementia management strategies was sufficient in this circumstance and queried if further medical opinion should have been sought regarding Resident A's mental capacity and emotional state. She was also concerned that the police had not been informed particularly after the incident on 1 April 2015. She highlighted further impact to Resident A who had formed a dependency on resident B's companionship and became *'…annoyed…and…probably confused, sad and angry that someone important to her was no longer allowed to sit with her each day…a much crueller scenario than if he had been made to leave much earlier, affording her time to readjust…'* The complainant felt the impact on Resident A could have been avoided had Resident B left the residential unit sooner.

44. The complainant believed the notes were *'…intentionally "missing"…'* and this along with the absence of full investigation, no system in place for monitoring the situation and, lack of communication and transparency alarmed her.

45. In relation to the bruising incidents the complainant raised concerns about the openness and transparency of the Trust and the Home. She said that unless a conversation was backed up by written communication, there was *'… no guarantee that it will be acknowledged as having taken place at all…*' She wished to highlight, to others, the need to follow-up important discussions with further written communication.

Trust's Response to draft report

46. The Trust explained that when the Home reported the incidents of 8 and 9 March 2015 there was a stand-alone, short intervention, as reported on the Vulnerable Adult paperwork. As a consequence, the Designated Officer did not record the incident as screened out. The rationale for the intervention was outlined. *'...Families were informed and information gathered as part of the process. Following information gathering it was considered that the proportionate response to manage the incidents was through Dementia management. This included ongoing monitoring and a protection plan, which was put in place under the direction of the keyworker. At that point in time, when the outcome of an investigation was that the situation was managed in accordance with Dementia management, the Keyworker was the responsible person…'*

47. The Trust went on to say that in March 2015, when it investigated these cases, regional paperwork did not require a detailed rationale for decision making. New regional Adult Safeguarding policy built on improved consistency and quality of recording and a more detailed rationale in decision making but, these regional procedures were not issued to Trust until 8 September 2016. The Trust would *'…suggest that the staff involved acted in accordance with the Vulnerable Adult Standard Operating Procedure in operation at that time…'* It also outlined training provided to Designated Officers since 2016 which included:-

- Dec 2018: Good Practice in Recording;
- May 2019: Recording Analysis and Decision Making;
- June & Oct 2019: Recording and Report Writing; and
- Dec 2019: Risk Assessment and Management in Adult Safeguarding.

48. In relation to the communication with the complainant about the March 2015 incidents it said *'…Standard practice was that the Keyworker informed/discussed all incidents with family members /next of kin. Both incidents were reported to the Keyworker at the same time and recorded on the same VA1 report…'* The Trust re-iterated that records also reflected these incidents were further discussed at Resident A's care review on 27 March 2015 and no issues or concerns were raised at that time. It said care home staff had completed the *'adverse events'* section of the review template and that it '…*would be standard practice that the keyworker would go through all areas of the review template, including those completed in advance by the Care Home staff, and there is no reason to suggest this was not the case on 27 March 2015…*' It was the Trust's view that *'...On balance of all the evidence…both incidents were discussed at the review with the complainant present…'*

49. The Trust said it was not its *'…intent to be misleading or put up any barriers to the Ombudsman's investigation. The Trust investigation, up to the request from your office, had consisted of a thorough review of all information in Resident A's case records. There are no records in Resident A's case file regarding the incident of 1 April 2015…and as the member of staff involved no longer worked in the Trust, the respondent was unaware of the incident…'* The Trust apologised and said it *'…would take learning from this situation.'*

50. In relation to the placement of Resident B the Trust said *'…It is likely that the Trust would have shared the rationale for placement with the care home, and support / review / risk management arrangements would have been clarified and agreed…' The Trust accepted that a detailed risk assessment was not available, but '…would assert that decisions to admit are based on a full*

consideration of all relevant information, and this would have been provided at least verbally, if not in writing, [with the Home]…'

Analysis and Findings

i. Safeguarding incidents

Actions of the Trust

8 and 9 March 2015

51. As set out in Appendix five (a) paragraphs one to six I considered the Trust's actions taken in response to the Home's notification of the incidents that occurred between Residents A and B. I also considered the complainant's records as set out in Appendix five (a) paragraphs 14 to 16 and note she said she was not informed about the incident that occurred on 9 March 2015 and would not have agreed to certain strategies had she been aware of the incident. I note the Trust's comments that *'…records would evidence that the Trust investigated the concerns at the time under Vulnerable Adult Procedures…with recommendations for ongoing monitoring and liaison with relevant professional alongside appropriate Dementia Management strategies…The incidents were discussed… at [Resident A's] Care Review on 27 March 2015…and no concerns or issues were identified.* I further note the Trust's comments that the Designated Officer did not record the incidents as screened out as the Key worker implemented a stand-alone short intervention. I also note the actions taken as part of this intervention.

52. I considered the SW IPA's advice about the process the Trust undertook in relation to the Home's notification of the incidents on 8 and 9 March 2015. '*The Designated Officer allocated an Investigating Officer and subsequently a strategy discussion was held...A decision was taken for the matter to be closed under the Adult Protection process and for the matter to be addressed by the Key Worker under the processes for assessment of need…'* I also note her advice that '*...certain initial actions were agreed with the home…'* and '*These were, on the surface of it, appropriate….'* I further note the SW IPA's advice about the differences in the Trust's comments to the complainant and comments on the 'Decision to close adult protection investigation' form that an investigation was completed. This compares to the information given to this

office that, she advised, implied *'…a decision was actually taken not to investigate.'*

53. I note the SW IPA's advice that *'…It is…entirely within reason that upon occasions, a decision is taken at the 'screening' stage not to proceed to investigation…'* but that she could *'…not identify a clear rationale for this decision in this case…and in particular why it was not deemed necessary to speak to ether of the residents involved…'* I also note the SW IPA's advice that she could not establish if the two residents were spoken to *'…in order to establish their views about the incidents and about their relationship moving forward or to consider their respective capacities to make decisions about that relationship…'* She would have also expected the '…*capacity of either one of them to enter into a relationship…to be explored via safeguarding processes, and analysed and specifically addressed in the decisions made moving forward.'* I further note the SW IPA's advice that Home staff were not interviewed about the residents ongoing relationship or about the practicality of implementing management measures.

54. I further note the SW IPA's advice that both the Trust's Safeguarding Good Practice Guide and the Department's Safeguarding Guidance state, rationale for decisions should be recorded. She also advised '…*A decision not to proceed with a safeguarding investigation is clearly a key decision and the rationale for it should be able to be easily identified from the file…'* In this case '…*the rationale for the decision not to proceed to further investigation and exploration of this quite complex situation is not available.'*

55. I refer to Department's Safeguarding Guidance which outlines the purpose of a safeguarding investigation and states that, if appropriate, the alleged victims are interviewed and '*The needs of the vulnerable adult, informal carer or carers and, where appropriate, the alleged abuser should be considered…'* The guidance also states '…*In all instances where an investigation is not pursued, the reasons for this decision…should be noted.* I also refer to the Trust's Safeguarding Good Practice Guide which states that the Designated Officer should record *'…the rationale regarding the decision not to proceed [to*

investigation]. It also states that during an investigation the investigating officer should '…*Make contact with all of the people who might have relevant information to contribute to the investigation...'*

56. I acknowledge the confusion the SW IPA highlighted as to whether an investigation was carried out but accept the Trust's comments that the incidents were not screened out. Given the available evidence I am satisfied that the Designated Officer screened the referral, allocated an investigating officer, and had a strategy discussion, about the March 2015 incidents, with the investigating officer (the first step the investigation process). I am also satisfied that initial management/intervention actions were put in place. However, I consider no further detailed investigation took place after the stand alone short intervention. While I acknowledge that it is entirely within reason that on occasions, more in depth investigations may not be required, I accept the SW IPA's advice that on this occasion the residents' views should have been sought and consideration given to their capacities about that relationship. I also the consider the Trust should have spoken more fully with Home staff. Given the available evidence and, taking into account the circumstances of both residents, I find it extremely concerning that a more thorough investigation, was not carried out. A more thorough investigation would also have gone some why to establish if the management of the incidents via dementia management strategies was appropriate.

57. I consider the Trust's failure to thoroughly investigate the Home's referral of incidents on 8 and 9 March 2015 as a failure in Resident A's care and treatment. As a consequence of this failure, I consider that Resident A experienced the loss of opportunity to ensure any potential vulnerabilities were thoroughly assessed and if necessary protected.

58. I note the SW IPA's advice that the rationale for the decision not to proceed to further investigation and exploration has not been recorded and this is not in line with Trust's Safeguarding Good Practice Guide and the Department's Safeguarding Guidance. I acknowledge the Trust's comments that regional paperwork, at the time of the incidents, did not required a detailed rational for

decision making. However, it is my opinion that both the Trust's Safeguarding Policy and the Department's Safeguarding Guidance infer a requirement for record keeping. Namely under Section 5 - investigation and section 6 - Making Decision of the Trust Policy and, under Section 12 – Outcomes of Screening, Section 13, Strategy Discussion and Section 14 – Investigation of the Department's guidance. I refer to the First Principle of Good Administration '*Getting it Right'* which requires bodies to act in accordance *'…with the law and relevant guidance…with the public body's policy and guidance (published or internal)…'* and take *'…proper account of established good practice...'* I also refer to Third Principle of Good Administration '*Being Open and Accountable'* which requires bodies to state *'…criteria for decision making and giving reasons for decisions…'* I consider the Trust failed to follow its and the department polices. Therefore, I am satisfied that the Trust's failure to record a rationale for the decision not to proceed to further investigation and exploration as maladministration. I consider the complainant experienced uncertainty around the decision making process within the safeguarding assessment/investigation for these incidents.

59. In relation to communication with the complainant about the incidents I considered the SW IPA's advice. I note she advised that while it was sufficient for the Key worker and the Home to contact the complainant about the incidents '*…it is very unclear exactly what was communicated to the complainant. She remains adamant that she was not informed of the second incident…and it is feasible, but not provable either way, that the verbal discussions in the review of 27th March did not mention the second incident…'* The SW IPA acknowledged that this is difficult to understand given Home staff rang her soon after the incident on 9 March 2015. I acknowledge the information the Key worker and Designated Officer documented in the care review template relating to the March 2015 incidents. However, the complainant did not sign of this particular care review.

60. I acknowledge the Trust's comments that both incidents in March 2015 were discussed at the care review meeting. However, given the available evidence in the complainant's journal, her letter to the Trust, dated 4 February 2021, and

the unsigned care review template, I consider that on the balance of probabilities the Trust did not tell the complainant about the incident that occurred on 9 March 2015. I refer to the Trust's Safeguarding Good Practice Guide which states the investigating officer will be responsible for direct contact with carers and to the Third Principle of Good Administration *'Being Open and Accountable'* that requires bodies to ensure that information provided *'…is clear, accurate and complete...'* I consider the failure to provide the complainant with full information about the incident on 9 March 2015 as maladministration. I am satisfied that as a consequence of this maladministration the complainant experience the loss of opportunity to fully consider the protection strategies the Trust and Home implemented and to decide if she was content with them.

