Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Southern Health & Social Care Trust

NIPSO Reference: 16991

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

I received a complaint concerning the care and treatment provided to the complainant's late mother by the Southern Health & Social Care Trust (the Trust), while she was a patient at Craigavon Area Hospital (CAH). The complainant believed that the Trust did not appropriately respond to issues raised by her in relation to her mother's care. In addition, the complainant believed that the Trust did not manage her mother's discharge from CAH to the nursing home appropriately. The investigation also led me to consider the handling of the complaint by the Trust.

As part of the investigation I obtained independent advice from a consultant Nurse for Older People and two social work advisors. Having taken account of the advice the investigation established that the Trust adequately communicated with the nursing home following the patient's discharge from CAH, as the Community Care Manager implemented a number of actions addressing concerns raised by complainant while her mother was in hospital.

However, the investigation established that the Trust failed to organise a timely discharge meeting prior to the patient's discharge from CAH. It also established that the Trust failed to organise a meeting between the complainant and the Acute Directorate Team, to discuss the complaint, within an appropriate timeframe. The investigation also established that the Trust made a number of record keeping failures.

I made a number of recommendations including an apology to the complainant for the failings identified and a recommendation for the Trust to remind relevant staff of the importance of good record keeping and handling complaints in a timely and efficient manner.

THE COMPLAINT

1. The complaint concerned the care and treatment provided to the complainant's late mother, the patient, by the Trust. Her complaint is in relation to the period her mother was a patient at CAH, between 12 and 24 February 2012.

2. On admission to CAH, the complainant stated that a nurse expressed concern in relation to her mother's condition. She stated that the nurse commented that the patient was severely dehydrated and that her personal hygiene was poor. The complainant stated that she discussed her concerns in relation to her mother's care and treatment at the nursing home with the nurse, and showed her photographs of the patient's ear[1]. She stated that the nurse expressed concern and advised her to continue taking photographs.

3. In addition, the complainant said that she subsequently raised concerns in relation to the care and treatment being provided to her mother in the nursing home with the hospital social worker (HSW A). The complainant stated that HSW A advised her that the patient would be staying in hospital as she was too frail, and advised her that staff on the ward had taken photographs to evidence the patient's poor condition. The complainant stated that HSW A encouraged her to make a formal complaint, and advised her the hospital would be raising a complaint. However, the complainant explained that she did not feel comfortable making a complaint, as it may have affected her mother's care on return to the nursing home. She complained that neither the nursing staff nor HSW A escalated her concerns or raised a safeguarding concern.

4. On the patient's discharge from CAH, the complainant also complained that hospital staff failed to organise a revised care package to reflect her mother's needs on return to the nursing home. The complainant stated that HSW A stated that she would meet her on the ward on 23 February 2012 to discuss her mother's discharge. However, the complainant stated that HSW A failed to

[1] Prior to admission to CAH, the patient had been diagnosed with cellulitis.

show up, even though she was on site. The complainant believes that there was a total lack of communication between CAH and the nursing home at this time. In addition, the complainant stated that her mother returned to the nursing home by ambulance on 24 February 2012, without a family member escort.

5. On consideration of the complaint, this office decided to investigate the complainant's concerns about Dunlarg Nursing Home as a separate complaint (Case Ref 17253).

Issues of complaint

6. The issues of the complaint against the Trust, which I accepted for investigation were:
7.

Issue 1: Whether the care and treatment provided by the Southern Health and Social Care Trust, while the patient was at Craigavon Area Hospital (between 12 and 24 February 2012), was of a reasonable standard?

Issue 2: Whether the complaint handling by the Southern Health and Social Care Trust was of a reasonable standard?

INVESTIGATION METHODOLOGY

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

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

- **Consultant Nurse for Older People, RGN, BA (Hons), MSc, PGCert (HE) (N IPA) –** 15+ years' experience, with clinical experience across acute care and care homes, including expertise in caring for frail older people with complex needs, including Parkinson's disease, falls, advance care planning, safeguarding adults and continuing healthcare.
- **Social Worker (SW IPA 1)** – 30+ years' experience as a qualified social worker.
- **Social Worker (SW IPA 2)**[2] – Certificate of Qualification in Social Work and a diploma in supervisory management.

10. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

11. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

12. The general standards are the Ombudsman's Principles[3]

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsmen Principles for Remedy

13. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and

[2] During my investigation, the SW IPA 1 advised that she was no longer available to continue providing independent professional advice. As a result, the SW IPA 2 was engaged to aid completion of outstanding advice.

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

professional judgement functions of those Trust individuals whose actions are the subject of this complaint.

14. The specific standards relevant to this complaint are:

- Department of Health, Social Services and Public Safety Circular, ECCU 1/2010, Care Management, Provision of Services and Charging Guidance (Care Management Guidance)
- The Southern Health & Social Care Trust's Safeguarding Vulnerable Adults Policy, Operational Procedures and Guidance, January 2012 (Safeguarding Policy)
- Department of Health, Social Services and Public Safety's Discharge from hospital: pathway, process and practice (Discharge from Hospital Guidance), 28 January 2003
- Nursing & Midwifery Council (NMC), The Code, 2008 (the NMC Code)
- The Southern Health & Social Care Trust's Policy for the Management of Complaints, June 2013 (Complaint's Policy)
- Northern Ireland Social Care Council's (NISCC) Codes of Practice for Social Care Workers and Employers of Social care Workers, September 2002 (NISCC's Code of Practice)

15. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings. As part of the NIPSO process, a copy of this draft report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Whether the care and treatment provided by the Southern Health and Social Care Trust while the patient was at Craigavon Area Hospital (12 February 2012 to 24 February 2012) was of a reasonable standard.

Detail of Complaint

16. The complaint concerned the care and treatment provided to the complainant's late mother by the Trust, while she was a patient at CAH between 12 and 24 February 2012.

Admission to CAH

17. The patient was admitted to CAH, via the Accident and Emergency Department (ED) on 12 February 2012. On admission, the complainant stated that her mother was unconscious and extremely dehydrated. She explained that doctors tested the patient, and on receiving the test, results expressed concern for her condition. As there were no available ward beds, the complainant stated that her mother spent the night in an ED bay.

18. On 13 February 2012, the patient was moved to the Medical Assessment Unit (MAU). The complainant said that a nurse expressed concern for her mother's conditions, and advised that she was very dehydrated. The complainant stated that she shared her concerns with the nurse regarding her mother's care in the nursing home, and shared a photo of the open wound on her mother's ear[1]. She stated that the nurse advised her to continue taking photos of her mother to document her condition.

Actions of CAH Social Work Team

19. On 19 February 2012, the complainant requested to meet with the HSW A, and an appointment was scheduled for 21 February 2012.

20. At this meeting, the complainant stated that she explained to HSW A that she had concerns in relation to her mother's care and treatment at the nursing home. She stated that she asked HSW A if her mother could remain in CAH, in order to safeguard her. The complainant stated that HSW A assured her that her mother would remain in hospital, as she was too frail to leave. The complainant also stated that HSW A shared her concerns regarding her

mother's care at the nursing home. The complainant stated that HSW A advised that staff had taken photographs of the patient as evidence of her poor condition. The complainant stated that the HSW encouraged her to make a formal complaint against the nursing home, and advised that the hospital would be lodging its own complaint.

Discharge from CAH

21. On 23 February 2012, the complainant stated that she was advised that her mother was being discharged from CAH, and that she would be returning to the nursing home. The complainant said that HSW A stated that she would meet with her on the ward on 23 February 2012 to discuss the discharge. However, the complainant complained that HSW A failed to attend the meeting, even though she was present on site.

22. During the patient's time in hospital, the complainant explained that she was attended by the speech and language team (SALT), to investigate and test concerns in relation to her ability to swallow. However, the complainant stated that Trust staff failed to organise a revised care package for her mother's return to the nursing home, and that there was a lack of communication between CAH and the nursing home in relation to the discharge.

23. In addition, the complainant complained that her mother returned to the nursing home by ambulance on 24 February 2012, without a family member escort.

Evidence Considered

24. I considered the Care Management Guidance, specifically in relation to the discharge of individuals from hospitals to care home settings:

'Trusts should have arrangements in place for the safe and effective discharge of people from hospital and their transfer between care settings. Discharge and transfer procedures should be agreed between hospital and

community services and should be communicated proactively to all staff, service users, or their authorised representatives, as appropriate, and carers. HSC Trusts should ensure that service users and carers, or their individual advocates or representative organisations, are properly involved in drawing up and publicising discharge and transfer procedures which also have due regard for the needs of carers.'

25. I also considered the Care Management Guidance in relation to reviews:

'27. Review is an integral part of care delivery and is particularly important in case managed situations in view of the complexity of need and resources involved… As a minimum, a formal review should take place once a year. More frequent reviews may be required in response to changing circumstances or at the request of service users or other persons, including carers, or agencies involved in their care.'

26. In addition I considered the Safeguarding policy, which states:

*'**Principles***

5.1 The Southern Trust recognises that abuse of vulnerable adults is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (private, voluntary, independent sector) to be alert to the possibility of abuse.

5.2 Trust staff who have concerns regarding alleged, suspected or confirmed abuse of a vulnerable adult, have an obligation to report their concerns immediately.

5.3 All allegations of abuse of a vulnerable adult will be fully investigated and a protection plan put in place where appropriate…'

27. I have also considered the Discharge from Hospital Guidance, specifically section 1.4, which states:

'The key principles for effective discharge and transfer of care are that…

- *Discharge is a process… it has to be planned for at the earliest opportunity across the primary, hospital and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate;*
- *the process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'. This involves liaison with the pre-admission case co-ordinator in the community at the earliest opportunity and the transfer of those responsibilities on discharge;*
- *Staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process…'*

28. I have also considered section 5.4.3, in relation to discharge, which states:

'A decision that a patient is medically fit for discharge can only be made by the patient's consultant… or by another doctor who is responsible for the care of the patient. Patients, who have both health and social care needs, must only be discharged when they are clinically fit. This is a decision made by the multidisciplinary team when considering all the factors, which will include the relative safety of remaining in hospital or being elsewhere and the patient's and carer's view of these risks.'

29. In addition, I considered the NMC Code, specifically Standard 43, which states that nurses *'must keep clear and accurate records of the discussion you have, the assessments you make, the treatment and medicines you give, and how effective these have been.'*

30. I considered Standard 6 of the NISCC Code of Practice, which states that social workers must maintain *'clear and accurate records as required by procedures established for your work.'*

Trust's Response to Investigation Enquiries

31. As part of investigation enquiries, the Trust was asked to respond to the complaint about the care and treatment provided to the patient at CAH between 12 and 24 February 2012.

