CASE DIGEST

06/2024

Northern Ireland Public Services Ombudsman

CARE HOMES

A guide to best practice in responding to complaints in a Care Home setting

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Introduction

from the Northern Ireland Public Services Ombudsman

Learning from complaints to improve public service delivery is a key aim for my office. The combination of older age and poorer health can mean that moving to a Care Home is in the best interests of an individual. Despite this, it can still be a difficult decision to make for all involved. When someone we care about moves into a Care Home it is essential that their needs and personal preferences are met and that the views of those who know them best (often family members) are heard and valued. Responding to and valuing feedback of all kinds is a key feature in an effective Care Home, whether that is in care planning, assessments, care and treatment and dealing with complaints.

This Case Digests highlights learning from 24 individual Care Home complaints that went to further investigation by NIPSO. Whilst many people receive good care and treatment from Care Homes, my investigations found serious and significant concerns around the care and treatment of residents. Unfortunately, in many cases, these issues were further

compounded by poor complaints handling by the Care Home or the Health and Social Care Trust responsible for the residents care management.

Care Homes are entrusted with the protection of some of the most vulnerable members of society and not all residents are fortunate enough to have regular visits from friends and family. The complaints featured in this digest were all brought to my office by family members, who saw a loved one let down by poor care and treatment or unsafe practice. Many of those family members expressed fear or concern in raising a complaint and sadly it is often when a loved one has passed away that someone feels able to raise or pursue a complaint. This raises questions about the care and safety of those without visitors or a regular advocate. To ensure the highest standard of care and safeguarding it is essential care homes have simple, compassionate and effective complaints processes and that they analyse and implement learning from complaints data.

Learning from mistakes and complaints data across the Care Home sector must become standard practice, and residents, family and friends of residents must feel confident and empowered to share their feedback. NIPSO is committed to sharing learning from our investigations to help improve public service delivery and through our Complaints Standards work we hope to transform the complaints landscape in Northern Ireland.

Through this Case Digest, NIPSO hopes to encourage Care Homes to review their complaints handling approach and practices to support good quality service delivery. We also hope that the complaint case summaries will encourage people to share feedback and concerns with Care Home staff, and with NIPSO, if necessary.

Margaret Kelly
Northern Ireland Public Services Ombudsman

About this Case Digest

This Case Digest highlights some of the key findings from Care Home investigations carried out by the Northern Ireland Public Services Ombudsman (NIPSO) over the past seven years. Not all complaints brought to NIPSO proceed to further investigation and where appropriate the Office can support resolution of the complaint at an earlier stage. This achieves an outcome for complainants without the need for a detailed investigation process. Out of 77 complaints about Care Homes brought to NIPSO, 24 proceeded to further investigation. We are sharing anonymised summaries and key findings from these cases to illustrate the importance of complaints in highlighting concerns and issues for improvement. The complaints investigated include both Residential Care Homes and Nursing Homes, but the generic term 'Care Home' is used to encompass both.

This Case Digest is primarily a resource for Care Home Managers and staff, the vast majority of whom are independent providers of care through contractual arrangements with the Health & Social Care Trusts (Trusts). However, it will also be of interest to the Trusts as the commissioning body (and Care Home provider) and to Care Home residents/ families. In sharing the key findings from our investigations, this Case Digest will highlight recommendations made by the Office to improve service delivery. It will also raise the importance of effective complaints handling and early intervention to resolve issues when possible.

It is important to note that any issue of concern should be raised with the Care Home as soon as possible. Sharing a concern early can often resolve the issue quickly and prevent the problem from escalating. If this does not solve the issue, the complaints process can then be followed. A copy of a Care Home Complaints Handling Policy should be easily accessible and clearly set out the steps to follow should someone wish to make a complaint. The policy should also be available in different formats and languages if needed. At the end of the Care Home complaints process, Care Homes must signpost complainants to NIPSO and the complaint can then be brought to the Office if the person remains dissatisfied.