61. I acknowledge and welcome the information the Trust supplied that, following a previous Ombudsman's investigation report, it has now implemented recommendations which included updating information within its Adult Protection documentation to record the rationale for decisions when screening out safeguarding referrals. This practice should continue without exception when considering safeguarding referrals. I also welcome the training since provided to Designated Officers.

1 April 2015

62. As set out in Appendix five (a) paragraph seven, I considered the Trust's actions taken in response to the Home's notification of the incident that occurred between Residents A and B on 1 April 2015. I note Key worker C informed the Designated Officer of the incident, which included information on the strategies already in place, and advised that Key worker A would follow-up on the referral on her return from annual leave. I also considered the Trust's comments that '…*a VA1 was completed in respect of both individuals being alleged vulnerable individuals…'* and this outlines that both residents *'…had permission to spend time in the service user's bedroom, so long as the bedroom door was left open and 30 minute observations were put in place. Following the incident it was recorded that staff were advised to continue with 30 minute observations, but that the service users were to spend time with*

each other in the lounge rather than the bedroom…' I also note the Trust apologised that the Key worker A did not follow-up on the referral following her return from leave. I acknowledge the complainant's comments regarding notification to the Police.

63. I also considered the Trust's comments, after additional enquires this Office made, it had *'…reported previously that there was no evidence in relation to [Resident A] of any other documentation or recording in the case file regarding further safeguarding incidents in and around the…beginning of April 2015, that remains the case…'* However, after reviewing Resident B's records at the request of this office the Trust found *'…there was evidence that an incident occurred between [Resident A] and [Resident B] on 1 April 2015…'* I note the additional records subsequently provided. I am concerned that it required additional enquiries and prompting from this office to review Resident B's records.

64. When I make a request for information to a body, I expect <u>all</u> relevant information to be supplied to me in a timely manner. Such requests offer the body concerned the opportunity to state its case. The fact that my Office was unable to obtain information from the Trust without having to consistently pursue it is of major concern to me. I would ask the Trust to reflect on this and to remind relevant staff to ensure they explore all possible avenues when providing information to investigation enquiries from this office.

65. Following additional investigation enquiries and the provision of further information from the Trust and Home I note and express my concern that Resident B may not have fitted the profile of residents in the Home and may have had additional risk factors for which no detailed risk assessment is available. I consider, given the circumstances, that a clear rationale for Resident B's placement in the home and any associated risks should have been recorded and provided to the Home staff at the time. I consider this a failing on behalf of the Trust.

66. I considered the SW IPA's advice that following notification from the Home '…*the Designated Officer was made aware and that the matter was allocated to the Key Worker [A] to address upon her return from leave…The matter should have been considered under the safeguarding vulnerable adults procedures and a decision taken as to whether the matter would proceed to investigation, with a rationale being made out and recorded if this was not to happen. Furthermore, family members should have been involved in discussions about the next steps and an appropriate plan.'* As there had already been a safeguarding referral from the Home in March 2015 and the incident on 1 April 2015 was an escalation of relations between Resident A and B I accept the advice of the SW IPA that the Trust should have considered this referral under its Safeguarding Policy and Safeguarding Good Practice Guide which would have included notifications, if appropriate, to other bodies. I find it extremely concerning that the Trust did not do this.

67. I consider the Trust's failure to assess the Home's referral of the incident on 1 April 2015, a failure in Resident A's care and treatment. As a consequence of this failure, I consider that Resident A experienced the loss of opportunity to ensure any potential vulnerabilities were thoroughly assessed and if necessary protected.

Additional concerns

68. I note the SW IPA and N IPA's advice about further entries made in the Home's daily progress notes, on 5, 12 and 18 April 215, in relation to additional concerns about Resident A and Resident B. I acknowledge that it would have been the responsibility of the Trust to consider these concerns under its Safeguarding Policy and Safeguarding Good Practice Guide. However, I accept the Trust were unable to consider any of the concerns as the Home did not relay them to it. The actions of the Home in relation to these additional concerns will be considered in paragraphs 77 and 78.

69. I uphold this element of complaint in relation to the Trust's actions.

Actions of the Home

8 and 9 March 2015

70. As set out in Appendix five (a) paragraphs 8 to 13 I considered the Home's actions taken in response to the two incidents involving Residents A and B. I note and accept the N IPA's advice that the Home's recording and reporting of these incidents was appropriate and therefore in accordance with the Home's Safeguarding January 2015 policy.

71. However, I also considered the N IPA's advice about the observation records for Resident A. I note the Home introduced visual observations on Resident A in response to the safeguarding concerns on 8 and 9 March 2015 and set out an initial plan for 15 minutes observations which subsequently changed to 30 minute observations. I further note her advice that *'…There are no 30 minute observation logs until 08/06/2015… These continue to October with exception of…22 July to 7 Aug and 8 August to 6 September…As specific documentation of the 30 minute checks is missing, it cannot be verified whether they were carried out on all dates as planned*…' The Home's daily progress notes indicate that a further incident, on 1 April 2015, involving Resident A and B came to light as a result of a 30 minute observation check.

72. Given the N IPA's advice I am extremely concerned that there are no records available to provide contemporaneous evidence that Home staff undertook visual observations for a period of almost 3 months. I refer to the Department's Residential Homes Standards which require residential homes to maintain appropriate records for each resident. I also refer to the Third Principle of Good Administration *'Being Open and Accountable'* that requires bodies to keep *'…proper and appropriate records…'* I consider the absence of documentation of visual observations for Resident A wholly unacceptable.

73. 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 IPAs 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. 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. Therefore, I consider the Home failed to act in accordance with the Department's Resident Homes Standards and the Third Principle of Good Administration. I am satisfied that the absence of visual observation records for the period 9 March to 8 June 2015 constitutes maladministration. I consider the complainant experienced the loss of opportunity for a more thorough investigation into her safeguarding concerns.

74. I also considered the N IPA's advice that Home staff *'…could have adopted a more person-centred approach the issue of whether Resident A and Resident B had the capacity to make decisions about sexual / intimate relationships…'* I further note her advice about Resident A's care plan for *'…expressing sexuality..'* and that there is *'…no mention of [Resident A'] interactions with Resident B…'* as well as no specific references as to *'…whether either resident had mental capacity to consent to forming a sexual relationship…'*

75. I refer to the Department's Residential Homes Standards which states ***'…**Each resident's right to develop and maintain intimate personal relationships with people of their choice is respected unless a resident is assessed as lacking the capacity to consent to such a relationship…'* Given Resident A's diagnosis of dementia and issues surrounding Resident B and following the incidents on 8 and 9 March 2015. I consider Home staff should have updated Resident A's '*expressing sexuality'* care plan and, in conjunction with Trust staff, and if necessary, appropriate medical professionals, should have assessed the capacity of both residents to consent to forming an intimate relationship. I consider this a failure in Resident A's care and treatment.

1 April 2015

76. As set out in Appendix five (a) paragraph 12 I considered the Home's actions taken in response to the incident that occurred between Resident A and Resident B on 1 April 2015. I note and accept the N IPA's advice that the

Home's recording and reporting of these incidents was appropriate and therefore in accordance with the Home's Safeguarding January 2015 policy.

Additional concerns

77. I note the N IPA's advice about further entries made in the Home's daily progress notes, on 5, 12 and 18 April 215, in relation to additional concerns about Resident A and Resident B. I accept her advice that '…*In view of the recent history and absence of specific action planning, I think that this should therefore by default have been a report to the Trust…'* I consider the Home failed to notify the Trust of the concerns documented on 5, 12 and 18 April 2015 in line with its Safeguarding January 2015 Policy. I consider this failure maladministration. As a consequence of this maladministration, I consider that Resident A experienced the loss of opportunity to have the concerns documented considered by the Trust under its Safeguarding Policy and Safeguarding Good Practice Guide.

78. I partially uphold this element of complaint.

Bruising incidents

Actions of the Trust

79. As set out at Appendix five (a) paragraphs 14 to 17 I note the actions of the Trust taken in response to the complainant's concerns about bruising on Resident A's arm which included referral to the APGT. I note the advice of the SW IPA that these actions were reasonable. While I acknowledge the concerns of the complainant and have no reason to disbelieve that bruising was present on Resident A's arm, given the available evidence, I am satisfied that the Trust appropriately actioned the complainant's concerns. Therefore, I do not uphold this element of complaint.

Actions of the Home

80. I considered the records provided by both the Home and complainant as set out at Appendix five (a) paragraphs 18 to 20 and note the Home's comments that '…*All bruising should be noted and actioned…' and '…On this occasion it seems that this had not been completed...'* I note the N IPA's advice that

Resident A would be a risk from bruising but that it is was not possible to conclude that washing could have caused skin damage. I further note her advice medication was unlikely to have contributed to any bruising. While I accept the evidence of the complainant that bruising was presence on Resident A's arm and she raised concerns with Home staff, given the available evidence I am unable to determine as to how this bruising may have arose.

81. However, I am concerned the N IPA was unable to find any record that the complainant raised concerns to the Home staff on 13 May 2018. The Home's Safeguarding July 2015 policy states '…*It is the responsibility of all staff to act on any concerns, suspicion or evidence of abuse…'* The Social Care Council's Standards also re-iterate this responsibility. Given the available evidence, I am satisfied that the Home failed to record and act on the complainant's concerns in line with its Safeguarding July 2015 policy.

82. I consider the failure to record and act on the complainants concerns about bruising on Resident A's arm a failure in Resident A's care and treatment. I consider that Resident A and the complainant experienced the loss of opportunity to have the presence of bruising investigated fully. I am also satisfied the complainant experienced upset. Therefore, I uphold this element of complaint.

83. I note the Home apologised to the complainant, within its investigation report dated 29 November 2019/2 December 2019, (the Home's findings report) for not recording and actioning the complainant's concerns about the bruising on Resident A's arm.

Issue Two: Whether the Resident A's transfer from residential care to nursing care in 2017 was handled appropriately and in accordance with relevant policies and standards. In particular this considered:

- **Decision to move resident from residential to nursing care;**
- **Suitability of new nursing unit environment; and**

- **Communication with complainant about the transfer.**

Detail of Complaint

84. The complainant raised concerns about Resident A's transfer from the residential unit to the nursing unit of the Home. In June 2017 the complainant said she stopped an initial transfer to the nursing unit by way of an urgent note. She further said the Trust and Home did not give her a reason for this transfer, but the Home told her it was on the instructions of Resident A's key worker, and this was recorded within Resident A's notes which she said she viewed. The complainant also said the Home later removed this entry from Resident A's records. The complainant believed Resident A's transfer to the nursing unit was based on care staff opinion and not medical opinion. She believed Resident A did not need the same level of care as other patients in the nursing unit. She further believed the transfer was unsuitable and premature and the later reassessment indicated Resident A as suitable for the residential care in July 2018 evidenced this.

85. The complainant also said that Trust did not give her the opportunity to view the nursing unit, the room the resident would be moving to or the opportunity to view another home. She further said that Resident A moved from the quiet residential unit to a noisy nursing unit which was overwhelming. The complainant believed the move from the residential unit to nursing unit caused Resident A undue stress and premature decline, which included weight loss. The complainant also raised concerns about the communication when the transfer was to take place and said she only found out that the transfer had happened after the event.