Admission to CAH

32. The Trust advised that the nursing staff in ED and the MAU *'were not interviewed in relation to the taking of photographs.'* It stated that prior to the letter sent from this Office to the Trust on 22 November 2018, *'there had been no mention of photographs being taken in the Emergency Department.'* The Trust stated that '*there is no evidence that any photographs were taken by nursing staff at ward level.'*

Actions of CAH Social Work Team

33. The Trust stated that *'a referral was received by the hospital social work team on 20 February 2012 as [the complainant] was requesting to speak to the hospital social worker, [HSW A].* The Trust stated that a meeting was arranged for the following day. At the meeting with HSW A on 21 February 2012, the Trust stated that the complainant '*expressed some concerns regarding her mother's care in the nursing home but was unclear whether she wanted her to return.'*

34. In relation to the taking of photographs, the Interim Chief Executive advised that he wished *'to refute [the complainant's] statement that there was a discussion between the hospital social worker and [the complainant] regarding the taking of photographs at ward level.'* In addition, he stated that '*[HSW A]*

did not relate that the hospital were to take forward a complaint.'

35. The Trust also responded to the complaint that HSW A assured the complainant that her mother would be remaining in hospital, as she was too frail to leave. The Trust stated that *'decisions regarding whether a patient is medically fit to leave hospital is a decision of medical staff and beyond the remit of hospital social work.'*

Discharge from CAH

36. Following the meeting with HSW A on 21 February 2012, the Trust stated that *'it was agreed [with the complainant] that contact would be made on Thursday 23 February 2012, when the [hospital] social worker returned to duty.'* On Wednesday 22 February 2012, the Trust stated that the HSW on duty, HSW B, *'sought to contact [the complainant] on her mobile. [However] there was no reply and she was unable to leave a message.'*

37. Subsequently, on Thursday 23 February 2012, the Trust stated that HSW A *'sought to contact [the complainant] at her home on two occasions. She then sought contact via her mobile on three occasions. Contact was eventually made at 2.40pm.'* The Trust stated that the complainant *'initially requested a meeting before her mother returned to the nursing home.'* However, it stated that *'the [Community] Care Manager was unable to attend a meeting on 24 February 2012 and [the patient] was medically fit for discharge.'*

38. As a result, the Trust stated that HSW A *'made contact with [the complainant] on the morning of discharge and she agreed to transfer her mother back to the nursing home with an urgent Care Management Review.'* The Trust stated that the complainant was discharged on 24 February 2012 *'and this information was shared with'* the community social worker. The Trust stated that it was *'satisfied that there was an agreement by all parties, including [the complainant], prior to discharge, that the concerns were to be formally reviewed in the community.'* Finally, the Trust stated that *'a revised care*

package of care was not required as the patient was returning to nursing home care.' The Trust stated that it was '*satisfied that there was an adequate assessment of [the patient's] needs prior to and upon her discharge'* from CAH.

39. In relation to the communication between CAH and the nursing home regarding discharge, the Trust stated that *'the nursing notes evidence that [the nursing home] was contacted regarding the transfer back. In addition, a discharge letter and discharge medication were sent with [the patient]. This is evidenced on the transfer sheet included within the nursing notes attached.'* The Trust stated that HSW A also made contact with the Care Management Office on 24 and 27 February 2012 to advise of the patient's discharge *'and the need for a Care Management review in the community.'*

40. In response to the complaint that the patient was transferred back to the nursing home unescorted, the Trust stated that *'it would not be normal practice for Care Home patients to be accompanied during transfer back'* from hospital.

Clinical Records

41. I have reviewed the patient's ED admission record, which states '*Diagnosis "Dehydration? UTI [Urinary Tract Infection]".'*

42. I have also reviewed the patient's nursing record on admission, which notes '*NPU (not passed urine). Broken area noted on Rt [right] ear, red inflamed. Medical doctor informed – wound cleaned. IV fluids running. Admit MAU.'*

43. I reviewed the patient's medical notes, dated 23 February 2012, which state *'D/C [discharge] once SW [Social Worker]/ daughter happy, medically fit.'*

44. In addition, I reviewed the patient's social work entries for 21, 22 and 23 February 2012:

21 February 2012 [HSW A]

'Daughter [the complainant] did express… some concern [regarding] her mother's care, however still unsure if she wants her to return [to nursing home].'

23 February 2012 [HSW A]

'spoke with daughter this pm [evening]. After requesting a formal meeting with home management… daughter did not want another T/F back to this [nursing home]…'

24 February 2012

'daughter in agreement to T/F [transfer] back to [nursing home] with view to r/v [review] c.mgt [care management] next week in the home. Can n/staff [nursing staff] contact [nursing home] and update of care (@daughter request).Daughter unaware of d/c [discharge] today/ to be advised if for d/c [discharge].

'Daughter contacted regarding transfer to nursing home. Nursing home contacted regarding transfer.'

45. I also reviewed the Core Patient Information document, which has a handwritten comment *'ring this number [the complainant] not NH [nursing home]'*.

Relevant Independent Professional Advice

46. As part of investigation enquiries, I received independent professional advice from the SW IPA 1, SW IPA 2 and N IPA, in relation to the patient's care and treatment while at CAH between 12 and 24 February 2012.

Admission to CAH

47. On admission to CAH, the N IPA advised that there is no record *'that the hospital staff suspected signs of possible abuse or neglect.'* On review of the nursing records, the N IPA advised the patient was *'transferred to bed. Sacral area red. NPU (not passed urine). Broken area noted on Rt [right] ear, red inflamed. Medical doctor informed – wound cleaned. IV fluids running. Admit MAU.'* The N IPA advised that *'the observation that [the patient] did not pass urine at this time is a potential symptom of dehydration or poor hydration. The ED [Emergency Department] record states Diagnosis "Dehydration? UTI [Urinary Tract Infection]".'*

48. The N IPA advised that the medical team subsequently confirmed that the patient was dehydrated, *'on the basis of medical tests, vital signs and other physical presentations such as reduced level of consciousness.'* The N IPA also referred to the discharge letter, *'which recorded that [the patient] was admitted from the nursing home with "decreased level of consciousness and dehydration. She was diagnosed as having lower respiratory tract infection and treated with antibiotics and IV fluids.'*

49. In relation to safeguarding concerns, the N IPA advised that *'as dehydration is commonly associated with infection amongst frail older people, and there were no other signs of potential neglect or abuse recorded, this would not necessarily have immediately prompted a safeguarding concern in the emergency department.'* The N IPA advised that *'the staff in the Emergency Department would be expected to be alert to possible signs of neglect that could lead to dehydration, such as the possibility that carers had been withholding or failing to offer food or drink… it is the responsibility of the person concerned to raise this at the appropriate level… There is no evidence in the record that staff suspected any prior neglect or failure of care.'*

50. In addition, the SW IPA 2 advised that a form entitled *'Information for unplanned hospital admission for residents of care homes'*, noted that the

patient was *'taking nil orally'* and at *'risk of dehydration'.* The SW IPA 2 advised that *'this form is kept with the patient's nursing notes and indicates that both medical and social work staff were aware of [the patient's] medical condition on admission to hospital.'*

51. The N IPA also advised that following the patient's admission to CAH, there were *'initial concerns about her ability to swallow due to drowsiness',* and she *'was referred for [a] Speech therapy'* [SALT] assessment.' The N IPA advised that the *'SLT entry in the multidisciplinary report section of the notes, dated 15th February, identifies delayed pharyngeal swallow*[4]*, and recommends trials of fluid and syrup medications. This means that at that time [the patient] had impaired swallowing (this could be acute onset, immediately prior to admission).'* The N IPA advised that changes to swallow in Parkinson's *'are common, due to the deposition of lewy bodies in the gut (an abnormal cellular process that leads to dysfunction) and/ or the bradykinesia (slowing of movement) that is a cardinal sign of Parkinson's disease.'*

52. While in hospital, the N IPA advised that *'oral fluids were being encouraged by 17th February… by 20th February [the patient] was eating and drinking, and by 22nd Feb [ruary] she was seen by the SLT who concluded that [the patient] was tolerating small amounts of puree and thickened liquids and that written advice would be provided for the care home.'* The N IPA advised that the patient *'was recorded as "eating and drinking very well" on 23rd February.'*

Actions of CAH Social Work Team

53. On admission to hospital, the SW IPA 1 advised that the role of the HSW in circumstances such as the patients, is to liaise with them and their family member/ next of kin. In addition, the SW IPA 1 advised that the HSW's role involves bridging *'the gap between the patient/ next of kin and the clinical care*

[4] The swallowing process is commonly divided into oral, pharyngeal, and esophageal stages. During the pharyngeal phase, the vocal folds close to keep food and liquids from entering the airway. If the pharyngeal phase is impaired, food or liquid can move into the throat before the automatic swallow is triggered, resulting in food or liquid touching the vocal folds or penetrating the vocal folds and moving into the lungs.

provided' and advocating on behalf of the patient.

54. On review of the social work records, the SW IPA 1 advised that there *'is some evidence'* of HSW A liaising with the complainant. The SW IPA 2 advised that there is a '*Request for Assessment by Social Worker'* document, dated 20 February 2012, which details *'daughter wants to speak with social worker.'* The SW IPA 2 advised that *'the referral source for this entry is blank.'* In addition, the SW IPA 2 advised that *'there are two pages of handwritten notes detailed on a Craigavon Area Hospital Personal Social Services Department Assessment Form',* dated between 20 and 27 February 2012. The SW IPA 2 advised *'there are a total of six entries over this period. The first of these refers to initiating contact with [the complainant]… [and] contains limited initial recording… or detail of the patient/ family circumstances or 'Description of service requested' as would be expected.'*

55. The SW IPA 2 advised that the second entry details '*the subsequent meeting with [the complainant] and her husband [on 21 February 2012]… [and] contains a note that [the complainant] had concerns regarding her mother's health and wellbeing.'* The SW IPA 2 advised that '*there is no signature(s) in the appropriate place on the Assessment form'.* However, the SW IPA 2 advised that whoever made the entry noted that they would *'contact [the nursing home] but gave no information on what specific issues or concerns needed to be addressed or if there is any particular plan of action that needs to be implemented.'* The SW IPA 2 advised that *'this lack of detail limits the value of the recording.*'

56. In relation to the social work documentation, the SW IPA 2 advised that the *'substantial gaps in the recorded material',* reflects *'an unacceptable level of communication which limits understanding of and monitoring of the files content and any actions needed.'* However, the SW IPA 1 advised that *'while there is an absence of detail there is reference within medical notes of staff awaiting the outcome of discussions between [the complainant] and [HSW A] as [the complainant] is unhappy about her mother's care.'* The SW IPA 1

advised that *'from the brief written records it does appear that [HSW A] and other staff were aware of [the complainant's] concerns about the care provided to her mother in [the] Nursing Home.'*

57. I note the SW IPA 1 advised that *'it would be reasonable to assume that [the complainant] did share detailed concerns with the social worker, which should have been appropriately followed up by the hospital social worker.'* However, the SW IPA 1 advised that *'there appears to be a variance between what [the complainant] reports she was told by the hospital social workers and what actually happened in regards to the ongoing care of her mother. It is impossible to ascertain from the Trust records the hospital social worker's response to the issues raised.'* However, the SW IPA 2 advised that '*the key issues presented by [the complainant] were being addressed by [the Community Care Manager]. This included a referral to the Speech and Language Therapist and ongoing discussions with DNH staff re overall care needs.'*

58. I also note that the SW IPA 1 advised that there is *'no evidence'* that HSW A or the hospital staff shared the complainant's concerns or that they were considering making a complaint themselves.