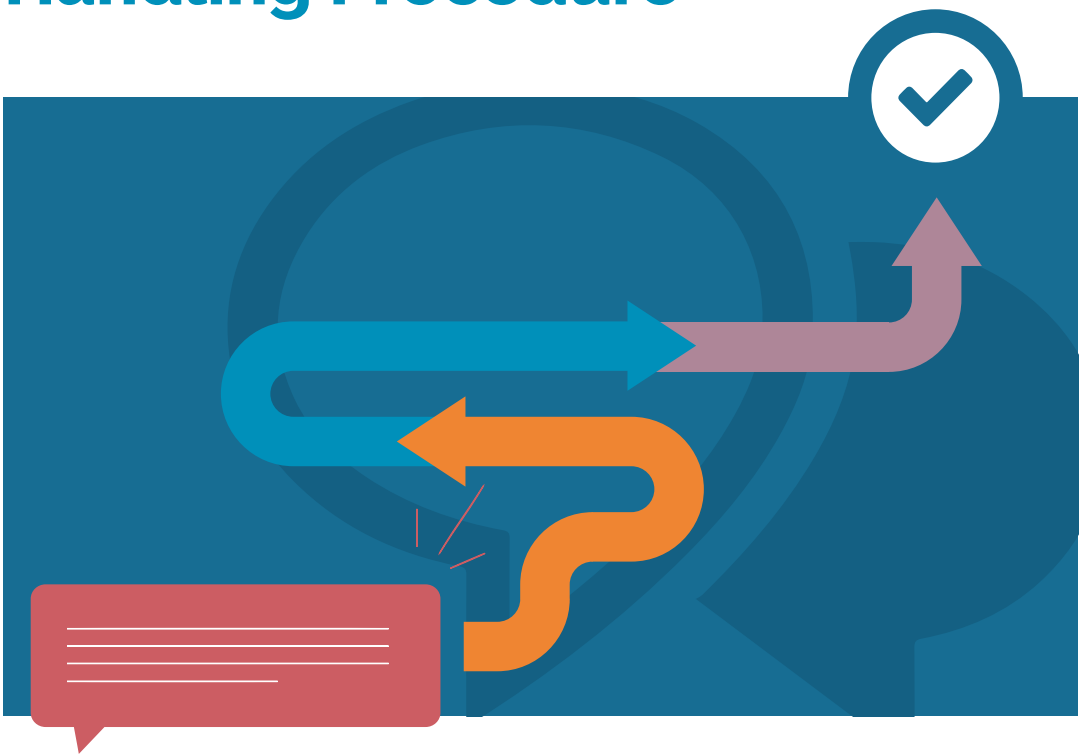
Role of NIPSO

NIPSO has legal powers to investigate complaints regarding various public services, including Care Homes. This includes Care Home provision delivered directly by the Trusts and independent Care Homes delivering care on behalf of the Trust. NIPSO provides an independent, free service available for those who remain dissatisfied at the end of the Care Home's complaints process.

NIPSO's work is underpinned by The Principles of Good Administration and The Principles of Good Complaints Handling. Principles of Good Administration are:

1. ***'Getting it right'*** requires public bodies to act in accordance with *'recognised quality standards, established good practice … with regard for the rights of those concerned.'*
2. ***'Being customer focused'*** requires public bodies to respond to people's needs. This means *'ensuring people can access services easily'*, being sensitive to individual needs and adhering to commitments and published service standards.
3. ***'Be open and accountable'*** providing information that is clear, accurate and complete, providing honest evidence-based explanations and giving reasons for decisions.
4. ***'Acting fairly and proportionately'*** requires public bodies to ensure complaints are investigated thoroughly and fairly to establish the facts of the case. This also means they should *'avoid being defensive when things go wrong'.*
5. ***'Putting things right'*** requires public bodies to *'acknowledge mistakes and apologise where appropriate' and* offer *'appropriate remedy when a complaint is upheld'.*
6. ***'Seeking continuous improvement'*** requires public bodies to learn *'lessons from complaints and use these to improve services and performance'.*

Model Complaints Handling Procedure



Part 3 of the Public Services Ombudsman Act (Northern Ireland) 2016 enables NIPSO to produce and publish complaints handling procedures for public services.