Evidence Considered

Policies/Guidance

86. I considered the following policies/guidance:
    - the Department's Care Management Guidance;
    - the Department's Care Standards;
    - the Home's transfer policy;

- the Social Care Workers Standards; and
- the Social Worker Care Standards;

I enclose relevant sections of the guidance considered at Appendix four (b) to this report.

The Bodies' response to investigation enquiries

The Trust

87. The Trust explained on review of case records *'…evidence would show that during the Care Review held in 20 November 2017…attended by [the complainant] that concerns were raised regarding suitability of a residential placement to meet [Resident A's] needs. At that time, contact records of the Care Review on 20 November 2017…state that [the complainant] was satisfied that if assessments indicated need for transfer, there was agreement to proceed. The Trust carried out comprehensive assessments of [Resident A's] care and support needs and at that time, they demonstrate her care needs had increased and the residential facility could no longer safely meet these needs due to the complexity of her needs…'*

88. It further explained that in relation to the complainant's concerns that she was not involved in the actual transfer of [Resident A] to the nursing unit *'…It would be the Trust's view that family in attendance, during a transition, would be of great support and reassurance for the person. At the time of arranging [Resident A's] transfer, the contact records of 1 and 7 December 2017…evidence that the Keyworker attempted to contact [the complainant] on both those dates to arrange transfer. On 8 December 2017, contact records…evidence that [the complainant] contacted the Keyworker and advised that her mother had already moved. Neither [the complainant] nor the Keyworker had been advised of this in advance according to the records…'* The previous Home regional manager *'…addressed the transfer from the Residential unit to the Nursing unit in her response to [the complainant] and has apologised for how this was handled.'*

The Home

89. The Home explained '*The suitability of placement is determined by the well-being of the resident and the level of need and independence of each individual. Transfer from a residential placement to a nursing placement will be required where there are enhanced care needs and where there is a need for the intervention of a qualified health care professional. The home would not make this decision without an initial nursing assessment, which is usually arranged by the Care Manager in conjunction with the home management team and other stakeholders. The decision to change a category of care is a collective agreement and the placing Trust has to agree the funding for any change in care. The family are informed and involved in any change of need as this is part of the normal process in relation to changes of category of care.'*

Relevant Trust, Home, and Complainant records

90. Resident A's Trust, and Home records were considered as well as entries made within the complainant's journal. Relevant extracts from these records are enclosed at Appendix five (b) to this report.

Relevant Independent Professional Advice

i. Decision to move Resident A from residential unit to nursing unit

SW IPA

91. The SW IPA advised that she could not identity, from the records, anything to suggest that the Key worker A was considering a transfer in June 2017 and indeed *'…the review just a few months later stated clearly that [Resident A's] needs continued to be met in residential care…'* However, she went on to advise *'…The Daily Progress Notes for the home, however, show that [a transfer] was briefly the understanding of the home's staff…and that they conveyed it to the complainant. The notes also clarify that this was an incorrect understanding on the part of those staff and that the complainant was told this at the time…Taking all of this into account it seems that the residential home staff were simply totally mistaken in their view and in the information that they passed on to the complainant. It is inexplicable, but the home did correct the misunderstanding with the complainant at the time…'*

92. In relation to the care review completed in November 2017 the SW IPA advised that the *'…client's abilities decreased significantly and in particular that she did not return to her previous level of functioning after her hospital admission… She was becoming increasingly confused and withdrawn and requiring an increased level of physical care and support…'* She further advised that the care review was an '…*appropriate way to respond to reports of the service-user's abilities decreasing…'* The SW IPA also advised that Key worker A commissioned '…*the appropriate health-based assessments to inform a decision as to whether someone needs to move from residential care(social care) to nursing care (qualified nursing care.) A Complex Assessment was completed by the Trust on 27.11.17, based on the information available including the specialist assessments received and this supported the move to nursing care. This was all within the relevant guidance…'*

93. In relation to Resident A's second assessment in June 2018 and whether it would be considered reasonable that she could be reassessed as suitable for the residential unit when previously assessed as requiring nursing care six months earlier the SW IPA advised '*This is unusual, but it is not unheard of and is it [sic] not unreasonable either. People's presentations can change over time, and this can include improvement as well as deterioration. The facts of the matter appear to be that after the service-user moved to the nursing unit, her requirements for care somewhat lessened, and so could be accommodated in residential care once again. She had in effect now returned to the baseline that she had not initially returned to after her hospital admission…All appropriate assessments were carried out and were supportive of this return to residential care.'*

N IPA

94. In relation to the consideration of Resident A's transfer to the nursing unit in June 2017 the N IPA advised that the Home's records confirmed that *'…a transfer was being considered in June 2017 but that formal assessment had not been commenced.'*

95. In relation Resident's A transfer assessment in November 2017 the N IPA advised that on review of the various records provided *'…this resident had significant changes in mental and physical abilities associated with a deterioration of dementia: dysphasia, difficulty taking medication, unsteady on feet/ fall, worsening motor coordination requiring assistance at mealtimes, doubly incontinent, requiring assistance of 2 with personal care, assistance of 2 to transfer…'* and she concluded that the review/assessment of Resident A's care needs *'… was appropriate.'*

ii Suitability of new nursing environment

SW IPA

96. In relation to the determination of the suitability of a nursing unit the SW IPA advised '…*the nursing assessment of 22nd November 2017 does not set out any highly specialised or unusual needs for this service-user and it would therefore be reasonable for the Key Worker to conclude that her needs could be met in any EMI registered nursing setting.'* She further advised that the Department's care management guidance sets out what a Key worker should consider however, '…*it is not clear how specifically all of these points were considered prior to placement. I do not by this suggest that they were not considered; the home may have been well-known to Trust staff in which case they may already have been in possession of the information about the home and about its nursing unit that they needed in order to decide whether it was an appropriate placement. It is clear that one consideration was that it might be less disruptive for the resident to move to another unit within the same home rather than move somewhere entirely new, and this was not an unreasonable approach by any means.'*

iii Communication with complainant about the transfer

SW IPA

97. The SW advised on the Trust's communication of the care assessments to the complainant '…*The possibility of nursing care had already been discussed with the complainant…as had the possibility of placement at [the nursing unit] if assessments supported nursing care…It was therefore broadly reasonable for the Trust staff to think that the complainant had indicated the high likelihood of*

her agreement to a move to nursing care if that was indicated by the assessments. However…I think that the complainant should have been given the opportunity to view the unit before the move was made and that her final decision should have been confirmed with her after that viewing and after communication with her about the outcome of the assessments.'

98. In relation to family members viewing a new setting the SW IPA advised '…*The complainant appears not to have visited the unit…it is my view that to make an arrangement for admission to any type of facility without asking the family to visit is not good practice in terms of assisting family members to make informed choices about placement….'* The SW IPA also advised on practice to of having family members present during a transfer '…*Clearly, where a resident has dementia, as was the case here, it may be beneficial for a family member to be present when there is a transfer so as to reassure the person and assist in their introduction to the new environment. Under normal circumstances, the Key Worker would act as the link and would inform the family about the transfer, giving the opportunity for them to be involved in discussions about how this might be managed, including whether their presence might assist. It is clear in this case that the Key Worker attempted to contact the complainant on 1st December 2017…and left a message. On the same date, the home agreed to let the Key Worker know the date of transfer when it was known to them. However, the home then made the transfer on 7th December without seemingly letting the Key Worker know. Another attempt was made to contact the complainant to inform her of what was happening but she was not available…'*

99. She further advised that the Home's response to the complainant *'…dated 25th October 2019 provides an apology for this and it is in effect an acknowledgement that the transfer should not have happened without appropriate plans having been put in place. In my view, these should have included enabling the complainant to visit the unit, discussing the outcome of the assessments with her and discussing and agreeing the actual process for transfer and whether her presence might be of help to her mother.'*

100. In relation to the impact to Resident A as a result not having family present during her transfer the SW IPA advised '*I don't think there is any way to evaluate this. It may have made the transfer more difficult, distressing and disorientating for her, or it may not, dependent upon her mental state at the time…the home's daily progress notes for 6th December 2017 to 31st December 2017 are missing, so I cannot gain a clear picture of her presentation immediately following the transfer. There is a reference in the review of 4th July 2018 to her having been tearful following the transfer, but I am of course not able to say that this was due to the transfer or that she would have presented any differently had her family been involved. It is however very likely the case that the complainant would have felt more assured about her mother's welfare and her reaction to the move had she been able to be there in person to assist with it.*'

Complainant's response to draft report

101. The complainant said the entry about a potential transfer to the nursing unit in June 2017 impacted Resident A. She said this was evidenced by the trauma caused by her eventual move to nursing care. She believed that this and other issues illustrated and highlighted a *'hugh problem'* in the areas of staff selection and training.

102. The complainant said that prior to Resident A's transfer to nursing unit, Resident A was *'…walking with a rollator without the assistance of 2 and was recovering from a very recent TIA[10]…'* She considered the report from Home staff *'…painted a significantly bleaker picture…'* to justify the request to transfer Resident A to nursing care. The complainant also raised comments by a nursing unit staff that influenced her belief that the transfer was premature. The complainant did not agree that the Resident A's transfer to nursing care was *'…entirely justified…'*

103. In relation to the communication of Resident A's transfer, the complainant said, both her landline and mobile phone had the ability to receive messages and

[10] A transient ischaemic attack (TIA) or "mini stroke" is caused by a temporary disruption in the blood supply to part of the brain.

disagreed that messages had been left. She said she *'…did not believe [the Trust or Home] attempted to call me…'* as she was waiting for this important call. The complainant also disagreed with the SW IPA's comments that she could not gain a clear picture of Resident A's presentation immediately following the transfer. She said the care review, carried out in January 2018, reflected the detrimental effect of the transfer on Resident A which included a significant impact on Resident A's mental wellbeing.

104. Given the IPA's comments that Resident A had returned to her baseline, the complainant queried why the nursing unit did not proactively check for such improvement, particularly following a TIA. She also raised concerns for residents that had no relatives that could put forward a case *for '…re-categorising care requirements towards a move back to a more appropriate, residential care setting…'*

Trust's response to draft report

105. The Trust re-iterated the circumstances around Resident's A transfer to the nursing unit in December 2017. It said that Key worker C's contact record sheet for 20 November 2017 documented that the care review discussed *'…Resident A's increased care needs, and the layout of the Care Home...There was also a discussion that a move within the Care Home may be less disruptive for Resident A.'* The Trust further said as it *'…commissions an individual's care, they would not normally arrange for next of kin to view placements. Standard practice would be that next of kin arrange these once an individual's increased needs have been identified.'*

106. The Trust also re-iterated Key worker B's attempts to contact the complainant as set out at Appendix five (b) paragraphs eight and nine. It went on to say *'…Care Home staff moved Resident A to the EMI Nursing Unit on 7 December 2017 without informing the Trust Keyworker or the complainant…'*

Analysis and Findings

i. Decision to move resident from residential to nursing care.