59. The SW IPA 1 advised that *'the social worker is not a clinician and would be reliant on the medical staff to highlight and identify any safeguarding concerns in regards to the patient.*' However, the SW IPA 1 advised that *'it is the role of the social worker and all attending clinicians to raise safeguarding concerns if they become aware of them.'* The SW IPA 1 advised that if the clinical staff were concerned with the care provided to the patient by the nursing home, then *'they should have raised it with [HSW A] who in turn should have raised these concerns with the nursing home and R.Q.I.A.*[5]*'*

60. In addition, the SW IPA 1 advised that *'a further issue of concern… is that the questions in relation to safeguarding concerns on the admission*

[5] Regulation and Quality Improvement Authority.

documentation have not been completed.' However, the SW IPA 2 advised that *'care and protection issues have been identified and addressed… as such an adult safeguarding process, was not necessarily appropriate as it would have resulted in similar actions to that which… had already been implemented.'*

Discharge from CAH

61. In relation to the meeting on 23 February 2012, the SW IPA 1 advised that if HSW A agreed to meet the complainant on the ward and failed to do so, *'then the social work response was not adequate.'*

62. In relation to the multidisciplinary review prior to discharge, the SW IPA 1 advised that *'the role of the social worker is central to the discharge planning arrangements for any complex case.'* The SW IPA 1 advised that when a patient is declared medically fit, the HSW will *'plan for a prompt and appropriate discharge.'* The SW IPA 1 explained that the role of a HSW on discharge includes arranging *'a discharge planning meeting where there is a multi-disciplinary input to the ongoing care plan once the patient is returned to the community'* liaising *'with the care manager in the community team',* and liaising '*with the community social worker particularly where there are significant changes to the patients care needs as was the case with [the patient].'*

63. In addition, the N IPA advised that '*I did not see any policy documents from CAH relating to the nursing staff role in discharge to care homes.'* At this time, the N IPA advised that Discharge from Hospital Guidance states that '*There is consistent evidence to suggest that best practice in hospital discharge involves multidisciplinary teamwork to actively manage all aspects of the discharge process… In care of the elderly services team co-ordination is frequently organised through routine weekly multidisciplinary meetings.'*

64. As a result, the N IPA advised that she *'looked for evidence in the hospital*

records that multidisciplinary working on the ward rounds addressed discharge planning and that nurses were involved in this.' On 22 February 2012, the N IPA advised that there is a record detailing *'patients daughter to speak with social worker tomorrow [regarding] if pt [patient] is to return to the same nursing home… tried to contact daughter via telephone – no answer.'* On the same date, the N IPA advised that the medical entry stated *'pt [patient] remains medically fit for discharge'.*

65. The N IPA advised that *'the role of the hospital nurse within the multidisciplinary team is usually to support communication between the hospital team, care providers (including social work and care home) and relatives; order medicines for discharge (or this may be done by the pharmacy team); complete the nursing transfer letter; liaise with transport services; ensure the patient is checked to be fit and comfortable to travel.'*

66. On review of the patient's hospital records, the N IPA advised that *'discharge planning was carried out with multidisciplinary and multi-agency involvement.'* The N IPA also advised that *'there is a nursing transfer sheet [dated 24 February 2012[6]] which is hand written and legible. It records that the daughter has been informed of the transfer. It lists the medication, property level of orientation, communication, diet, nutritional needs, personal hygiene and skin, mobility and sleeping pattern. There are additional hand written information specifying "puree fluids, needs a lot of time with feeding. Has been eating and drinking well last few days. Alert during the day, tearful @ [at] times in the evening".'* The N IPA advised that *'in my opinion the level of information in the transfer letter is adequate.'*

67. Overall, the N IPA advised that *'the hospital team addressed discharge planning in an appropriate multidisciplinary approach according to national guidance, and the nursing team contributed to this process.'*

[6] This document is dated 24 February 2012 on the front, and 24 February 2011 on the reverse. As the document lists the patient's symptoms as cellulitis, and records that she requires 'a pureed diet' due to her swallow, it is most likely that this document is from her discharge on 24 February 2012.

68. As part of investigation enquiries, the SW IPA 2 was asked to consider if the actions undertaken by the hospital social work team were in accordance with the Northern Ireland Single Assessment Tool (2011). The SW IPA 2 advised that the NISAT (2011) 'is *an inclusive assessment process, which allows all professionals involved in the assessment of an older person to undertake a complete assessment thus reducing the need for duplication.'*

69. The SW IPA 2 advised that '*one of the core elements of NISAT is to ensure that any service user…. Will be allocated a Key Worker who will have overall responsibility for the care of the person… This was… [the Community] Care Manager… Planning for discharge is the joint responsibility of the Key Worker and if appropriate the identified lead person for discharge, which in this case was the hospital social worker… [HSW A].'* The SW IPA 2 advised that both the Community Care Manager and HSW A *'had direct contact with [the complainant]'* prior to the patient's discharge.

70. In relation to whether the patient was medically fit for discharge, the SW IPA 2 advised that *'there is no need for the social worker to separately seek confirmation that [the patient] was medically fit to leave hospital. This is the role of the medical staff and they had responsibility to ensure that [the patient] was physically and mentally fit to leave hospital.'* The SW IPA 2 advised that *'the Social Work Department is included in information on discharge. The ongoing liaison and work with, and on behalf of, [the patient] should ensure that the social worker was aware of impending discharge processes.'* The SW IPA 2 advised that *'there is no evidence to suggest this [cooperation] did not occur…. There is no note of this in the information provided.'*

<u>Discharge planning meeting</u>

71. One issue of *'significant concern'* raised by the SW IPA 1, was that *'a discharge planning meeting did not take place'* prior to the patient being discharged from CAH. The SW IPA 1 referred to the Departmental Circular ECCU 1/2010 Care Management, Provision of Services and Charging

Guidance, which *'states that Health and Social Care Trusts should have arrangements in place for the safe and effective discharge of people from hospital and their transfer between care settings. Discharge and transfer procedures should be agreed between hospital and community settings and should be communicated proactively to all staff/ service users or their representatives as appropriate.'*

72. The SW IPA 1 advised that '*[the patient] was a woman with very complex needs and the plan for her ongoing care required a multi-disciplinary review to develop an appropriate plan for ongoing care'* in the nursing home. In this case, the SW IPA 1 advised that this meeting *'would have been particularly important… in light of the fact that [the complainant] had raised concerns about her mother's care at the time of her mother's admission to hospital'* and as the patient's *'care needs had changed significantly.'* The SW IPA 1 advised that *'the planning meeting took place four days after the discharge.'*

73. In addition, the SW IPA 1 advised that *'records do show that attempts were made by [HSW A] to progress this meeting prior to discharge however [the patient] was deemed medically fit and discharged before this meeting took place.'* In addition, the SW IPA 1 advised that *'the failure to hold a discharge planning meeting prior to discharge, as the proposed date did not suit the community social worker, is a significant failing in this case. A delay of a day or two would have been appropriate… but potentially difficult to achieve given the pressure on hospital beds particularly during the winter months.'*

74. The SW IPA 2 confirmed that *'[the patient] returned to [the nursing home] with no formal transfer of information having taken place.'* However, the SW IPA 2 advised that *'there will have [already] been a comprehensive care plan developed for [the patient] to cover all aspects of her health and wellbeing. This will not have fundamentally changed after her discharge from hospital.'* The SW IPA 2 advised that '*a revised care package results from changes in circumstances which demand an increase or considerable change to a current care package.'*

75. In the patient's case, the SW IPA 2 advised that the nursing home was required *'to place increased emphasis on aspects of her day to day care including hydration, appetite and emotional wellbeing… there was no need for a new care plan rather the emphasis was on delivery of [the patient's] needs as identified in the original care plan with a continued emphasis on high quality care to be monitored by the home and her social worker.'* Furthermore, the SW IPA 2 advised that the DHSSPS' focus is that *'care packages are developed… largely in community/home circumstances',* and *'residential nursing care'* best met the patient's needs.

76. The SW IPA 2 advised that the discharge planning meeting '*is a core part of transfer from the hospital back into the community to ensure that care and support needs of the individual and their carer(s) are met through communication between hospital and community support services.'* In the patient's case, the SW IPA 2 advised that *'her underlying health needs did not significantly deteriorate from pre to post her hospital care. Her stay in hospital addressed her immediate health issues including dehydration, oral hygiene and a respiratory tract infection.'* The SW IPA 2 advised that *'these symptoms could and be well within the skill and scope in a residential nursing home.'*

77. The SW IPA 2 advised that *'the discharge meeting should have taken place to ensure a comprehensive and smooth transfer from hospital to the community. This did not take place as [the patient's] social worker was not available.'* The SW IPA 2 advised that *'given the short notice at which discharges occur it is inevitable that on occasions this will happen.'* In this case, the SW IPA 2 advised that *'this resulted in the hospital social worker having knowledge of [the complainant's] concerns about the [the nursing home] staff's ability to properly care for her mother which was not available to the community [Care Manager]…until later.'*

78. In addition, the SW IPA 2 advised that the complainant had not raised concerns in relation to her mother's care '*with the social worker with primary responsibility for her mother's care and wellbeing in the residential setting.'*

The SW IPA 2 advised that it *'would have been of value to have [the patient's health issues] assessed by the social worker at the point of discharge.'*

79. However, the SW IPA 2 advised that *'there should not have been any adverse effect on [the patient's] health as [the nursing home] had the detail of her needs and as a nursing home had the facilities and expert staff to provide this responsibility for [the patient's] care.'* In addition, the SW IPA 1 advised that *'following discharge all relevant steps were taken to meet [the patient's] assessed needs.'*

Alternative options for discharge

80. The SW IPA 2 advised that *'the discharge process should be led by the social worker and reflect both the needs and concerns of the patient and their carer(s). This would ensure that best practice is followed in ensuring both health and well-being needs and the wishes of the individual and carer(s) play a central part in decision making processes.'* In this instance, the SW IPA 2 advised that *'there is no indication that [the patient] or her daughter… were suggesting a specific alternative to her existing placement in [the nursing home]. The issues and concerns raised by [the complainant] reflect changes needed to ensure her mother's health and wellbeing in the nursing home environment.'* The SW IPA 2 advised that *'[the complainant] had raised in discussion the possibility of taking her mother home to reside with her. [However] there is no detail of this being given consideration as part of the discharge process.'*

81. In addition, the SW IPA 1 also advised that *'there is no evidence in the Trust records of [HSW A] exploring alternative options for the discharge of [the patient] including exploring the possibility of a discharge to family.'* The SW IPA 1 advised that *'this possibility and others should have been explored particularly given [the complainant's] great concerns about her mother's ongoing care if discharged to the nursing home. This would all have been explored and initially discussed at the discharge planning meeting had one taken place prior to discharge.'* However, the SW IPA 2 noted that *'it had*

previously been agreed between the staff in [the Trust] and [the complainant] that [he patient's] needs would be best met in a nursing home residential setting.'