NIPSO is committed to working with public bodies and representatives of the public to develop a Model Complaints Handling Procedure (MCHP) for all public services to follow on a rolling programme basis. Work to develop a MCHP for the Health & Social Care Trusts (Trusts) is currently underway.

Once a Trust MCHP is developed and published, Trusts and organisations delivering 'on behalf of' Trusts will have a statutory duty to follow the MCHP.

This means that independent Care Homes who provide NHS-funded care on behalf of Trusts and Trust-run Care Homes will be using the same,

simplified complaints procedure. This is an important opportunity to:

- Simplify complaint processes, making it easier, quicker and clearer for complainants and their families to complain.
- Support and train staff to respond to and manage complaints early, locally and appropriately.
- Improve complaints handling standards across the public sector.

NIPSO plans to engage with the independent Care Home sector to help Care Home personnel prepare for this, as well as provide additional support, guidance and training resources, to help providers adopt and implement the new procedure. There will be a focus on welcoming and valuing complaints as a source of learning and improvement. Also, sharing evidence with the public about how Care Home providers are using their complaints information to inform care and treatment and improve service delivery. Further information on the MCHP is available on NIPSO's website from this link: Complaints Standards for NI.

In advance of the MCHP being developed and implemented, NIPSO would encourage all Care Home providers to review their current complaints processes and begin to think about what the MCHP will mean in their setting. As a quick guide, the key MCHP expectations are:

- A two-stage process with an initial 5 working days for early resolution (Stage 1) and 20 working days for more complex cases (Stage 2)
- Timeframes at both stages which can be extended if appropriate and required. However, complainants and their families must be kept updated with progress and expected timescales

Where it has not been possible to resolve the complaint at Stage 1

- The recording, regular reporting and publishing at least annually of complaints information
- Publication of evidence of how providers are learning from complaints
- Provision of support to complainants and families to remove any barriers to complaining.

Care Home Complaints landscape in Northern Ireland

Concern about the reporting of Care Home Complaints in NI has been well documented in a number of significant reports. The Commissioner for Older People for Northern Ireland's (COPNI) 'Home Truths Report'[1] and the Department of Health's (DoH) independent report by CPEA[2], both highlighted the need for improvement in complaints procedures and better use of complaints data.

Current complaints data published by the Trusts does not fully reflect the number of complaints made about independent Care Homes and Care Home providers are not asked to publish their complaints data. The MCHP will change this by ensuring that all Care Home complaints data is published and accessible to the public.

1 COPNI Home Truths Summary Report
2 DoH (CPEA) Independent Review into Safeguarding & Care at DMCH

Care Home Complaints brought to NIPSO

Figure 1 shows the total number of Care Home related complaints brought to NIPSO between 2016-2023. Out of a total 77 complaints received over the past seven years, 24 complaints (31%) were assessed as requiring further investigation. This is a higher proportion than is seen for complaints about other sectors and reflect the serious concerns raised.

Complaints are typically closed in the Initial Assessment stage because the complainant has not fully exhausted the Care Home complaints procedure. Complaints are closed at the Assessment stage for a number of reasons, in some cases further investigation will not add further value to the investigation that has already been done, or an investigation will not achieve the outcome the complainant hopes for.

Figure 1

CARE HOME COMPLAINTS CLOSURE STATUS[3]

Closed at Initial Assessment	34	44%
Closed at Assessment	19	25%
Closed at Investigation	24	31%
Total	**77**	**100%**

3 Since April 2024 NIPSO has changed the names of these three stages to Assessment, Investigation and Further Investigation.