Actions of the Trust

107. I considered the Trust's records as set out in Appendix five (b) paragraphs 1 to 11 including contact records, care review and assessments completed. In relation to the possibility of an initial transfer, for Resident A, to the nursing unit in June 2017, given the records, and taking into consideration the advice of the SW IPA, I consider there is no evidence to suggest that the Trust was considering a possible transfer at this time. The actions of the Home in relation to a possible transfer in June 2017 will be considered in paragraphs 111 to 116 below.

108. I note the Trust comments that in November 2017 it carried out *'…comprehensive assessments of [Resident A's] care and support needs…'* which demonstrated *'…her care needs had increased and the residential facility could no longer safely meet these needs due to the complexity of her needs…'*

109. In relation to the Resident A's transfer to nursing care in December 2017 and reassessment, to return to residential care, in June 2018, I considered the SW IPA's advice. I accept the assessments completed in November 2017 were due to Resident A's declining abilities, and the Trust commissioned the appropriate assessments, in line with Department's care management guidance. I also accept the SW IPA's advice regarding Resident A's reassessment in June 2018 that '*…All appropriate assessments were carried out and were supportive of this return to residential care.'* Given the available evidence I am satisfied the assessments considering Resident A's transfer to and from nursing care, in November 2018 and June 2018 respectively, were appropriate and therefore I do not uphold this element of complaint.

110. I note the complainant's concerns about re-categorisation of patients' needs and would refer her to the Department's Care Management Guidance which sets out how changes in residents' care requirements should be monitored and reviewed.

Actions of the Home

111. I considered the Home's records as set out in Appendix five (b), paragraphs 12 to 18. I also considered the complainant's journal entries for June 2017,

Appendix five (b), paragraphs19 to 20. I note the Home's comments that it would not make decisions to transfer a resident from a residential placement to a nursing placement '...*without an initial nursing assessment, which is usually arranged by the Care Manager in conjunction with the home management team and other stakeholders. The decision to change a category of care is a collective agreement and the placing Trust has to agree the funding for any change in care…'*

112. I note the complainant's comments that Home staff advised her, in June 2017, that Resident A was to be moved to the nursing unit on Key worker A's instructions. I further note that the complainant saw this documented within Residents A's notes but said that the Home later removed this entry from the notes. On review of the Home's records, I can confirm that the entry in Resident A's notes, regarding a possible transfer, was present in the records provided to me. While I cannot say why the entry may have absent when the complainant reviewed the records, I am content that the Home provided me with all the records available and I hope this provides reassurance to the complainant.

113. I note the N IPA's advice that in June 2017 a transfer was being considered but '…*that formal assessment had not been commenced.'* I further note the advice of the SW IPA that, briefly it was the Home's staff view that a transfer was being considered and this was conveyed to the complainant. I also note her advice that this was an incorrect understanding on the part of the Home and the *'…that the complainant was told this at the time…'* As set out in paragraph 107 there was no evidence to suggest that the Trust was considering transferring Resident A from residential to nursing care in June 2017. Given the available evidence I have been unable to determine why Home staff made this assumption and therefore informed the complainant. However, I am satisfied that the incorrect information was provided to the complainant.

114. I refer to the Social Care Workers Standards which require social care workers to communicate in an *'...appropriate, open, accurate and straightforward way…'* I consider the Home failed to act in accordance these standards when it informed the complainant that Key worker A was starting to make

arrangements for Resident A to move to nursing care. I am satisfied that this failure constitutes maladministration. As a consequence of the maladministration identified, I consider that the complainant experienced frustration and upset. This is because the complainant had to take time to prevent a transfer that the Trust was not considering.

115. I acknowledge and accept the complainant's comments that Resident A was walking with a rollator without the assistance of two members of staff. However, I also note the N IPA'S advice that Resident A was *'…unsteady on feet/ fall…'* and required *'…assistance of 2 with personal care, assistance of 2 to transfer…'* I considered the N IPA's advice in relation to Resident A's assessments in November 2017 and that given Resident A had '…*significant changes in mental and physical abilities associated with a deterioration of dementia...'* the need for assessments was appropriate. I note the SW IPA also concurs with this advice. Nevertheless, given the failing identified in paragraph 114, and the comments by a member of the nursing unit staff the complainant raised, it is understandable why the complainant believed Resident A's transfer to the nursing unit was based on care staff opinion and not medical opinion. However, I am satisfied that it was appropriate for Home staff to request the Trust to review the care needs of Resident A. I also consider this review was carried out appropriately as set out in paragraph 109, and I hope this provides reassurance to the complainant.

116. Therefore, I partially uphold this element of complaint.

ii. Suitability of nursing unit environment.

Actions of the Trust

117. I considered the Trust's records as set out in Appendix five (b). I note the Trust comments that '…*contact records of the Care Review on 20 November 2017…state that [the complainant] was satisfied that if assessments indicated need for transfer, there was agreement to proceed.* I further note it would not normally arrange for next of kin to view placements but that standard practice would be for next of kin to arrange such viewings. I acknowledge the Trust's comments. I note its contact records show Key worker C discussed the

possibility of a placement at the Home nursing unit as well as the nursing unit's layout with the complainant. However, I also note the advice of the SW IPA '…*the complainant should have been given the opportunity to view the unit before the move was made and that her final decision should have been confirmed with her after that viewing and after communication with her about the outcome of the assessments.'*

118. I also note the SW IPA's advice that it would have been '…*reasonable for the Key Worker to conclude that [Resident A's] needs could be met in any EMI registered nursing setting…'* I also note that although the SW IPA was unable to determine how the Key worker considered the requirements of paragraph 55 of the Department's care management guidance she does not *suggest that they were not considered…[the Key worker] may already have been in possession of the information about the home and about its nursing unit that they needed in order to decide whether it was an appropriate placement…'* I further note her advice that the Key worker considered *'…that it might be less disruptive for the resident to move to another unit within the same home rather than move somewhere entirely new…'* and this approach was reasonable.

119. The Department's Care Standards state that relatives of prospective residents should have all the information they need to make an informed choice about moving into a home and should have at least one opportunity to visit the home and meet with staff and other residents. I acknowledge that the nursing unit was in the same Home as the residential unit and that it may have been less disruptive for the Resident A to move to this unit rather than move to a new home. I also acknowledge the Trust may have had all the relevant information to consider the nursing unit appropriate and recognise its standard practice around next of kin arranging viewings of proposed placements. However, this should not have taken away from the complainant's opportunity to view the nursing unit before any final decision was made. I refer to the First Principle of Good Administration *'Getting it Right'* which requires bodies to act *'…in accordance with the law and relevant guidance...'* I consider the failure to inform the complainant she could have an opportunity to view the nursing unit in the home as maladministration. As a consequence of this failure, I consider

that the complainant experienced the loss of opportunity to make an informed decision about the suitability of Resident A's new placement. Therefore, I uphold this element of complaint.

120. I note the SW IPA's advice that Resident A's needs could be met in an EMI nursing setting but that she was unable to fully determine what information the Key worker took into account, other than the disruptiveness to Resident A, when determining the suitability of the nursing unit of the Home. I refer to the Social Worker Care Standards that require social workers to be accountable for their actions and able to explain and account for their actions and decisions. I consider the lack of documentation in relation to the Key worker's determinations about the suitability of the nursing unit of the Home a service failure. I would ask the Trust to reflect on this principle and ask it to remind staff involved in determining the suitability of nursing placements that they fully record the information they considered when making such determinations.

Actions of the Home

121. I considered that the suitability of the nursing placement fell within the remit of the Trust and therefore any actions of the Home were not considered under this heading.

iii. Communication with complainant about the transfer

Actions of the Trust

122. I considered the Trust's records as set out in Appendix five (b), which included the care review completed in January 2018 I note the Trust comments that on 1 and 7 December 2017 *'…the Keyworker attempted to contact [the complainant]…'* and the Home had not advised the Key worker it had moved Resident A. I also acknowledge the complainant's comments that she did not believe that Trust attempted to call her. However, given the available evidence in Key worker B's contact records, I am satisfied that the Trust did try and contact the complainant prior to Resident A's transfer to give a potential date for the move. I am also satisfied that the Home was to provide the Trust with an exact date of transfer. However, I note the Trust was not informed of the transfer until after it had occurred, at which time it tried to contact the

complainant. Given the available evidence I am satisfied that the actions of the Trust were appropriate given it was dependent on information the Home supplied. Therefore, I do not uphold this element of complaint. The actions of the Home under this issue will be considered at paragraphs 123 to 129.

Actions of the Home

123. I considered the Home's records as set out in Appendix 5b. I also considered the complainant's journal entries for June 2017. I note the Home's comments, within its findings report that '…*the move itself was not carried out in a sympathetic manner for [Resident A]…'*

124. I note the SW IPA's advice that '…*the home agreed to let the Key Worker know the date of transfer when it was known to them. However, the home then made the transfer on 7th December without seemingly letting the Key Worker know...'* I further note her advice that*, '…where a resident has dementia…it may be beneficial for a family member to be present when there is a transfer so as to reassure the person and assist in their introduction to the new environment…'* I also considered the SW IPA's advice that the Home's daily progress notes from 6 December 2017 to 31 December 2017 were missing and she was unable to ascertain how not having the complainant present during the transfer impacted on Resident A. She advised it was however likely '…*the complainant would have felt more assured about her mother's welfare and her reaction to the move had she been able to be there in person to assist with it.'*

125. The Home's transfer policy states that '…*good communication and planning for continuity of care will reduce the risk to the resident… It is essential that there should be a smooth transition to the next place of residence and that continuity of care is maintained…The Named Nurse will arrange for a staff member or a responsible relative or friend to escort the resident if necessary...Relatives should also be informed and included in the arrangements, if the resident so wishes…'* Given the available evidence I am satisfied that the Home failed to inform both the complainant and the Trust when it was transferring Resident A to the nursing unit in line with its own transfer policy.

126. I consider the failure to provide the complainant and the Trust with information on the date of Resident A’s transfer a failure in Resident A’s care and treatment and Resident A experienced upset, a negative impact on her well-being, as well as the loss of opportunity to have the complainant present during the transfer. I am also satisfied the complainant experienced upset and the loss of opportunity to support her mother during the transfer. I uphold this element of complaint.

127. I acknowledge in the Home’s findings report it sincerely apologises for the manner in which Resident A’s transfer was carried out and that it has reviewed the process internally and suggests that a more thorough approach was now being taken. I welcome this improvement.

128. I refer to the Home’s recording keeping (6 – 31 December 2017) and note the Department’s Care Standards, which require nursing homes to ensure systems are in place for the management of records and the information held on record is accurate, up-to-date and necessary. Due to the absence of records for the period identified, I have been unable to establish if Resident A experienced any additional injustice from that identified in paragraph 126 above. Daily progress notes were available for all the other periods of Resident A’s time in the Home and I acknowledge the effort the Home made to locate the missing records for the period identified. However, I have been unable to establish if the absence of these records is due to inadequate archiving procedures or the lack of recording. Whatever the reason for the records absence I consider their unavailability unacceptable.

129. I refer to my comments in paragraph 73. I consider the Home failed to act in accordance with the Department’s Care Standards. I am satisfied that the absence of records for the period 6 - 31 December 2017 constitutes maladministration. I consider the complainant experienced the loss of opportunity for a more thorough investigation.