82. The SW IPA 2 advised that the *'levels of concern raised by [the complainant]… were not unreasonable changes to the focus and level of care and were well within the expectation of care in a residential nursing setting.'* Therefore, the SW IPA 2 advised that *'the most appropriate course of actions was to allow [the patient] to return to her own familiar surroundings and ensure that appropriate adaptations were in place to meet her needs.'* The SW IPA 2 advised that *'delaying the discharge to investigate suitable alternative care arrangements would have presented considerable challenges for [the patient], her family and the [Trust].'*

83. In addition, the SW IPA 2 advised that additional hospital care would *'not necessarily have been of benefit'* to the patient, as it would have been medically focused as opposed to reflecting her *'emotional and practical needs.'* The SW IPA 2 advised that *'from an emotional and practical level [the patient] would have been better served by being in a familiar environment, being taken care of by those with whom she was familiar and who knew her on a personal basis.'*

Communication

84. As part of investigation enquiries, the SW IPA 1 was asked to comment on the communication between the Trust and the nursing home prior to and just after the patient's discharge from hospital. The SW IPA 1 advised that *'the level of communication appears to have been inadequate.'* The SW IPA 1 advised that *'there is no evidence of a detailed care plan having been shared by [HSW A] with [the nursing home] in advance of the discharge.'* In addition, the N IPA advised that *'it would be good practice for the ward to telephone the care home to discuss the transfer of care in person. I did not identify any record that this occurred.'* The SW IPA 1 also noted that *'[the complainant] reports that it was she who took responsibility for advising the nursing home of how to*

meet her mother's changing needs until the formal meeting took place on 29 February.'

85. In addition, the SW IPA 1 advised that '*there is no evidence of [HSW A] discussing the concerns raised with the community social worker who had ongoing responsibility for the care management of [the patient] once discharged.'* The SW IPA 1 advised that the failure of HSW A to follow up the complainant's concerns or share them with the community social worker *'would be indicative of poor practice.'* However, the SW IPA 2 advised that *'it would appear that there [are] conflicting messages being given about [the complainant's] concerns. Much of this might have been avoided had [the complainant] expressed her concerns directly to the community based social worker.'*

86. Overall, the SW IPA 2 advised that *'there are gaps in the provision of a comprehensive approach to addressing [the patient's] health, well-being and care needs and the concerns raised by the daughter [the complainant] at different junctions during this time.'*

Escort home from hospital

87. In response to the complaint that the patient returned to the nursing home on 24 February 2012 without a family escort, the N IPA advised that *'it is safe to send a nursing home resident home from hospital without a family escort. While the presence of a relative would provide additional support, the hospital practice is acceptable.'*

The Trust's Response to IPA

88. As part of investigation enquiries, the Trust was given an opportunity to respond to the IPAs' advice.

Actions of CAH Social Work Team

89. In relation to the adequacy of the social care records, the Trust acknowledged

that *'there [are] no detailed records of [the complainant's] concerns or actions taken'* to address these. It recognised that *'the Hospital Social Work records are lacking in detail and the Hospital Social Work record does not indicate follow up of these concerns or sharing of this information with the Community Social Worker.'* However, the Trust referred to a social work record, dated 22 February 2012, which records a meeting with the complainant, and indicates *'concern [regarding] mothers care and unsure if she wants her to return.'*

Discharge from CAH

90. In relation to whether the HSW confirmed if the patient was medically fit for discharge, the Trust referred to the social work record which notes, 'w*ard staff report patient medically fit'.* The Trust stated that this '*would indicate… sharing of [this] information and confirmation'* of it by the HSW.

91. The Trust noted the SW IPA 2's comments in relation to the discharge meeting not taking place prior to the patient's discharge. However, it referenced the SW IPA 2's statement that *'given the short notice at which discharges occur it is inevitable that on occasions this will happen.'* The Trust referred to the SW IPA 1's statement that *'records show that attempts were made by the social worker to progress this meeting prior to discharge however [the patient] was deemed medically fit and discharged before the meeting took place.'* The Trust stated that it *'is of the opinion that this is reflective of the challenges faced in promoting early discharge.'*

92. The Trust also acknowledged *that 'no formal transfer of information took place'* on discharge between the HSW and the nursing home. However, the Trust stated that nursing staff *'provided a transfer letter on 24 February 2012.'* It also confirmed that the transfer letter followed the Trust's discharge policy. In addition, in respect of the patient's health and wellbeing prior to discharge, the Trust stated that *'the main care needs were in respect of swallowing difficulties.'* It stated that '*this had improved prior to discharge with clear guidelines and information shared with the Care Home on discharge.'*

93. In relation to record keeping, the Trust also accepted that the hospital social work '*records and entries were unclear and names and designations were missing on some of the recordings.'*

94. In relation to arranging alternative discharge options, the Trust acknowledged that its *'records do not provide any evidence of this, however the record of the 21 February 2012 refers to the daughter "unsure if she wants her mother to return" to the care home and then on 24 February 2012 records indicate that the daughter agreed to transfer back to the care home.'* It stated that *'any change in a permanent placement is not usually facilitated in a hospital admission/ discharge process unless clear Safeguarding concerns indicating the person would be in need of protection in this environment, permanent changes in placements are normally processed via the Care Manager/ Community Social Worker.'*

Communication

95. In relation to the complainant's comment that she informed the nursing home of her mother's changing needs, the Trust stated that *'as these changes are in respect on clinical care needs it would be Clinical Staff whom would share this information on discharge.'* It also stated that *'the hospital social work record… indicates a number of attempts were made to make contact with the Community Social Worker and messages left to discuss discharge.'*

Responses to Draft Report

The Complainant's Response

96. The complainant provided a detailed and comprehensive response to the draft report. I have included key elements of the response below.

97. On admission to hospital, the complainant stated that, following a discussion of her concerns, the nurse added her telephone number to the medical records, and wrote *'ring this number not NH', 'to ensure that I was the only person to be contacted regarding mum and to make sure no communication got back to DNH while mum was in hospital.'* The complainant also stated that

she informed the Trust that photographs of her mother were taken in the ED, at the beginning of her complaint.

98. The complainant also stated that she *'made it very clear to [HSW A] that I wanted my mum to remain in CAH as I feared for my mother's safety if she returned to DNH. [HSW A] even noted this herself… I was very relieved when [she] assured me mum would be staying in CAH.'*

99. On discharge, the complainant advised that *'I did not agree that mum would return to DNH, I was put in an impossible predicament with no support from anywhere. This [decision] was made under duress… I was not happy that mum was deemed medically fit, mum passed away three weeks later, she obviously was not medically fit.'* The complainant also advised that her mother *'was denied her last few weeks to be loved and cared for'* at home with her family.

100. Prior to her mother's discharge from CAH, the complainant stated that she had no contact with the Community Care Manager. She stated that she had not been in contact with the Community Care Manager since September 2010. The complainant believes that HSW A *'was in full support of [the patient's] abuse case until she spoke with [the Community care Manager], then her attitude along with all the other nursing staff, changed towards us.'*

101. The complainant also stated that she does not believe the Community Care Manager addressed her concerns on her mother's return to the nursing home. She stated that *'the key issues which I presented to [HSW A] were a concern of negligence of care by DNH and the failure of the Trust to provide continuing care[7] for mum in DNH.'*

The Trust's Response

102. In relation to safeguarding, HSW A advised that '*no safeguarding issues were*

[7] This issue was investigated in Case Ref 15508.

raised or documented either by nursing or medical staff during [the patient's] admission' to CAH. She stated *that 'any concerns raised by [the complainant] in relation to her mother's care and treatment in Dunlarg Nursing Home were not considered "safeguarding" issues and no discussion of "safeguarding" regarding [the patient] with [the complainant] occurred… Concerns raised by [the complainant] were in relation to staff's attitude in [DNH] [The complainant] did not wish to make a formal complaint, regarding these issues and no suggestion was made by [HSW A] that the 'hospital would be submitting a complaint regarding the Nursing Home.'*

103. The Trust also stated that *'no photographs were presented to [HSW A] by [the complainant] or to Medical or Nursing Staff and no discussion took place regarding photographs "to evidence [the patient's] poor condition"… Medical and nursing notes include no reference to such photographs or any safeguarding concerns noted or raised by family.'*

104. The Trust stated that *'[HSW A] would like to convey that she would not have failed to either document or act upon accordingly, any evidence or report of neglect or abuse nor would she blatantly ignore a safeguarding issue. Not only would the relevant protocol have been followed but this would have been formally documented, discussed and followed up.'* However, the Trust stated that *'[HSW A] does… acknowledge there may have been failures with regard to the inadequacy of the recording in this case… This however would not have resulted in [the patient] or [the complainant] suffering any form of injustice.'*

105. In relation to the sharing of adult safeguarding concerns, the Trust stated that *'this is done through sharing of Adult safeguarding alerts through the community keyworker/ community team.'*

106. In relation to discharge planning, the Trust advised that the complainant *'was consulted and agreed upon discharge that her mother return to [the nursing home] and that a follow up meeting with Care Management would take place*

in [the nursing home] at [the complainant's] request.' The Trust stated that *'[the complainant] did not wish for the Social Worker to discuss the issues raised with the home or make any formal complaint and Nursing Staff made contact with the home on discharge and forwarded a discharge letter.'*

107. The Trust also stated that when the discharge meeting *'was not able to be facilitated by the Community Care Manager and did not proceed, was this not an opportunity for [the complainant] to advise she was not agreeing to discharge before the meeting took place with any of the multi-disciplinary professionals in the Acute Hospital.'* In addition, HSW A stated that she *'finds it very difficult to comprehend as to why, if [the complainant] had such grave concerns, including photographic evidence to support such concerns, why she failed to act upon these prior to admission to Craigavon Area Hospital by discussing with care management or making a formal complaint and subsequently why, following her mother's transfer back to Dunlarg Private Nursing Home her mother remained in Dunlarg until her death one month later.'*

108. The Trust stated that HSW A '*has an excellent work record and her practice and professionalism has been exceptional and this report is not reflective of this staff member's practice.'*

Analysis and Findings

Admission to CAH

109. On admission to CAH, I note the complainant stated that hospital staff expressed concerned in relation to her mother's condition. I note she stated that she shared concerns with a nurse, in relation to the care and treatment being provided to her mother by the nursing home, and showed her photographs of her mother. I note the complainant stated that the nurse advised her to continue taking photographs of her mother to document her condition. She also stated that she advised the Trust that photographs of her mother were taken in the ED, when she first submitted her complaint.

110. I refer to the patient's ED and nursing records on admission, which state *'Dehydration? UTI'* and *'NPU (not passed urine)'* respectively. I note the N IPA advised that on subsequent review by the Medical Team, the patient was confirmed as being dehydrated. I also note the SW IPA 2 advised that a social work record made by the Community Care Manager, dated 12 February 2012, notes that the patient was *'taking nil orally'* and at *'risk of dehydration'* The SW IPA 2 advised that *'this form is kept with the patient's nursing notes and indicates that both medical and social work staff were aware of [the patient's] medical condition on admission to hospital.'* In addition, I note the N IPA advised that the patient's nursing notes record that a '*Broken area [was] noted on Rt [right] ear, red inflamed. Medical doctor informed – wound cleaned. IV fluids running.'*

111. I also note the complainant stated that when discussing her concerns, the nurse added her telephone number and wrote *'ring this number not NH', 'to ensure that I was the only person to be contacted regarding mum and to make sure no communication got back to DNH while mum was in hospital.'* I note the *'Core Patient Information'* document has a handwritten comment *'ring this number [the complainant] not NH [nursing home]'*. However, I note there are no records of the complainant raising concerns with nursing staff on admission to CAH, or of staff noting their concerns in relation to the patient's condition. I also note the N IPA advised that there is no record *'that the hospital staff suspected signs of possible abuse or neglect'* of the patient.

112. In relation to the taking of photographs, I also note the Trust stated that prior to this office's letter on 22 November 2018, *'there had been no mention [by the complainant] of photographs being taken'* in the ED. In addition, it stated that *'there is no evidence that any photographs were taken by nursing staff at ward level.'*

113. Having carefully considered all of the available evidence and the N IPA's advice, I note there are no contemporaneous records of the complainant raising concerns with nursing staff on admission in relation to the care and

treatment being provided to her mother by the nursing home. In addition, I have not identified records of ED or MAU staff raising concerns about the patient's condition on admission to CAH, or evidence of staff taking photographs. However, I do note the social work record, questioning if *'any concerns [were] raised.'* I have addressed the issue of record keeping in paragraph 161.

114. Although I have no reason to doubt the complainant's account of events, due to the lack of contemporaneous records detailing concerns I am unable to conclude on this element of the complaint.

115. In addition, I note the N IPA advised that dehydration is a common consequence of infection *'amongst frail older people'*, and as *'no other signs of potential neglect or abuse [are] recorded'*, it would not necessarily have immediately prompted a safeguarding concern in ED.

Actions of CAH Social Work Team

<u>The complainant sharing her concerns with HSW A</u>

116. I note the complainant stated that she met with HSW A, on 21 February 2012 and expressed her concerns in relation to her mother's care and treatment at the nursing home. I note the Trust confirmed that this meeting took place, and the social work records, dated 21 February 2012, state, *'Daughter [the complainant] did express… some concern [regarding] her mother's care.'* I note the SW IPA 1 advised that this entry *'contains limited initial recording… or detail of the patient/ family circumstances or 'Description of service requested' as would be expected.'*

117. I also note the SW IPA 2 advised that the patient's social work records lack detail that *'would be expected… this lack of details limits the value of the recording.'* I note the SW IPA 1 advised that *'while there is an absence of detail [within the social work records] there is reference… [to] staff awaiting the outcome of discussions between [the complainant] and [HSW A] as [the complainant] is unhappy about her mother's care.'* Therefore, the SW IPA 1 advised that *'it would be reasonable to assume that [the complainant] did*

share detailed concerns with [HSW A] which should have been appropriately followed up by her.'

118. I note the SW IPA 2 advised that the *'gaps in the recorded material'* highlight an *'unacceptable level of communication',* which *'limits the understanding of what actions are required.'* I note the SW IPA 1 advised that the complainant's concerns should have been *'appropriately followed up with [HSW A]'*, however *'it is impossible to ascertain from the Trust records the hospital social worker's response to the issues raised.'* In response, I note the Trust recognised that *'the Hospital Social work records are lacking in detail'*, and they do *'not indicate follow up of [the complainant's] concerns.'*

119. I also note the SW IPA 2 advised that on review of the records *'the key issues presented by [the complainant] were being addressed by [the Community Care Manager]. This included a referral to the Speech and Language Therapist and ongoing discussions with DNH staff re overall care needs.'* I note the complainant disputes this, as *'the key issues which [she] presented to [HSW A] were a concern of negligence of care by DNH.'*

120. On review of the available evidence, I accept the SW IPA 1's advice that the HSW appears to have been aware of the complainant's concerns in relation to her mother's care and treatment at the nursing home. I also accept the SW IPA 2's advice that due to the lack of detail within the records, it is unclear what actions were required to address the complainant's concerns, or if HSW A completed those required actions. I consider that there was a failure in the Trust's record keeping, which I have addressed in paragraph 161. However, based on the available evidence, I consider that there is evidence of actions taken to address the complainant's concerns post discharge. Therefore, I do not uphold this element of the complaint.

121. As part of her complaint, I also note the complainant stated that she asked HSW A if her mother could remain in hospital, and she was assured that her mother was too frail to leave. In response, I note the Trust stated that *'decisions regarding whether a patient is medically fit to leave hospital is a decision of medical staff and beyond the remit of hospital social work.'* I have

no means of determining the detail of the interaction between the complainant and HSW A in this regard. However, I am satisfied that the decision on fitness for discharge is the responsibility of the clinical team and it would not be for the HSW to provide such an assurance.

122. I also note the complainant stated that HSW A shared her concerns and advised that staff had taken photographs of her mother as evidence of her poor condition. However, I note the Trust contested that *'there was a discussion between the hospital social worker… regarding the taking of photographs at ward level.'* I also note the complainant complained that HSW A encouraged her to make a formal complaint against the nursing home, and advised that the hospital would be lodging a complaint. I note the Trust stated that '*[HSW A] did not relate that the hospital were to take forward a complaint.'* I also note the SW IPA 1 advised that there is '*no evidence'* that HSW A or the hospital staff shared the complainant's concerns or that they were going to make a complaint themselves.

123. On review of the hospital notes, I note that there are no records of:

- HSW A assuring the complainant that her mother would remain in hospital as she was too frail to leave;
- The hospital social work team taking photographs of the patient;
- HSW A advising the complainant to submit a complaint in relation the nursing home;
- HSW A advising the complainant that the hospital would be submitting a complaint regarding the nursing home; or
- The hospital social work team sharing the complainant's concerns.

124. I have no reason to doubt the complainant's account of events. However, I remain concerned about the lack of detail in the HSW records. Therefore, I cannot conclude on whether these actions did not occur, or whether the HSW failed to record them.

Safeguarding concern

125. I note the complainant also complained that HSW A did not escalate her

concerns or raise a safeguarding concern.

126. I note the SW IPA 1 advised that *'the social worker is not a clinician and would be reliant on the medical staff to highlight and identify any safeguarding concerns in regards to the patient.'* However, I also note the SW IPA 1 advised that *'it is the role of the social worker and all attending clinicians to raise safeguarding concerns if they become aware of them.'* I refer to the Trust's safeguarding policy, which states that the '*abuse of vulnerable adults is everyone's business and therefore requires all Trust staff and services commissioned by the Trust (private, voluntary, independent sector) to be alert to the possibility of abuse.'* On review of the patient's records, I note the SW IPA 1 advised that *'the questions in relation to safeguarding concerns on the admission documentation have not been completed.'*

127. However, I note the SW IPA 2 advised that there is evidence that the HSW discussed concerns in relation to the patient's health and wellbeing with the complainant (as noted above in paragraph 116) and the staff in the nursing home. I note the SW IPA 2 advised that *'care and protection issues have been identified and addressed… as such an adult safeguarding process, was not necessarily appropriate as it would have resulted in similar actions to that which… had already been implemented.'*

128. On review of the available evidence and IPAs' advice, I note that the Trust's admission documentation includes questions in relation to safeguarding. I consider these are included to ensure that staff appropriately consider this issue. The failure to complete these questions is a significant concern given the issues raised by the complainant. I consider this amounts to a failure in the patient's care and treatment. However, I consider that the complainant did not suffer an injustice as a result of this failure. I note the SW IPA 2 advised that an adult safeguarding process was '*not necessarily appropriate as it would have resulted in similar actions to that which… had already been implemented'* following discharge. However, I remain concerned on the basis of the contemporaneous records as to whether sufficient steps were taken to safeguard the patient pre discharge. I therefore uphold this element of the complaint.

129. In addition, as detailed in paragraph 120, I note that there are no records detailing how the social work team addressed the complainant's concerns or how it decided not to escalate her concerns. I note that the SW IPA 1 advised that the lack of evidence of staff raising safeguarding concerns was *'indicative of poor practice.'* I note the Trust advised that there were no records as safeguarding issues were not identified. However, I note there are records detailing that the complainant had advised the HSW A of concerns. Therefore, I consider that the Trust should have recorded how these concerns were addressed.

130. I consider that records are necessary in order to ensure that public bodies are being open and accountable in relation to their decision making and their reasons for making decisions. I have addressed the issue of record keeping in paragraph 161. I am critical of the social work team's failure to keep a record of its decision making in relation to safeguarding procedures. However, I note that a number of actions were subsequently taken to address the complainant's concerns, albeit after the patient was returned to the care home and without evidence that the complainant's concerns had been adequately addressed. The actions taken post discharge included ensuring that the nursing home staff had specific instructions in relation to the patient's eating and drinking, with the aim of care being to prevent choking and an SLT referral.

Discharge from CAH

131. In the complaint to this Office, I note the complainant stated that HSW A failed to meet her on the ward on 23 February 2012 to discuss her mother's discharge. In response, I note the Trust stated that numerous attempts were made by HSW A to contact the complainant on 23 February 2012. It stated that when contact was made, the complainant requested a meeting with the community social worker and the nursing home management, prior to her mother being transferred back to the nursing home. I note the Trust stated that the social work records do not indicate the agreed date and time. However, the Trust stated that it would appear that the meeting organised was that of 24 February 2012, as there was a record stating that the

Community Care Manager was unable to attend on this date.

132. However, I note the SW IPA 1 advised that if HSW A agreed to meet the complainant on the ward on 23 February and failed to do so, *'then the social work response was not adequate.'* I am of the opinion that if HSW A made a commitment to meet the complainant on the ward on 23 February 2012, then as a courtesy she should have attended. However, due to the lack of detail within the Trust's records (see paragraph 161) and the conflicting accounts, I am unable to conclude if a meeting was arranged for 23 February 2012 to discuss the patient's discharge.

Medically fit for discharge

133. On 24 February 2012, I note the Trust stated that the patient was deemed medically fit for discharge. I note the SW IPA 2 advised that *'there is no need for the social worker to separately seek confirmation… This is the role of the medical staff.'* However, I note the SW IPA 2 advised that the ongoing multidisciplinary liaison *'should ensure that the social worker was aware of impending discharge processes.'* I note the SW IPA 2 advised that *'there is no evidence to suggest this [cooperation] did not occur… There is no note of this in the information provided.'* I acknowledge the comment from the SW IPA 2, however I would have expected to see evidence in the social work records which confirmed the liaison did occur.

134. On review, however, I note the medical records, dated 23 February 2012 state *'D/C [discharge] once SW [Social Worker]/ daughter happy, medically fit',* indicating that the patient's status was shared between the medical staff and social work team. I also note the Trust referred to the social work records, which stated that *'ward staff report patient medically fit'.* Therefore, I accept the N IPA's advice that the medical staff deemed the patient medically fit to be discharged, and I consider that this information was appropriately communicated to the social work team.