Issue 3: Whether the care and treatment provided to the resident from 6 December 2017 to 17 September 2018 was appropriate and in accordance with relevant policies and standards. In particular this considered:

- **Prevention/treatment of Resident A's chest infections;**
- **Staffing levels from May 2018 to 17 September 2018;**
- **Dignity and respect; and**
- **Stimulation and interaction.**

Detail of Complaint

130. In September 2018 Resident A suffered from a chest infection. The complainant raised concerns that had Home staff adhered to specific notes flagged at the front of Resident A's file, the chest infection would have been less severe and may have been prevented. She believed that this highlighted the inadequacy of care provided to Resident A and a lack of professional judgement by nursing staff who disregarded a pre-agreed protocol. The complainant raised concerns about staffing levels in the nursing unit from May 2018 to 17 September 2018 and in particular the Trust documented that she could not find staff for over 10 minutes on 12 June 2018.

131. The complainant further raised concerns that Home staff did not maintain Resident A's dignity and respect. She said on 25 December 2017, when the lounge was full of visitors, she found Resident A sitting in a chair and was not wearing a skirt or trousers. The complainant also said that on several occasions Resident A was not wearing any socks, vest or cardigan and as a result on one occasion she found Resident A shivering. She also said that when Resident A moved to the nursing unit, she no longer wore her false teeth, her hair was not brushed and had a bib put on at meal times. The complainant also raised concerns that Home staff did not respect Resident A's or her wishes regarding the provision of chiropody and Resident A had chiropody forced upon her. The complainant further raised concerns about the nursing unit's lack of stimulation and lack of appropriate and planned activities. She believed there was a poor level of interaction between staff and Resident A.

Evidence Considered

Policies/Guidance

132. I considered the following policies/guidance:

- the Trust's independent sector provider complaints guidance;
- the Department's Care Standards; and
- the NMC Code.

I enclose relevant sections of the guidance considered at Appendix four (c) to this report.

The Bodies' response to investigation enquiries

The Trust

Chest infection

133. The Trust explained *'…Concerns raised regarding nursing staff identifying that [Resident A's] condition had deteriorated in a timely manner, were investigated by [Key worker B] in May 2018…The outcome of the investigation showed the need for staff to recognise the importance of conditions such as infections in a timely manner and getting the appropriate treatment commenced. The learning from this was communicated by [the Home] management to staff emphasising the need to treat the prescribing of antibiotics as urgent. These issues were then followed up as part of nurse supervisions and nurse meetings. The importance of following concerns raised by family members was also addressed with staff. A daily flash meeting was implemented that allowed the manager to review with nursing staff any changes in residents' conditions...'*

Staffing levels, Dignity and respect, and stimulation and interaction.

The Trust

134. In relation to the complainant's concerns about the provision of chiropody the Trust explained *'…It would be the Trust's view that next of kin should be consulted and in agreement with any planned chiropody appointments. The Home Manager acknowledged this fault and apologised for same. No further incidents were reported thereafter…'*

135. In relation to the other concerns the complainant raised the Trust explained *'…Having reviewed the care records, the Key worker addressed and responded to the individual concerns raised by [the complainant] regarding [Resident A's] care in the Independent Sector Provider Complaint form…Trust representatives met on 6 July 2018 to review the concerns raised and other issues that had been brought to the Trust's attention. The outcome of this was that a meeting was convened with [the Home]…managers to discuss concerns raised…The Trust was given assurances that the provider was taking necessary steps to rectify the issues and concerns raised. The Trust agreed to keep the situation under review and convene a further meeting if necessary. The Trust worked in partnership with and supported [the Home] to make improvements required to be compliant with the minimum standards…'*

The Home

136. *'...A complaint form forwarded to the Monitoring officer of the Trust on 25 June 2018 was forwarded to the home on 25 June 2018 which detailed various concerns with aspects of the care provided. Recommendations and actions included: Care review agreed for 5 July 2018 to further address concerns and to assess the appropriateness of the current placement. Following further concerns raised by [the complainant] with regard to [Resident A's] care a detailed investigation report in respect of concerns raised was carried out by the previous Regional Director of Northern Ireland…in respect of various aspects of care and finance concerns. This report was completed in the period of between 29 November 2019 and 2 December 2019. [The complainant] was provided with the opportunity to meet with [the previous Regional Director] and unfortunately declined…'*

Relevant Trust, Home, and Complainant records

137. Resident A's Trust, and Home records were considered, as well as entries made within the complainant's journal. The RQIA's Unannounced Care Inspection Report 23 July 2018, and its Unannounced Follow Up Care Inspection Report 15 Oct 2018 were also considered. Relevant extracts from these records are enclosed at Appendix five (c) to this report.

Relevant Independent Professional Advice

N IPA

i. Treatment of chest infections

138. The N IPA advised that the Home's records indicated that Resident A *'…displayed signs of a chest infection/cold on 10th September 2018…'* and the subsequent actions of the Home staff were *'…all appropriate in terms of informing relatives, monitoring vital signs, seeking medical advice, administering paracetamol, nebulisers and antibiotics and promoting rest, diet and fluids…'* Following the care review In July 2018 the N IPA advised that Resident A's breathing care plan was updated with the entry *'…"At the first sign of a cold please contact GP and order and ABX GP is aware of strength of ABX as [Resident A] is prone to chest infections".*

139. The N IPA further advised that *'…whilst the care plans provide basic information that was applicable in September 2018, they have only been partially updated with regard to actions following the care review of July 2018. Whilst there is evidence from the progress notes/ Kardex that antibiotics were collected urgently (with the assistance of [the complainant's daughter) I did not find any update to the care plans detailing how to recognise chest infection following this review, nor on whether liquid medication would be beneficial…the care plans should have been updated following the care review of July 2018 to include guidance on recognition of signs of chest infection and action to be taken if infection was suspected (ie record vital signs, contact GP) and whether liquid/syrup preparations should be considered when administering treatment. This information should have been written in the action planning column rather than the evaluation section.'*

ii. Staffing levels

140. Making particular reference to staffing on 8 May 2018 and 12 June 2018[11] the N IPA advised *'…According to the rotas supplied, skill mix was adequate on both dates…'* and *'…Overall, the actual staffing numbers given on both dates*

[11] NB – the N IPA was asked to look at staffing levels for two dates. This was due to a difference in dates noted within the Trust and complainant's records. The Trust documented the complainant raised concerns about the 12 June 2018. However, the complainant's journal referenced 8 May 2018.

are close to the recommended target...However, it is not possible to verify that staffing levels were appropriate because the numbers must be interpreted by dependency data, which has not been supplied for these dates.'

iii. Dignity and respect

141. The N IPA advised *'…the available care planning demonstrates that Resident A's needs were identified, a personal plan of care drawn up and staff support being provided to support this resident in daily hygiene needs, wearing appropriate clothing and footwear. This is in accordance with RQIA standards (minimum standard 21). There are no recorded exceptions such as Resident A refusing to dress appropriately or removing her clothing…'*

iv. Stimulation and interaction.

142. The N IPA advised that Resident's A communication plan dated 9 December 2017 stated *'…' involve [Resident A] in simple activities to begin with' and 'introduce activities manager and formulate activities plan'…This plan is consistent with approaches to care for a person with dementia and RQIA standards that activities should be planned and provided…'* She also advised that the care plan dated 6 January 2018 stated *'…"upon request of family…[Resident A] is meant to be encouraged to remain in her bedroom rather than going into communal areas". This care plan does not mention how activities might be delivered on a one-to -one basis in her bedroom. It is not necessarily inconsistent with a person centred care plan although it has implications for resource of activities coordinator if one to one activities are needed. The plan is apparently contradicted by later evaluation, eg "[Resident A] enjoy [sic] spending time in lounge in company of peers, also visits from her family" (03/03/2018) and "[Resident A] is encouraged to take part in activities".'*

143. The N IPA advised that for January, February, March, April, June and August 2018 the Home's daily progress records do not record any activities or entertainment. She further advised that a monthly activities record for Resident A dated May 2018 contained *'…a weekly timetable specifying 4 -6 activities per week…'* but Resident A '…declined activities on 4 occasions, but participated with hairdresser and outings on 7 occasions…' The N IPA also advised

'…There is an activities log for July 2018…which has 12 entries between 3 and 27 July. [Resident A] declined 'games' or 'arts and crafts' on 5 occasions but otherwise is recorded to have engaged with and enjoyed activities…' In September 2018 the N IPA advised that it was recorded that Resident A *'…is encouraged to take part in activities…'*

144. The N IPA went onto advise *'…Overall the provision of monthly activity plans and log for two months is evidence of good practice in accordance with RQIA standards, but…does not provide more detail about activities or any psychological care. The absence of any recorded activities during the majority of Resident A's stay in the nursing unit is not appropriate…'* She goes on to advise on Dementia UK's research on the potential benefits of activities for a person with dementia in a nursing home and states *'…Resident A would not have been able to enjoy these potential benefits of activities if they were not provided.'*

Analysis and Findings

Complainant's response to draft report

145. The complainant wished to provide clarification on the circumstances around the provision of antibiotics to Resident A in September 2018. She said that a Staff Nurse had contacted her on 10 September 2018 to inform her that Resident A had a chest infection and the GP had prescribed antibiotics which would *'…be here today…'* However, when the complainant visited at 18:00 no antibiotics had arrived, but staff assured her they would *'…be here later…'*. She described Resident A as being dehydrated, sweating and *'...so ill she appeared unconscious…'* A staff member confirm that Resident A had a cold that morning and perhaps over the weekend but could not provide confirmation as to when the cold started. After a further visit, later in the evening, the complainant found that no antibiotics had arrived and so she contacted the out of hours doctor, of her own volition, and collected the medication. The complainant said that had she not done so, Resident A would not have started the antibiotics that evening.

146. The complainant said that a note in Resident A's records on 10 September 2018 about a '*heavy cold'* was *'…incorrect…'* and not a *'…true and accurate account…'* of what occurred. She said that this heavy cold was unlikely to have started at this point and staff should have observed any decline and detected and treated the cold earlier. She believed that there was lack of professional judgement that illustrated poor awareness of the importance of observing early signs of a chest infection. Particularly, as Resident A, had already suffered chest infections in the nursing unit which began with a cold first. The complainant also raised concerns that nursing staff should have the knowledge regarding identifying chest infections whether or not the information was on Resident A's care plan. She further emphasised that nursing staff never raised the option of Resident A having liquid medication with her.

147. The complainant wished to provide clarification in relation to the reference in Resident A's care plan of 16 January 2018 that, documented the family requested Resident A be encouraged to stay in her bedroom. She clarified that this request was to respect Resident A's preference when she initially entered the nursing unit and was to help her to adjust to the new, busy, loud surroundings which overwhelmed her. The complainant also raised concerns about how the Home provided activities for bedridden residents who should also be entitled to the benefit of activities.

148. The complainant also said she believed that the records from Christmas day 2017 were *'…intentionally withheld…'* given her complaint about Resident A's state of undress that day.'

Actions of the Trust

149. For the purposes of the investigation, I examined the actions of the Trust in relation to how it dealt with the issues the complainant raised in 2017, about the treatment of chest infections, staffing, dignity and respect and stimulation and interaction, via its independent sector provider complaints guidance.