135. When a patient is declared medically fit, I note the SW IPA 1 advised that the HSW will *'plan for a prompt and appropriate discharge.'* I note the SW IPA 1 advised that this will include arranging *'a discharge planning meeting',* liaising

'with the care manager in the community team', and liaising '*with the community social worker particularly where there are significant changes to the patients care needs as was the case with [the patient]'.*

Multi-disciplinary review prior to discharge

136. I note the N IPA advised that there are no *'policy documents from CAH relating to the nursing staff role in discharge to care homes.'*

137. However, I note the Discharge from Hospital Guidance states that best practice in hospital discharge involves *'integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process.'* On review of the patient's medical records, I note the N IPA advised that there was evidence that *'discharge planning was carried out with a multidisciplinary and multiagency involvement.'* I also note the N IPA advised that there was evidence in the nursing notes of the nursing team and the social work team liaising, and of the patient being seen by SALT in respect of her diet and swallow.

138. On review of the available evidence, I accept the N IPA's advice that the hospital team's multi-disciplinary planning prior to the patient's discharge was *'appropriate'* and *'according to national guidance.'*

Discharge planning meeting

139. I note that the complainant stated that the Trust failed to organise a revised care package for her mother prior to her return to the nursing home. In response, the Trust stated that the Community Care Manager*, 'was unable to attend'* the discharge meeting. Therefore, I note the Trust stated that HSW A *'made contact with [the complainant] on the morning of the discharge and she agreed to transfer her mother back to the nursing home with an urgent care management review.'* However, I note the complainant stated that *'I did not agree that mum would return to DNH, I was put in an impossible predicament with no support from anywhere. This [decision] was made under duress… [my mother] 'was denied her last few weeks to be loved and cared for'* at home with her family.

140. I note the Trust stated that *'a revised care package of care was not* required *as the patient was returning to nursing home care.'* I note the Trust stated that it was *'satisfied that there was an agreement by all parties, including [the complainant], prior to discharge, that the concerns were to be formally reviewed in the community.'*

141. However, I note the SW IPA 1 raised *'significant concern'* that the discharge meeting did not take place prior to the patient's discharge, '*as the proposed date did not suit the community social worker'*. I acknowledge the SW IPA 1 advice that *'attempts were made by the social worker to progress this meeting',* and that '*a delay of a day or two would have been appropriate… but potentially difficult to achieve given the pressure on hospital beds particularly during the winter months.'* Similarly, I note the SW IPA 2 advised that *'given the short notice at which discharge occurs it is inevitable that on occasions this will happen.'* In response to the independent professional advice, I note the Trust stated that the delay *'is reflective of the challenges faced in promoting early discharge'.*

142. However, I note the SW IPA 1 advised that '*[the patient] was a woman with very complex needs and the plan for her ongoing care required a multi-disciplinary review to develop an appropriate plan for ongoing care'*. I also note the SW IPA 1 advised that a discharge meeting was particularly important in this case as the patient's *'care needs had changed significantly.'* However, I note the SW IPA 2 advised that *'there was no need for a new care plan'* as *'a comprehensive care plan' was already in place, and her needs 'will not have fundamentally changed after her discharge from hospital.'*

143. I refer to the Care Management Circular, which states that Trusts *'should have arrangements in place for the safe and effective discharge of people from hospital and their transfer between care settings. Discharge and transfer procedures should be agreed between hospital and community settings and should be communicated proactively to all staff/ service users or their organised representatives as appropriate.'* I also note the Discharge from Hospital Guidance, which notes that '*patients, who have both health and social care needs, must only be discharged when they are clinically fit. This is*

a decision made by the multidisciplinary team when considering all the factors, which will include the relative safety of remaining in hospital or being elsewhere and the patient's and carer's view of these risks.'

144. On review of the available evidence, and the IPAs' advice, I consider that there should have been a discharge planning meeting to discuss alternative care packages for the patient prior to her discharge on 24 February 2012. I acknowledge that there are challenges facing hospital resources, and in ensuring that all of the required individuals are present at the meeting. However, the delay of four days in arranging this meeting is a failing. I note the complainant was left in a very difficult position on 24 February 2012, when without alternatives have been discussed or planned, she was advised her mother was to be discharged, I consider that due to this lack of planning and discussion she was left with no other option but to agree to discharge back to the care home.

145. Given the concerns raised by the complainant in relation to her mother's care and treatment by HSW A, I am of the opinion that the meeting was vital to ensure that the patient's needs were addressed appropriately. Although there is evidence of multidisciplinary working prior to the patient's discharge, I consider that a discharge meeting was still required at this time in order to ensure a *'comprehensive and smooth transfer'* to the nursing home and to ensure the complainant's concerns were addressed and care plans updated

146. I also note the SW IPA 2 advised that *'delaying the discharge to investigate suitable alternative care arrangements would have presented considerable challenges for [the patient], her family and the (Trust].'* In addition, I note the SW IPA 2 has advised that the patient's needs were covered by her existing care plan as *'her underlying health needs did not significantly deteriorate from pre-post care.'* However, I consider that this opinion has been formed with the benefit of hindsight, and that the discharge meeting was required to confirm this position at the time. Earlier discussion and planning may have prevented these challenges.

147. I consider that the Trust's failure to organise a timely discharge meeting prior

to the patient's discharge from hospital resulted in a failure in her care and treatment. I consider that this failure resulted in the complainant suffering the injustice of uncertainty as to the care and treatment the patient was receiving prior to the meeting. She also suffered the injustice of loss of opportunity to discuss her concerns prior to discharge. Therefore, I uphold this element of the complaint. I will address a remedy for this failure at the end of my report.

148. However, I note the SW IPA 2 advised that while there was a delay in the patient's discharge meeting, *'there should not have been any adverse effect on [the patient's] health as [the nursing home] had details of her needs… [and] had the facilities and expert staff to provide… [the patient's] care.'* I note the SW IPA 2 advised that the patient's immediate health issues such as dehydration, oral hygiene and the respiratory tract infection had been addressed during her stay in hospital. Similarly, I note the N IPA advised that the patient's swallow had improved prior to discharge, and that she was *'eating and drinking very well'* on 23 February 2012. On review, I also note the patient's hospital transfer sheet provides guidelines and information in relation to her current needs.

149. I remain concerned that the patient's discharge occurred prior to a discharge meeting. I consider that this would have allowed an opportunity for the complainant's concerns to be addressed and alternatives considered if appropriate. However, I accept the SW IPA 2's advice that the delay in the patient's discharge meeting did not have an effect on her overall care and treatment on return to the nursing home.

Alternative discharge

150. I note the SW IPA 1 advised that '*there is no evidence in the Trust records of the social worker exploring alternative options for discharge… including the possibility of discharge to the family.'* I refer to the social work record, dated 21 February 2012, which notes '*unsure if [the complainant] wants her mother to return'* to the nursing home. In response, I note the complainant stated that she clearly advised HSW A that she did not want her mother to return to the nursing home. Subsequently, I note the social work record dated 24 February

2012 notes that the complainant agreed to transfer her mother back to the nursing home. Again, I note the complainant advised that she believes this decision was made under duress.

151. I note the Trust advised that '*any change in a permanent placement is not usually facilitated in a hospital admission/ discharge process unless clear safeguarding concerns'* are identified. In addition, I note the SW IPA 2 advised that *'from an emotional and practical level [the patient] would have been better served in a familiar environment, being taken care of by those with whom she was familiar and who knew her on a personal basis.'* I note the SW IPA 2 advised that *'the focus therefore should have been on ensuring that the comprehensive care package… would meet [the patient's] needs.'*

152. On review of the available evidence, I accept the SW IPA 2's advice that, as medical staff raised no safeguarding issues, it was appropriate to discharge the patient back to the nursing home. I note the hospital social work records record that the complainant agreed to the discharge of her mother back to the nursing home, which the complainant disputes is the case. On consideration, I am of the opinion that the complainant was put in a very difficult position on 24 February 2012 due to a lack of forward planning. I remain concerned about the records and planning for discharge. However, it does appear that the patient's needs could be met in a care home and therefore discharge to DNH was reasonable.

<u>Communication between CAH and the nursing home</u>

153. I also note that the complainant complained that there was a lack of communication between CAH and the nursing home prior to discharge. I note the complainant stated that the Nursing Home Manager advised her that she was not contacted by CAH. I note the SW IPA 1 advised that the *'level of communication appears to have been inadequate'* and there is *'no evidence of a detailed care plan having being shared.'* I note the SW IPA 1 also advised that *'it would be good practice for the ward to telephone the care home to discuss the transfer of care in person.'*

154. However, I note the Trust responded, stating that *'the nursing notes evidence*

that [the nursing home] was contacted regarding [the patient's] transfer back. In addition, a discharge letter and discharge medication were sent with [the patient]. This is evidenced on the transfer sheet included within the nursing notes attached.' On review, I note the N IPA advised that the social work records state that the nursing *'team intended to contact [the nursing home] with an update.*' However, I note the SW IPA 2 advised that there was *'no information on what specific issues or concerns needed to be addressed or if there is any particular plan of action that needs to be implemented.'* In addition, I note the N IPA advised that the patient's nursing transfer sheet '*lists medication, property level of orientation, communication, diet, elimination needs, personal hygiene and skin, mobility and sleeping pattern… in my opinion the level of information in the transfer letter is adequate.'*

155. In relation to the complainant stating that she had to inform the nursing home of her mother's needs, I note the Trust stated that *'as these changes are in respect of clinical care needs it would be clinical staff whom would share this information on discharge.'* I note the Trust also stated that HSW A contacted the Care Management Office on 24 and 27 February 2012 to advise of the patient's discharge*, 'and the need for a Care Management review in the community.'* In addition, I note that the discharge letter provided the nursing home with information in relation to the patient's needs.

156. Following discharge from CAH, I note the SW IPA 1 advised that '*there is no evidence of [HSW A] discussing the concerns raised with the community social worker who had ongoing responsibility for the care management of [the patient] once discharged.'* I also note the Trust acknowledged that the social work records do '*not indicate'* the sharing of the complainant's concerns with the Community Care Manager.

157. I note the SW IPA 2 advised that *'it would appear that there [are] conflicting messages being given about [the complainant's] concerns. Much of this might have been avoided had [the complainant] expressed her concerns directly to the community based social worker.'* On review, I note the SW IPA 1 advised that the failure of HSW A to follow up the complainant's concerns or share them with the community social worker *'would be indicative of poor practice.'*

However, I note the SW IPA 2 advised that *'the key issues presented by [the complainant] were being addressed by [the Community Care Manager]. This included a referral to the Speech and Language Therapist and ongoing discussions with [nursing home] staff [regarding] overall care needs.'*

158. On review of the notes and records, and on considering the advice of the SW IPA 2 that there were *'gaps in the provision of comprehensive approach to addressing [the patient's] health'*. I consider that there is some evidence of communication between hospital staff and the nursing home in relation to the patient's care and treatment. However, the records of these communications are inadequate. I will address record keeping in paragraph 161. I also note that there are no records of HSW A's discussions with the Community Care Manager. However, as the Community care Manager has addressed the complainant's concerns, on the balance of probabilities I am of the opinion that these conversations are likely to have taken place.

159. I note the SW IPA 2's comments regarding raising concerns directly with the community social worker. It is my view that it is not the responsibility of families to try and navigate the system, it is for the health professionals involved to ensure that information they receive is shared with the appropriate person. I consider that families may feel unable to raise concerns while their relative is in a care home. Therefore, in cases such as this, where the complainant felt able to raise her concerns when her mother was out of the care home and in hospital, it is incumbent on the professionals involved to listen carefully to those concerns and take appropriate action. However, in this instance, it does appear that there was communication between CAH and the care home. Therefore, I do not uphold this element of the complaint.