150. I considered the Trust's records as set out in Appendix five (c). I note that during the care review for Resident A, on 16 January 2018, the complainant

raised concerns about the dignity and respect of Resident A. I further note that there was agreement that the concerns raised would be addressed via the process of managing complaints about independent sector provider. I note that these concerns were addressed through this process, a response provided by the Home which was shared with the complainant and the complaint closed as the complainant did not wish to pursue any further action.

151. I also note the complainant spoke with Key worker B, on 22 June 2018, about several concerns which included the treatment of Resident A's chest infections, staffing levels in the Home, dignity and respect concerns (those previously raised in January 2018, along with new concerns) and stimulation/interaction concerns. I note these concerns were forwarded to the Home on 25 June 2018 and a care review for Resident A arranged for 5 July 2018. Key worker B also discussed the concerns with the Locality and Operations Managers and the Trust held a serious concerns meeting with the Home on 11 July 2018.

152. I further note the Home provided information, on 20 July 2018, on its investigation and findings. The Home also provided details as to how it would prevent recurrence of the concerns raised. I also note Key worker B discussed the Home's response with the complainant on 26 July 2018 and acknowledge that the complaint was closed although the complainant expressed concerns that any change would have to sustained and she no longer had trust in the Home.

153. I also note the complainant raised further concerns, to Key worker B, about the treatment of Resident A's Chest infections on 11 September 2018. The Home responded to the complaint on 29 October 2018 and the complainant advised of its response. Key worker B noted that the complainant was not satisfied with the Home's response and that she may pursue further action. The complaint was closed on the basis that the Trust monitoring Team would continue to monitor the Home.

154. I note the Trust comments that the complainant's concerns were addressed and responded to *'…in the Independent Sector Provider Complaint form…Trust*

representatives met on 6 July 2018 to review the concerns raised…The Trust was given assurances that the provider was taking necessary steps to rectify the issues and concerns raised... The Trust worked in partnership with and supported [the Home] to make improvements required to be compliant with the minimum standards…'

155. I wish to acknowledge the views of the complainant that she was not entirely satisfied with the Home's responses to the concerns she raised in June and September 2018. However, given the available evidence, I consider the Trust took appropriate actions, in line with its independent sector provider complaints guidance, when investigating the concerns raised by the complainant in 2018. Therefore, I do not uphold this element of complaint.

Actions of the Home

i. Treatment of chest infections

156. I considered the Home's and complainant's records as set out in Appendix five (c), paragraphs three to 12. I note Resident A's '*Breathing and Circulation'* care plan was updated following the completion of a Care review and the actions taken by Home staff in September 2018. I note the additional concerns of the complainant that Resident A's heavy cold would have started before 10 September 2018, her concerns around the accuracy of records and the awareness/judgments of nursing staff.

157. On review of the nursing notes there is no documentation to indicate an earlier decline of Resident A. While acknowledging the complainant's concerns, I cannot determine if the nursing records at that time are incomplete. Therefore, I note and accept the N IPA's advice that when Resident A displayed signs of a chest infection, on 10 September 2018, Home staff took all appropriate actions '…*in terms of informing relatives, monitoring vital signs, seeking medical advice, administering paracetamol, nebulisers and antibiotics and promoting rest, diet and fluids…'* However, I acknowledge the Resident A only began antibiotics that evening due to the complainant have having obtained them from the out of hours GP service. Given the available evidence, I am satisfied that the Home appropriately treated Resident A's chest infection.

158. I also considered the N IPA's advice about Resident A's *Breathing and Circulation'* care plan. I note it contained '… *basic information that was applicable in September 2018…'* and it '…*should have been updated following the care review of July 2018 to include guidance on recognition of signs of chest infection and action to be taken if infection was suspected (ie record vital signs, contact GP) and whether liquid/syrup preparations should be considered when administering treatment.*

159. I refer to the NMC Code which requires nursing staff to maintain clear and accurate records. Given the available evidence, I am satisfied the Home failed to update and maintain an accurate record of Resident A's *Breathing and Circulation'* I consider this a failure in Resident A's care and treatment.

160. I partially uphold this element of complaint.

ii. Staffing levels

161. I considered the complainant's and RQIA's records as set out in Appendix five (c), paragraphs 15 to 19. I note that for the period from 2 July 2018 to 29 July 2018 the RQIA inspection found *'…the home was frequently operating below its planned staffing target. Observation of the delivery of care evidenced that patients' needs did not appear to be consistently met by the levels and skill mix of staff on duty…'*

162. I note on 8 May 2018 and 12 June 2018 the N IPA advised the *'..skill mix was adequate on both dates…'* and *'…Overall, the actual staffing numbers given on both dates are close to the recommended target…''* However, I also note that the N IPA was not able to'… *verify that staffing levels were appropriate because the numbers must be interpreted by dependency data, which has not been supplied for these dates.'*

163. I note the Home's comments in its findings report that if the Home had been understaffed '…*it has been due to very last minute staff sickness, and we have been unable to get cover…We would not however deliberately have a service*

run unsafely…we have also recently reviewed staff breaks, and allocated a different system.. A unit should never be left without staff at any time and we monitor this closely.'

164. I refer to Standard 41 of the Department's Care Home Standards which require care homes *'…to ensure the number and ratio of staff on duty at all times meet the care needs of residents…'* Given the available evidence I am unable to determine if the Home provided adequate staffing levels on either 8 May 2018 or 12 June 2018. However, as already determined by the RQIA inspection on 23 July 2018, staffing levels were not adequate for the period 2 July 2018 to 29 July 2018. Given the available evidence I am satisfied that the Home failed to provide adequate staffing levels in line with the Department's Care Home Standards. I consider this a failure in the care and treatment of Resident A.

165. As a consequence of this failure, I consider that Resident A experienced the loss of opportunity to the ensure her care needs were adequately met. I am also satisfied the complainant experienced upset and frustration. Therefore, I partially uphold this element of complaint.

166. However, I wish to acknowledge that the Home addressed the staffing concerns at the RQIA's Follow Up Care inspection on 15 Oct 2018.

iii. Dignity and respect

167. I considered the Home's and complainant's records as set out in Appendix five (c), paragraphs 25 to 33. I acknowledge the complainant's comments regarding the missing records from Christmas Day 2017. While I am unable to confirm if the Home intentionally withheld the records, I would refer to my comments at paragraphs 127 to 128 and the failing identified. I note and acknowledge the N IPA's advice that the Home identified Resident A's needs by means of care plans and there was evidence that staff provided support to meet these needs. I also note the care review conducted on 4 July 2018 documented that all parties discussed dignity and respect issues. I considered that at this time the complainant confirmed that she was happy for Resident A to wear a bib if

Resident A requested to do so, and she was made aware that on occasions Resident A would refuse to wear her dentures.

168. However, I consider that the journal entries, provided by the complainant, provide sufficient evidence to demonstrate to that on occasions the Home did not maintain Resident's A's dignity and respect, particularly in relation to the provision of chiropody services and the wearing of appropriate clothing. I consider this a failure in the care and treatment of Resident A. I uphold this element of complaint.

169. I wish to acknowledge that in the Home's findings report it said *'…at no time should residents be wearing less than appropriate clothing leading to dignity issues. For this we sincerely apologise…'* I further acknowledge the Home accepted that it should not have had chiropody carried out on Resident A and again apologised to the complainant.

iv. Stimulation and interaction.

170. I considered the Trust and Home's records as set out in Appendix five (c), paragraphs 34 to 41, which included the care reviews completed 16 January 2018 and 4 July 2018 as well as Resident A's care and communication plans. I note that initially, upon request of the family, Resident A was meant *'…to be encouraged to remain in her bedroom rather than going in communal areas…'* and where possible staff were to keep her engaged in activities. I further note in the care review of 16 January 2018 this was due to the communal areas being noisy and distressing to Resident A but that '…*[Resident A] now seems to have settled into the unit and will come out of her room into the lounge area showing no signs of distress…staff will continue to encourage [Resident A] to partake in activities…'*

171. I also considered the Home manager's comments within 4 July 2018 care review that '…*the activities and diversional therapies are currently "a work in progress" and an area…which…is continually and actively promoting…the garden area is currently being improved to promote residents being able to spend more time safely outdoors.* I also noted the improvements to diversional

therapist staffing levels. I further noted the Home's comments within the Home's findings report and its apology that the nursing unit environment was not stimulating for Resident A and that this aspect of the service was to be reviewed to try to achieve a more person centred approach.

172. Given the available evidence I am satisfied that the Home failed to offer sufficient meaningful activities and events to Resident A in line with Standard 11 of the Department's Care Standards. I consider this a failure in the care and treatment of Resident A.

173. As a consequence of this failure, I consider that Resident A experienced the loss of opportunity for potential benefits from activities for a person with dementia. I am also satisfied the complainant experienced upset. Therefore, I uphold this element of complaint.

Issue 4: Whether the level of care monitoring, provided by the Trust, from March 2015 to November 2017 was suitable and in accordance with relevant policies and standards.

Detail of Complaint

174. The complainant said there was gap in the Trust's care monitoring of Resident A with a lengthy period, 2015 to 2017, when the resident was without a Key worker. She also stated she was unable to make contact with a keyworker in June 2017 when seeking clarification about a possible transfer of Resident A to the nursing unit.

Evidence Considered

Policies/Guidance

175. I considered the following policies/guidance:

- the Department's Care Management Guidance.

I enclose relevant sections of the guidance considered at Appendix four (d) to this report.

The Trust's response to investigation enquiries

176. The Trust explained that documentation provided demonstrated *'…the keyworker liaised with the family/carers regarding the need to transfer case responsibility at the Care Review on 27 March 2015. Unfortunately due to staff absences, family/carer were not involved in transfer of case responsibility in 2016/2017. For this the Trust apologises.'*

177. The Trust further explained *'…care review meetings should be held annually...'* and *'…Residents, their carers/families and care home staff can also request an ad hoc review at any time…'* It went on to explain that contact records for October and November 2016 provided *'…evidence that a care review had been arranged for 4 November 2016 and unfortunately had to be cancelled due to key worker sickness…'* It also commented that the care records evidence that Resident A *'…was under the care of a key worker throughout the time she resided in a Care Home.'*

Relevant Trust and complainant records

178. Resident A's Trust records were considered as well as entries made within the complainant's journal. Relevant extracts from the Trust's records and complainant's journal are enclosed at Appendix five (d) to this report.

Relevant Independent Professional Advice

179. The SW IPA advised that '*…It is important to note…that when a service-user is in a settled placement it is not unusual for reviews to take place annually. Therefore, the important point is that family members, service users (where relevant) and providers (such as a home) know who/which team to contact in between annual reviews if there are any issues of concern. One would not expect those parties to necessarily wait until the next review to raise concerns, as this might be a lengthy wait…'* She went on to advise that *'…The Trust contact record of 27th March 2015 does appear to suggest that the complainant and the home were informed that the service-user's case management was being passed over to the Monitoring Team, but it is not clear whether or not the*

complainant was given the contact details of that team in case she needed to raise anything with them in between review dates.'

180. The SW further advised *'It appears that the service user was transferred to the Monitoring Team for ongoing monitoring and review in May 2015, the last review having been carried out in March 2015. A review was due in March 2016 but was not scheduled until October 2016, with a date for November 2016. The review planned for November 2016 was then cancelled and was not rearranged, and the next review took place in August 2017. Therefore, as far as I can see, there was no review of this service-user's care from March 2015 to August 2017, a period of over two years. Therefore, it would seem that there was a period when there was no Monitoring Officer allocated (May 2015 to October 2016), and that there was then a Monitoring Officer involved for a period but that this person failed to ensure that a review was carried out. After November 2016 and up to August 2017, it is not clear whether there continued to be an allocated Monitoring Officer or not, but it is clear that the review was not arranged until August 2017.'*

181. In relation to the impact to Resident A and her family the SW IPA advised *'…It is difficult to comment upon the experiences of the service-user as (due to her dementia) she may or may not have been aware that she ought to have access to the Monitoring Team (ideally, a named Key Worker) in case of any concerns or issues. From the point of view of her family…the absence of an identified Key Worker would mean that they may not have clarity about who to contact in the event that they had any concerns about the service-user's care or welfare or about her needs being met in the home.'*

182. In relation to how regularly care review meeting should take place the SW IPA advised *'This is according to the level of need. An annual review is not unusual and in this case the review of March 2015 states that the next review was due in March 2016, indicating that annual reviews were to be the plan from that point forward. I am however of the view that, given the situation that came about in March 2015 and early to mid-April 2015, it would have been wise to review Resident A's care sooner than March 2016. I think this because a*

concerning situation had arisen between the residents A. and B. and it was important that any strategies put in place by the home to manage the situation were reviewed at an earlier point than one year later, so that all concerned could discuss whether these were proving to be effective. It would have been useful to review in three months' time. Annual or six monthly reviews could have been reverted to after this point if there were no concerns.'

183. The SW IPA went on to advise *'It is difficult to evaluate the actual impact of the lack of reviews from March 2015 to November 2017…However, process of reviews does serve the purpose of the Trust checking that the person's needs are still being met…'*

Complainant's response to draft report

184. The complainant said that she, (and believed Resident A did also) felt unsupported and insecure, especially given the safeguarding incidents in 2015. She said *'…Relatives should be made more aware of the existence and important role…'* of the Key worker and request that it is *'….made a priority that a personal introduction by keyworker is made to each resident and relative, at the very outset of home placement, without home staff present, so that relatives are fully informed and can speak confidentially, and that they are at no point left without this point of contact.'*

Trust response to the draft report

185. The Trust said *'…Unfortunately, due to staff sickness and staffing issues, the Trust was unable to adhere to the minimum standard for care monitoring during this period. The Trust apologises for the length of time between reviews and contact with Resident A's daughter. To ensure that up to date Trust keyworker details are provided to next of kin/Care Home staff, an updated ISO Procedure was implemented in July 2022.'*

Analysis and Findings

186. I considered the Trust's records as set out in Appendix 5d including contact records and when key workers completed, and postponed care reviews. I also considered the complainant's journal entries for June 2017 when she was trying

to contact a key worker and the difficulties she experienced when trying to speak with an appropriate person. I note the Trust's comments *'…due to staff absences, family/carer were not involved in transfer of case responsibility in 2016/2017…'* and there was *'…evidence that a care review had been arranged for 4 November 2016 and unfortunately had to be cancelled due to key worker sickness…'* I further note its comments that Resident A *'…was under the care of a key worker throughout the time she resided in a Care Home.'*

187. I note the SW IPA's advice that '…*it would have been wise to review Resident A's care sooner than March 2016. I think this because a concerning situation had arisen between the residents A. and B. and it was important that any strategies put in place by the home to manage the situation were reviewed at an earlier point…'* While I acknowledge the Trust's comments that it cancelled the November 2016 care review, due to staff sickness, I note it was not re-scheduled until August 2017. This resulted in a period of over two years during which it did not complete a care review.

188. The Department's care management guidance states that the care managers should '*…make sure that reviews take place (the frequency of which will be dictated by the circumstances and complexity of the individual's care or care package no less than annually)…'* Even given staff sickness, I consider this length of time unacceptable. I consider the Trust's failure to carry out a care review in an appropriate timescale a failure in Resident A's care and treatment.

189. I also note the SW IPA's advice that family members should *…know who/which team to contact in between annual reviews if there are any issues of concern…'* I further note that while Key Worker A informed the complainant, during the care review on 27 March 2015, that Resident A's case management was being passed over to the monitoring team the SW IPA advised '…*it is not clear whether or not the complainant was given the contact details of that team in case she needed to raise anything with them in between review dates…'* I further note her advice that *'…it would seem that there was a period when there was no Monitoring Officer allocated (May 2015 to October 2016)…After*

November 2016 and up to August 2017, it is not clear whether there continued to be an allocated Monitoring Officer.'

190. While I acknowledge the complainant's comments Resident A was without a key worker for a lengthy period, I also note the Trust's comments that Resident A was under the care of a key worker during her time in the Home. I also note the dates the SW IPA provided when she advised that it was unclear if a monitoring officer had been allocated. I cannot conclude with certainty whether a monitoring officer was allocated to Resident A. However, given the evidence the complainant supplied and the obvious difficulties she had contacting an appropriate person in June 2017, I accept the SW IPA's advice that it is not clear the complainant was provided with contact details of any new monitoring officer when Resident A's case management was handed over in May 2015.

191. The Third Principle of Good Administration 'Being open and accountable' requires bodies to ensure that *'…information, and any advice provided, is clear, accurate and complete.'* I consider the Trust failed to act in accordance with this principle when it failed to keep the complainant updated as to the contact details of the Resident A's monitoring officer. I am satisfied that this failure constitutes maladministration.

192. I consider that Resident A experienced the loss of opportunity to ensure her needs were still being met and the effectiveness of strategies implemented following the safeguarding incidents in March/April 2015. I also consider the complainant experienced the injustice of frustration. This is because she did not know who the appropriate person was to contact should she have concerns about her mother's care.

193. I uphold this element of complaint. I wish to acknowledge that the Trust has since implemented an updated procedure to ensure that up to date Trust Key worker details are provided to next of kin/Care Home Staff and provided evidence of this. I would also ask it to reflect on the comments of the complainant about personal introductions to Key workers.

Issue 5: Whether the Trust responses to the complainant from May 2019 to May 2021 were appropriate and in line with relevant policies and standards.

Detail of Complaint

194. The complainant raised concerns about the Trust's handling of her complaint. She believed the Trust's response letters did not deal adequately with her issues and she feels the process of making a complaint about a care home could be simplified.

Evidence Considered

Policies/Guidance

195. I considered the following policies/guidance:
    - the Department's Complaints guidance; and
    - the Trust's complaints policy.

    I enclose relevant sections of the guidance considered at Appendix four (e) to this report.

Trust's response to investigation enquiries

196. The Trust explained that it *'…follows the Regional Guidance regarding the process of making and responding to a complaint.'* In relation to the complaint raised by the complainant the Trust explained this was *'… initially raised by [the complainant] on 23 March 2019 and responded to by the Trust on 23 May 2019…and subsequently raised again by [the complainant] on 25 June 2019 and 4 February 2021 and responded to by the Trust on 24 January 2020 and 21 May 2021…respectively.*

197. The Trust also explained that a complaint in relation to the safeguarding investigation was *'…initially raised by [the complainant] on 21 April 2020 and responded to by the Trust on 18 June 2020…'*

The Trust's complaint records

198. The Trust's complaint records are enclosed at Appendix five (e) to this report.

Complainant's response to draft report

199. The complainant highlighted that her efforts to bring her complaints were made extremely difficult due to *'…delays, untruths and non-disclosure of relevant information…'* by the Trust and the Home. She welcomed this office's work towards a more simpler complaints procedure.

200. The complainant also highlighted her reasons for not accepting an invitation to meet with the Home during the complaints process and said the rejection of this meeting was *'essential'* These reasons were:

- Having already invested considerable time in telephoning and meeting with the Home and the Trust on many occasions undertakings given at these meetings were not carried through;
- Verbal meetings were of no benefit as due to previous experiences, unless comments were made in writing, she could not rely upon anything that was discussed;
- She had met with other complainants who had experienced such meetings and believed they were'…intentionally persuasive in terms of discouraging the continuation of the complaint; and
- By the time she had removed Resident from the Home she had experienced such *'great sadness and fear…'* to have to attend the Home or encounter Home staff again would have been *'…too much to bear…'*

Trust's response to draft report

201. In relation to the response provided to the complainant on 23 May 2019, the Trust apologised that its response did not respond individually to the points raised but provided a summary response. It also said it would take learning from this.

202. In relation to the complainant's letter of 19 August 2019, to the Assistant Director of Older People's Services, that referenced previous safeguarding concerns, the Trust said *'…these issues had already been addressed and*

outcomes agreed with the complainant at the care review 27 March 2015…' It also provided evidence that the complainant's letter of 19 August 2019 was shared with the complaints department as was the subsequent reply issued on 30 August 2019. The Trust apologised that its response of 30 August 2019 did not directly reference *'…that the safeguarding concerns had already been satisfactorily investigated at the time of reporting in March 2015.'*

203. In relation to the safeguarding incident on 1 April 2015, the Trust also referred to its comments as set out at paragraph 49.

Analysis and Findings

204. I considered the Trust's complaint records as set out in Appendix five (e).

205. I note on 23 March 2019 the complainant raised 14 specific concerns to the Trust in relation to Resident A's care and treatment in the Home. I also note the Trust responded to the complaint on 23 May 2019. I note the Trust response did not specially address each of the 14 concerns raised but, provided a summary as to how it had dealt with the same concerns the complainant raised in 2018 via its Independent Service Providers complaint process. The response also documented that work was ongoing to improve the quality of care issues raised.

206. I considered the Trust's response letter to the complainant, dated 24 January 2020. I am satisfied that the Trust did consider the 14 issues of concerns initially raised by the complainant on 23 March 2019. However, it is my view that it failed to address the additional safeguarding concerns the complainant raised on 19 August 2019. I note the Trust comments to the complainant, on 21 April 2020 that *'…The reason for this omission was that…your letter dated 23 March 2019…'* did not include this specific issue. I accept this was the case however, I also note the complainant wrote directly to the Assistant Director of Older People's Service (Assistant Director) on 19 August 2019 and this was shared with the complaints department on 29 August 2019. I further note the Assistant Director provided a response to the complainant on 30 August 2019. However, while I note the Trust's comments that the safeguarding concerns

were addressed in the care review in March 2015, this response letter did not specially address the safeguarding concerns raised. I acknowledge the response of 30 August 2019 was shared with the complaints department on 03 September 2019.

207. I considered the Trust's final response to the complainant on 21 May 2021. I acknowledge again the complainant 's views that she was unhappy about the information contained within the response. However, given the available evidence I am satisfied the Trust fully responded to the complainant's issues as set out in her letter of 4 February 2021.