<u>Escort home from hospital</u>

160. I note the complainant also complained that her mother was transferred from CAH to the nursing home on 24 February 2012 without a family escort. In response, I note the Trust stated that *'it would not be normal practice for Care Home patients to be accompanied during transfer back'* from hospital. I note the N IPA advised that *'it is safe to send a nursing home resident home from*

hospital without a family escort. Whilst the presence of a relative would provide additional support, the hospital practice is acceptable.' I accept the N IPA's advice, and consider that in this instance the Trust's actions were appropriate. I do not uphold this element of the complaint.

Record keeping

161. Although not raised by the complainant, a common theme, which appeared during the investigation, was the quality of the hospital social work team and the nursing team's record keeping.

162. During the investigation, I have identified the social work team's failure to record:

- details of HSW A's discussion with the complainant, in relation to concerns regarding her mother's care and treatment in the nursing home. This includes details of the actions required to address the concerns, and the outcome of these actions;
- the date and time of the meeting organised between HSW A and the complainant prior to the patient's discharge;
- details of the discussions between HSW A and the Community Care Manager;
- a signature in the appropriate place on the social work assessment form;
- how the complainant's concerns were addressed and/ or followed up; and
- details of the information shared between the hospital social work team and the nursing home, and any follow up actions from these discussions.

163. I refer to the NISCC Code of Practice, which states that social care workers must maintain *'clear and accurate records as required by procedures established for your work.'* I note the SW IPA 2 advised that the lack of detail in the hospital social work records *'limits the value of the recording',* and advised that the *'substantial gaps in the recorded material… limits [the] understanding of and monitoring of the files content and any actions needed.'* I note the SW IPA 1 advised that *'it is impossible to ascertain from the Trust records the hospital social worker's response to the issues raised.'* However, as noted in paragraph 120, there is evidence that actions were taken to

address the complainant's concerns.

164. I consider that the compiling and maintaining of proper records is a basic necessity. Good record keeping has the advantages that those involved are clear about what took place and have the opportunity to query if in doubt. I consider that it is also contrary to the Third Principle of Good Administration, *'being open and accountable',* which requires public bodies to keep *'proper and appropriate records.'*

165. I also note that the nursing team failed to record details of the conversations it had with the nursing home. I refer to the NMC Code, which states that nurses must *'must keep clear and accurate records of the discussion you have, the assessments you make, the treatment and medicines you give, and how effective these have been.'*

166. I consider that the social work and nursing team's failures to keep appropriate records constitutes maladministration and a failure to meet the professional standards set by the NMC and the NISCC. As a result of these failures, I consider that the complainant suffered the injustice of uncertainty. I will address remedy in the conclusion of my report.

167. I note the Trust acknowledged that the hospital social work *'records and entries were unclear and names and designations were missing on some of the recordings.'*

168. I have investigated the complaint and I am, partially upholding it. I note the Trust failed to organise a timely discharge meeting prior to the patient's discharge from hospital. In addition, due to a lack of records, I cannot conclude on what steps were taken by HSW A to address the complainant's concerns in relation to her mother's care and treatment at the nursing home, or whether sufficient steps were taken to safeguard the patient prior to discharge from hospital.

Observation

169. During the course of investigation, I note the SW IPA 2 also advised that there was a missing residential review from 2011, while the patient was placed as a

care managed patient at Dunlarg Nursing Home by the Trust. I refer to the Care Management Guidance, which states that *'as a minimum, a formal review should take place once a year.'* In response, I note the Trust *'acknowledges that there was no annual review conducted in 2011, which it attributes to staff shortages at that time.'* It stated that *'the lack of a formal care review… is regrettable.'*

170. On review of the SW IPA 1's advice, I consider that during this time, the Trust retained responsibility for ensuring the patient's needs were being met in Dunlarg Nursing Home. I am critical of the Trust's failure to ensure that this review took place. I am of the opinion that the Trust should aim to have a yearly residential review to ensure that the care needs of a patient can continue to be met in the care home.

Issue 2: Whether the complaint handling by the Southern Health and Social Care Trust was of a reasonable standard?

Detail of Complaint

171. On receipt of the complaint, this office advised the Trust, that it was separating the complaint into three distinct strands. It was this Office's opinion that the Trust had attempted to address one of the issues at local resolution (Case Ref 15508). However, it was decided that the two remaining issues would be referred back to the Trust for local resolution before investigation would be considered by this office.

172. The two issues referred back to the Trust for local resolution related to the care and treatment provided to the complainant's mother, while she was a patient at Dunlarg Nursing Home (Case Ref 17253), and on her discharge from Craigavon Area Hospital (Case Ref 16991). The complainant complained to the Trust in relation to the care and treatment at the nursing home, as she felt that she could not complain directly to the nursing home.

173. The investigation into the complaint led me to consider the Trust's handling of these two issues at local resolution. In particular, I examined whether the

Trust addressed the key matters of the complaint at the meeting on 6 May 2016. In addition, I considered whether the Trust offered a subsequent follow up meeting within an appropriate timeframe.

Evidence Considered

174. I considered the Trust's Complaints Policy, which states:

'2.3 Role of Operational Directors, Assistant Directors and Heads of Service

All Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage…

2.6 Role of Governance Co-ordinators and Governance Officers

The Governance Co-ordinators will lead their Directorate Governance Team in ensuring that at each level of the Directorate staff have access to timely, high quality and appropriate information in relation to complaints…

4.4.2 Meeting with the Complainant

Offer of facilitation of a meeting with the relevant staff. This will be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting. The notes of the meeting should be agreed upon by all that were present and issued to the complainant. This meeting should take place within 30 days of a second response being issued…'

175. I considered the minutes of the meeting on 6 May 2016, which state:

'The following actions were agreed:

'1. [The complainant] and [the complainant's husband] to advise the [Assistant Director for Primary Care] if they wanted him to facilitate a meeting with [the nursing home], either with them or on their behalf.

Action: [The complainant] to consider and to advise Assistant Director for Primary Care if she wished such a meeting to be arranged with [the nursing home].

2. Assistant Director for Primary care for follow up issues pertaining to what was described as a change of attitudes of Acute Hospital staff, with… Head of Social Work for Acute Directorate and to facilitate a meeting with Acute Hospital staff and for [the complainant] if so requested.

Action: [The complainant] to consider and to advise the Assistant Director for Primary Care if she wished such a meeting to be arranged.'

176. As part of investigation enquiries, the Trust was asked to provide evidence of its internal communications following the meeting on 6 May 2016, demonstrating its efforts to organise a follow up meeting between the Acute Services Team and the complainant.

177. I considered an email dated 19 August 2016, from the Governance Officer of the Directorate of Acute Services (Governance Officer), to members of the Acute Services Team, which states:

'Dear all…

I understand the OPPC [Older People and Primary care] have recently met with [the complainant] in relation to their issues and she has requested a meeting with the Acute Team to discuss any outstanding acute issues which I believe are nursing and social work issues.

I have asked [an assistant] to arrange a meeting so that we can meet with [the complainant] and her husband in the latter part of September 2016. She will be in contact with you regarding dates over the next day or two.'

178. I also considered a letter sent by the Governance Officer to the complainant on 19 August 2016:

'Dear [the complainant],

I understand from information we have received from… [the] Assistant Director for Primary care that you wish to have a meeting with Acute Services staff in relation to your late mother's care and treatment in Craigavon Area Hospital.

I can advise that we are currently in the progress of making arrangements for this meeting and we will be in contact with you in the not too distant future to confirm a date, which will most likely be end September or early October 2016.'

179. In addition, I considered subsequent emails dated between 26 August and 2 September 2016, which detail members of the Acute Services Team highlighting their availability on a number of dates in September and October 2016.

180. I considered an email from the Governance Officer to members of the Acute Services Team on 8 September 2016, which states:

'[an assistant] has kindly organised for us to meet on 7 October 2016 at 3pm in relation this complaint. I believe we need to have a pre-meeting separate to the actual meeting with the family in case there is anything that comes up at the pre meeting which we need to further investigate before meeting with the family.'

181. I also considered a letter from the Governance Officer to the complainant on 9 September 2016, in which he stated that *'I have provisionally booked a meeting with the relevant staff for Monday 17 October 2016.'*

182. In addition, I considered an email from the Governance Officer to members of the Acute Services Team on 14 September 2016, which states that the complainant advised that 17 October 2016 *'does not suit her… [Member of Acute Services Team], is there a date that will suit [Members of the Acute Services Team] the following week.'*

183. I considered the Acute Services Team's response on 14 September 2016,

which stated that *'the next date [Members of the Acute Services Team] have available is 15 November 2016 9am – 11am.'*

184. I also considered an email dated 22 September 2016 from the Governance Officer to members of the Acute Services Team, which states:

'I have spoken to [the complainant] and offered her the next available date which was 15 November 2016 and she has declined this date also.

She has advised that there seems to be a lot of toing and froing to get a mutually convenient date and time. She has requested a 3pm afternoon slot for the meeting and she feels having to wait to November is too long.

[Member of the Acute Services Team] – is there a date that you, [Members of the Acute Services Team] could free your diary and make yourselves available for an afternoon meeting…'

Trust's Response to Investigation Enquiries

185. The Trust stated that the complainant *'submitted a very detailed complaint… [and] senior staff spent many hours reviewing the details and providing responses which they hoped would provide closure for her.'*

186. On 6 May 2016, the Trust stated that *'the OPPC Directorate Senior staff met with [the complainant] and her husband'.* The Trust stated that it believed it had '*a very open and honest discussion regarding the concerns that [the complainant] had put forward... [however it] was unable to offer definitive answers on the actions of [the nursing home] staff at that time.'*

187. As a result, the Trust stated that it *'offered to broker a meeting with [the nursing home] as [the complainant's] advocate in an attempt to seek resolution of her remaining concerns with the treatment and care afforded to her mother.'* The Trust stated that *'[the complainant] chose not to avail of this offer.'*

188. In addition, *'as there was no representation from the Acute members of the Acute Directorate at the initial meeting',* the Trust stated that *'Assistant*

Director OPPC offered to request a meeting with the senior members of the Acute Directorate.' The Trust noted that this is reflected in the meetings minutes. The Trust stated that the Acute Services Team subsequently *'made several attempts to arrange a meeting with [the complainant].'* It stated that '*[the complainant] was offered an appointment for 17 October 2016, however this did not suit.'*

189. Therefore, the Trust stated that the Governance Officer spoke with the complainant on 22 September 2016 to offer a meeting on 15 November 2016. However, the Trust stated that this *'did not suit either'.* The Trust stated that the complainant complained to the Governance Officer *'that there appeared to be a lot of toing and froing to get the meeting arranged and [the Governance Officer] offered to secure an afternoon appointment to see if that suited better.'* The Trust stated that the Governance Officer *'assured [the complainant] he would try to get a further date as soon as possible… [and] contacted the relevant staff to ask for an afternoon appointment.'*

190. On 23 September 2016, the Trust stated that the complainant phoned the Governance Officer '*to say that she had considered the Trust's offer of a meeting and wished to decline it as the matter had been ongoing for so long.'*

191. As part of investigation enquiries, the Trust was asked to confirm if representatives from the nursing home or the Acute Team were invited to the meeting on 6 May 2016. The Trust stated that *'it was considered that as there were so many issues of complaint which spanned the two Care Directorates and [the nursing home] that a meeting including all parties would not be conducive to resolution due to the number of concerns for review and the number of senior staff that would be needed in attendance.'* On discussion with the Assistant Director of Primary Care Services, the Trust stated that *'it was decided that to have Senior Trust Staff from both Directorates at the one meeting would also create an environment which was "top-heavy" with Senior Trust staff and may not put [the complainant and her husband] in a position of ease.'*

192. Therefore, the Trust stated that *'the Acute Directorate were advised and in*

agreement, that the OPPC Directorate would arrange a meeting to discuss the issues relevant to the OPPC Directorate and [the nursing home] and that the Acute Directorate would proceed to arrange a separate meeting with the key staff from the Acute Directorate.' The Trust state that the '*agreement for the two Care Directorates to arrange separate resolution meetings reflects the subdivisions'* in this Office's complaint i.e. continuing healthcare, discharge from Craigavon Area Hospital in February 2012, and the care and treatment provided in the nursing home.