208. I also considered the information provided to the complainant in the Trust's letter on 18 June 2020. I note the response addresses the safeguarding investigation in relation to the incidents on 8 and 9 March 2015 but does not the incident of 1 April 2015. Given the safeguarding documentation provided to this office, it is my view this was because an audit was conducted only of Resident A's records and Trust staff did not consider auditing Resident B's records. I would reiterate my concern that when investigating any complaint, the Trust should endeavour to access all relevant information from any source available to ensure a full and thorough consideration of the evidence. However, I wish to acknowledge the Trust's comments that it did not intend to mislead the complainant or put up any barriers to my office's investigation and I welcome that the Trust will take learning from this situation.

209. I refer to the Department's Complaint Guidance which states a response letter should *'…address the concerns expressed by the complainant and show that each element has been fully and fairly investigated…'* and '…*be clear, accurate, balanced, simple, fair and easy to understand.* I also refer to the Trust's Complaints Policy which states '…*Any correspondence or contact received by A Directorate, which infers that the person wishes to make a formal complaint should be forwarded immediately to the Complaints Department…'* and *'…All investigations of complaints will be conducted promptly, thoroughly, openly, honestly and objectively.'* 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*'.

210. Given the complainant's letter, of 23 March 2019, detailed specific issues, it is my view, in line with the Department's Complaint Guidance, the Trust's Complaint Policy and the Third and Fourth Principle of Good Complaint Handling, that it was not appropriate for the Trust to provide, on 23 May 2019, a summary response which did not to fully address each individual issue of concern.

211. I am also satisfied the Trust did not provide an adequate response to the complainant regarding the safeguarding concerns in its response letters dated 30 August or 24 January 2020.

212. I consider that the Trust failed to provide complete information specifically in relation to the safeguarding incident that occurred in the Home on 1 April 2015. I consider this was not in line with the Trust's Complaints Policy or the Department's Complaint Guidance.

213. I am satisfised that these failings constitute. maladministration. I consider the complainant experienced the loss of opportunity for a thorough and complete response to her initial concerns as well as her safeguarding concerns and caused the complainant frustration and time and trouble by bringing a complaint to this office. I can also recognise how this maladministration has also undermined the complainant's trust and confidence in Trust. I partially uphold this element of complaint.

214. I wish to acknowledge the complainant's comments about the need to simplify the process when making complaints about the provision of health and social care, including Care Homes. I am in agreement with the complainant's sentiments and note that many complainants who come to our office reference similar concerns. I would like to highlight to the complainant the work that my

office is currently undertaking via our Complaints Standards team. The purpose of this team is to work with all public bodies, including the health sector, to introduce a simplified and standardised complaints procedure for any member of the public to use when they wish to make a complaint about health and social care.

CONCLUSION

215. I received a complaint about the Trust in relation to the care and treatment provided to the Resident A from March 2015 to September 2018 in the Home. I also opened a complaint relating to the actions of the Home staff. The complainant also raised concerns about the Trust's handling of her complaint.

Issue one

Actions of the Trust

216. The Investigation established a failure in Resident's A's care and treatment in relation to the following matters:
    - Failure to thoroughly investigate the Home's safeguarding referral of 8 and 9 March 2015 incidents; and
    - Failure to assess the Home's referral of 1 April 2015 incident under its safeguarding procedures.

217. I also considered the Trust failed to consider:
    - The appropriateness of Resident B's placement in the Home; or
    - A more detailed risk assessment for this placement.

218. I am satisfied that as a result of these failures Resident A experienced the loss of opportunity to ensure any potential vulnerabilities were thoroughly assessed and if necessary protected.

219. The investigation also established maladministration in relation the following matter:

- Failure to record rationale for the decision not to proceed to further investigation and exploration for the incidents that occurred on 8 and March 2015; and
- Failure to provide the complainant with full information about the incident on 9 March 2015.

220. I am satisfied that as a result of the maladministration the complainant experience uncertainty. I am also satisfied the complainant experienced the loss of opportunity to fully consider the protection strategies the Trust and Home implemented and to decide if she was content with them.

221. The investigation did not establish a failure in the relation to the following matter:
    - The appropriateness of the Trust response to the concerns of the complainant in relation to concerns about bruising on Resident A's arm.

Actions of the Home

222. The Investigation established a failure in Resident's A's care and treatment in relation to the following matters:
    - Failure to update Resident A's '*expressing sexuality'* care plan;
    - Failure in conjunction with the Trust, to assess the capacity of both residents to consent to forming an intimate relationship with the assistance of the Trust; and
    - Failure to record and act on the complainants concerns about bruising on Resident A's arm.

223. The investigation also established maladministration in relation the following matters:
    - Absence of Resident A's visual observation records for the period 9 March to 8 June 2015; and
    - Failure to notify the Trust of the concerns documented on 5, 12 and 18 April 2015 in line with the Home's Safeguarding January 2015.

224. The Investigation did not establish a failure in relation to the following matters:

- The recording and reporting of incidents that occurred in the Home on 8 and 9 March 2015; and
- The recording of reporting of the incident that occurred in the Home on 1 April 2015.

Issue two

Actions of the Trust

225. The investigation established maladministration in relation to the following matter:

- Failure to inform the complainant she could have an opportunity to view the nursing unit in the Home.

226. The investigation did not establish failures in the relation to the following matters:

- The Trust's assessments considering Resident A's transfer to and from nursing care; and
- The Trust's communication with the complainant about Residents A's transfer to the nursing unit in December 2017.

Actions of the Home

227. The investigation established a failure in Resident A's care and treatment in relation to the following matter:

- The provision of information to the complainant and the Trust in relation to Resident A's transfer date.

228. The investigation also established maladministration in relation the following matter:

- The provision of inaccurate information to the complainant, about the possible transfer of Resident A to nursing care in June 2017; and
- The absence of daily progress notes for the period from 6 December 2017 to 31 December 2017.

229. The investigation did not establish a failure in the relation to the following matter:

- The appropriateness of Home staff to request the Trust to review the care needs.

Issue three

Actions of the Trust

230. The investigation did not establish a failure in the relation to the following matter:

- The appropriateness of the Trust's actions when investigating the concerns raised by the complainant in 2018.

Actions of the Home

231. The investigation established failures in Resident A's care and treatment in relation to the following matters:

- Failure to provide adequate staffing for the period 2 July 2018 to 29 July 2018;
- Failure to update and maintain an accurate record of Resident A's *Breathing and Circulation'* care plan;
- Failure to offer sufficient meaningful activities and events to Resident A; and
- Failure to maintain Resident's A's dignity and respect, particularly in relation to the provision of chiropody services and wearing of appropriate clothing.

232. The investigation did not establish a failure in the relation to the following matter:

- The appropriateness of the Home's treatment of Resident A's chest infection.

Issue four

Actions of the Trust

233. The investigation established a failure in the care and treatment in relation to the following matter:

- Failure to carry out a care review for Resident A within an appropriate timescale.

234. The investigation also established maladministration in relation to the following matter:

- Failure to keep the complainant updated as to the contact details of the Resident A's monitoring officer.

Issue five

Action of the Trust

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

- The adequacy of the Trust's response dated 23 May 2019;
- The adequacy of the Trust's responses dated 30 August and 24 January 2020; and
- The adequacy of the Trust's response dated 18 June 2020.

236. I offer through this report my condolences to the complainant for the loss of her mother. I also wish to acknowledge the complainant's attentiveness and devotion to her mother when in the Home which is evident throughout the complainant's journals. It is very clear the complainant sought the best care and treatment for her mother at all stages while she was a resident in the Home.

Recommendations

237. I recommend the Trust and the Home provide to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration and failures identified within **one month** of the date of this report.

238. I recommend for service improvement and to prevent future recurrence the Trust:-

- Carries out a random sampling audit of safeguarding referrals (in the 12 months prior to the issuing of final report), that have reached investigation stage, to ensure an adequate investigation has taken place and where appropriate carers/family members have been provided with all the information on any incidents referred/investigated;
- Carries out a random sampling audit of safeguarding referrals post September 2021 to provide evidence that the updated Adult Protection documentation is being followed, particularly in relation to recording of rationale around decision meetings;
- Carries out a random sampling audit of Residential Home placements (in the 12 months prior to the issuing of final report) to ensure placements are appropriate and suitable risk assessments have been completed;
- Identifies service users that the Trust have transferred from the home's residential unit to the nursing unit in the 12 months prior to the issuing of final report. Of the service users identified, carry out a random sampling audit to ensure the Trust provided residents and/or their relatives/cares the opportunity to view the nursing unit within the home prior to any transfer;
- For the12 months prior to the issuing of final report, carries out a random sampling audit of service users to ensure care reviews are completed within appropriate timescales. This audit should also include service users involved in safeguarding investigations to ensure the appropriateness of care review timescales;
- Reminds Directorate staff that any correspondence received by it, which raises issues of complaint be forwarded directly to the complaints department; and
- Complaints Department staff are reminded that responses to complainants should fully and adequately address all the concerns they raised.

The Trust should include any recommendations identified in the audits above to this office.

239. I further recommend for service improvement and to prevent future recurrence the Home:-

- For the 12 months prior to the date of issue of the final report of this investigation carries out a random sampling audit of residents' records to ensure that any safeguarding concerns that have been documented by Home staff or family members have been appropriately referred to the Trust;
- For the 12 months prior to the date of issue of the final report of this investigation, identifies vulnerable residents that have strategies introduced following safeguarding concerns. Of the residents identified, carry out a random sampling audit to ensure any required documentation checks, for example visual observations, are recorded;
- Of the residents identified in the point above, review the Home's processes in relation to when Residents' '*expressing sexuality'* care plans should be updated and when residents' capacity to consent to forming inmate relationship should be assessed and who should conduct these assessments.
- If not already in place, establish a policy on sexuality and relationships which safeguards the rights of all residents, ensuring their privacy and promoting the emotional wellbeing and protection of everyone. The manager and staff of the Home should be aware of the policy and trained to respond appropriately to issues around relationships, and sexuality;
- For the 12 months prior to the date of issue of the final report of this investigation, identifies residents that have transferred from the home's residential unit to the nursing unit. Of the residents identified, carry out a random sampling audit to ensure Home staff have provided residents' relatives/cares with all the necessary information regarding the residents' transfer date; and,

- Carries out a random sampling audit of archived residents' records to ensure all relevant records have been retained. Take action to address any identified trends or shortcomings.

The Home should include any recommendations identified in these audits to this office.

240. I recommend the Trust and Home implement an action plan to incorporate these recommendations and should provide me with an update within **6 months** of the date of my final report. The Trust and Home should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

241. Priory Adult Care acknowledged the draft report and findings and said that following review of the draft report it recognised there were areas of shared learning with regards to communication and accurate record keeping in particular. It also recognised the importance of maintaining the collaborative approach with multidisciplinary teams and the families of those in its care. While Priory Adult Care also recognised that the Home had now been handed over to Healthcare Ireland it confirmed it would share and cascaded the learning within the report '…*to the remaining services within Priory as areas of reflection to further improve our services.'*

242. Priory Adult Care also apologised for any distress caused to the family during this period of time.

243. Healthcare Ireland confirmed an action plan would be implemented for the Home and I welcome the commitment from both care providers to implement improvements and share learning.

MARGARET KELLY
Ombudsman **06 November 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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 relevant guidance, 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.