Responses to Draft Report

193. In response to the Trust's action plans from the meeting on 6 May 2016, the complainant stated that they were *'totally untrue'*. Prior to leaving the meeting, the complainant stated that she had advised the Trust she did not want a meeting arranged with the nursing home, as she felt it was *'totally inappropriate… to go back to the place that had caused so much pain.'* She stated that the Trust's offer to broker a meeting with the nursing home was *'farcical… it was not a professional offer… more a surreal offer that [the Assistant Director for Primary Care] knew we would decline.'*

194. The complainant also advised that during this meeting she *'firmly requested to speak with more staff relating to mum's case and asked for a meeting to be arranged'*. Therefore, the Trust's action plan to arrange a meeting with Acute Hospital Staff following the complainant's consideration was *'untrue'.*

195. The Trust did not provide additional comments on review of the draft report.

Analysis and Findings

196. I note that on 6 May 2016, the Trust met with the complainant and her husband to discuss her complaint regarding her mother's care and treatment while at the nursing home and Craigavon Area Hospital. I note that members of the OPPC Directorate were present at this meeting, however there was no representation from the nursing home or the Acute Directorate.

197. In response to investigation enquiries, I note the Trust stated that '*as there*

were so many issues of complaint which spanned the two Care Directorates and [the nursing home]… a meeting including all parties would not be conducive to resolution due to the number of concerns for review and the number of senior staff that would be needed in attendance.' I note the Trust stated that it was internally decided that having senior staff from both Directorates present at the meeting was *'top heavy'*, and *'may not put [the complainant and her husband] in a position of ease.'* On consideration, I accept the Trust's explanation that a meeting with all parties present may not have been appropriate in these circumstances.

198. Therefore, I note the Trust stated that *'the Acute Directorate were advised and in agreement, that the OPPC Directorate would arrange a meeting to discuss the issues relevant to the OPPC Directorate and [the nursing home] and that the Acute Directorate would proceed to arrange a separate meeting.'* I note the minutes of the meeting on 6 May 2016 record that the Assistant Director for Primary care agreed *'to facilitate a meeting with Acute Hospital staff and for [[the complainant] if so requested.'* However, prior to this meeting, the Trust had already established that a separate meeting with the Acute Directorate was required. Therefore, I consider that the Trust should have offered the complainant a date for the Acute Directorate meeting at this time.

199. I also note the Trust acknowledged that the OPPC Directorate *'was unable to offer definitive answers on the actions of [the nursing home] staff at'* the meeting. Therefore, I note the Trust *'offered to broker a meeting with [the nursing home] as [the complainant's] advocate in an attempt to seek resolution of her remaining concerns with the treatment and care afforded to her mother.'* In response, I note the Trust stated that *'[the complainant] chose not to avail of this offer.'* On review, I consider that the purpose of the OPPC Directorate meeting was to enable the Trust to better understand the issues of the complaint, as her initial written complaint was comprehensive. Therefore, I consider that it was reasonable for the Trust to not have investigated the complainant's concerns in relation to her mother's care and treatment at the care home prior to this meeting. However, I consider that the timescales involved were not reasonable.

200. I note that on 14 June 2016, the complainant contacted the Trust and confirmed that she wished to have a second meeting with the Acute Directorate team. On review of the available evidence, I note that there are no internal Trust emails in June or July which evidence the organisation of this meeting.

201. On 19 August 2016, I note that the Governance Officer emailed members of the Acute Directorate Team and asked '*to arrange a meeting so that we can meet with [the complainant] and her husband in the latter part of September 2016.'* On the same date, I note that the Governance Officer sent the complainant a letter advising her that the Trust was '*currently in the progress of making arrangements for this meeting and we will be in contact with you in the not too distant future to confirm a date, which will most likely be end September or early October 2016.'*

202. I note that there were a number of internal Trust emails between 26 August and 2 September 2016, which evidences members of the Acute Directorate team attempting to organise a suitable date for the meeting. Subsequently, on 9 September 2016, I note the Governance Officer sent the complainant a letter inviting her to a meeting on 17 October 2016. However, I note the Trust stated that '*this did not suit'* the complainant. I note the complainant advised that the meetings did not suit as she was working, and had to collect her children from school/ I note that there were internal Trust emails on 14 September 2016, which attempted to identify a new date for the meeting.

203. Subsequently on 22 September 2016, I note the Trust stated that the Governance Officer offered the complainant an appointment on 15 November 2016. However, I note the Governance Officer advised the Acute Directorate team on the same date that *'I have spoken to [the complainant]… and she has declined this date also. She has advised that there seems to be a lot of toing and froing to get a mutually convenient date and time… she feels having to wait to November is too long. [Member of the Acute Services Team] – is there a date that you, [Members of the Acute Services Team] could free your diary and make yourselves available for an afternoon meeting…'*

204. On 23 September 2016, I note the Trust stated that the complainant contacted the Governance Officer, and advised that she *'wished to decline'* the meeting with the Acute Directorate, '*as the matter had been ongoing for so long.'* In response, I note the complainant advised that this was untrue. The complainant stated that, at this time, the Governance Officer advised her that this Office would be the best route.

205. On review of the available evidence, I note the Trust decided that the Acute Directorate Team would have a separate meeting with the complainant, prior to the meeting which took place on 6 May 2016. However, I note that no attempts were made to organise the Acute Directorate meeting until 14 June 2016, when the complainant confirmed that she would like it to proceed. Following this confirmation, I note that no attempts were made by the Trust to organise the meeting until 19 August 2016. Subsequently, I note the complainant was offered a meeting on 17 October 2016 and then 15 November 2016.

206. I refer to the Second Principle of Good Administration *'being customer focused'.* This principle requires public bodies to *'behave helpfully, dealing with people promptly, within reasonable timescales.'* In addition, I refer to the Fifth principle of good administration '*putting things right',* which states that *'public bodes should operate effective complaints procedures which investigate complaints thoroughly, quickly and impartially.'* I also refer to the Trust's Complaints Policy, which states that *'this meeting [with the complainant] should take place within 30 days of a second response being issued.'*

207. I am of the opinion that the Trust's failure to organise a meeting between the complainant and the Acute Directorate Team within an appropriate timeframe contrary to these principles. I consider that this failure amounted to maladministration. As a result of this failure, I consider that the complainant suffered the injustice of frustration and annoyance and ultimately gave up on the offer resulting in the complainant returning to this Office. I will address the remedy for this failure in the conclusion of the report. I uphold this element of the complaint.

CONCLUSION

208. The complaint concerned the care and treatment provided to the complainant's late mother by the Trust, while she was a patient at CAH between 12 and 24 February 2012. My investigation specifically focused on how the Trust responded to concerns raised by the complainant in relation to her mother's care, and how the Trust planned and managed the patient's discharge.

209. I am partially upholding the complaint. I have identified that the Trust did communicate with the nursing home following the patient's discharge, as the Community Care Manager implemented a number of actions, which addressed the complainant's concerns. However, I have found a failure in care and treatment in relation to the Trust's failure to organise a timely discharge planning meeting prior to the patient's discharge from hospital.

210. I am satisfied that this failure in care and treatment caused the complainant to suffer the injustice of uncertainty and loss of opportunity.

211. I also identified a failure in care and treatment in relation to the Trust's failure to complete the safeguarding questions on the patient's admission form. However, I consider that the complainant did not suffer any injustice as a result.

212. I have identified maladministration in relation to the Trust's failure to record:

- details of HSW A's discussion with the complainant, in relation to concerns regarding her mother's care and treatment in the nursing home. This includes details of the actions required to address the concerns, and the outcome of these actions;
- the date and time of the meeting organised between HSW A and the complainant prior to the patient's discharge;
- details of the discussions between HSW A and the Community Care Manager;
- a signature in the appropriate place on the social work assessment form;

- how the complainant's concerns were addressed and/ or followed up; and
- details of the information shared between the hospital social work team and the nursing team with the nursing home, and any follow up actions from these discussions.

213. I also identified maladministration in relation to the Trust's failure to organise a meeting between the complainant and the Acute Directorate Team within an appropriate timeframe.

214. I am satisfied that the maladministration I identified caused the complainant to suffer the injustice of uncertainty.

Recommendations

215. I recommend that the Trust issues the complainant with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified, and must be issued **within one month** of the date of my final report.

216. I also recommend that the Trust provides reminds relevant staff on the importance of:

    - good record keeping, ensuring that they keep a full and accurate record of actions taken, and ensuring that all decisions are recorded along with the reasons for that decision

    - Complaints handling, ensuring that that complaints are dealt with in a timely and efficient manner.

217. I recommend the Trust develops an action plan which outlines the steps considered in implementing my recommendations, and provides me with an update **within three months** of the date of the final report. The action plan is to be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/ or self declaration forms which indicate that staff have read and understood any relevant policies).

218. I am pleased to note the Trust accepted my findings and recommendations.

PAUL MCFADDEN

Deputy Ombudsman **September 2020**

APPENDIX ONE

ROLE OF THE OMBUDSMAN

The role of the Ombudsman is provided for in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The 2016 Act provides for the Ombudsman to investigate and report on complaints from a 'person aggrieved'. The Ombudsman may investigate and report on alleged maladministration by a listed authority through action taken in the exercise of administrative functions. The Ombudsman may also investigate and report on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care in consequence of the exercise of professional judgement, exercisable in connection with the provision of health or social care. In general, the purposes of an investigation are to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the 2016 Act, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment he must also consider whether this has resulted in an injustice. Injustice is also not defined in the 2016 Act but can include upset, inconvenience, loss of opportunity or frustration. The Ombudsman may recommend a remedy where he finds injustice as a consequence of the failings identified in her report.

Section 30 (6) of the 2016 Act states that *'the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the circumstances of the case'*. Therefore the Ombudsman has discretion to determine the procedure for investigating a complaint.

APPENDIX TWO

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.