Resolution of Complaints

In some instances, the complainant and the Care Home or Trust reach an understanding without the need for a further investigation. Typically, when resolution is achieved, the Care Home acknowledges the poor service, apologises and agrees to take action to prevent the issue re-occurring. Resolution can also help rebuild relationships which is important for ongoing care. Here is an example of where resolution was achieved without further investigation:

Case Example:
A daughter complained about her mother's care after Care Home staff failed to administer insulin on two consecutive days despite a hospital discharge letter advising of the change in her medication regime. When visiting her mother, she had concerns about how her mother was dressed and the poor presentation of her bedroom. Following NIPSO's intervention, the Care Home acknowledged its shortcomings and agreed to address the issues raised by the complainant. This included an acknowledgement of error, apology and agreeing to implement a number of improvements.

Complaint Investigation Outcomes

Twenty-four complaints made to NIPSO between 2016 and 2023 progressed to further investigation. The investigations featured in this Case Digest, were all brought to NIPSO by family members. Sadly, 15 of the residents died before the complaint was received by NIPSO, and regrettably two residents passed away during the course of the investigation. In four of the 24 cases a complaint was made against both the Care Home and the Trust.

- In 19 cases (80%) the complaints were either 'fully upheld' (4 cases 17%) or 'partially upheld' (15 cases 63%) by the Ombudsman.
- Complaints are described as 'partially upheld' when failings are found in some but not all of the issues raised by a complainant.
- Four (17%) investigations found failings for every issue highlighted and the complaint was fully upheld.
- Five (21%) of the investigations found no failings and the complaint was not upheld.

Figure 3 shows the outcome of the complaint investigations and whether the complaint was made about the Care Home or about the Trust.

None of the complaints at further investigation stage were about Care Homes managed by a Trust. Trust complaints related to issues such as, appropriateness of a resident's admission and/or placement to a Care Home or focused on how the Trust handled incidents and safeguarding investigations and Trust complaints handling.

Figure 2
COMPLAINT INVESTIGATION OUTCOMES

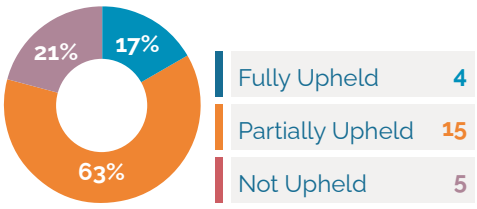


Figure 3 OUTCOME OF COMPLAINT INVESTIGATIONS (CARE HOMES AND TRUSTS)

Outcome	Care Home	Trust	Total
Fully Upheld	3	1	4
Partially Upheld	10	5	15
Not Upheld	1	4	5
Total	**14**	**10**	**24**

Key Findings

Care Homes Complaints Investigations

The 24 cases that progressed to further investigation were complex in nature and, significantly, contained several separate issues of complaint. Figure 4 shows the main failings found in the complaint investigations.

Figure 4

CARE HOME COMPLAINT ISSUES BY THEME

Key Issues in Care Home Complaints

ADULT SAFEGUARDING CONCERNS

In more than half of the complaints investigated we found safeguarding failings – failure to adhere to measures to protect residents from harm and abuse. This included medication errors, failure to identify injury, lack of access to appropriate health and social care and delays accessing medical care. We note that in six of the 14 adult safeguarding complaints family members moved their relative to another Care Home.

QUALITY & SAFETY OF CARE

In half of the cases investigated, complaints related to the care and treatment of residents. Examples of these highlight the significant impact on residents resulting from failures in what should have been routine care activities.

For example, a failure to follow routine dental hygiene tasks meant that opportunities were missed to identify that a resident's dentures had become lodged in their throat. The resident subsequently developed breathing difficulties and contracted pneumonia which proved fatal. Other examples include, lack of care during manual handling incidents which resulted in serious injury, inadequate wound care, mismanagement of medications, not following medical advice, poor practice when assisting a resident to eat and the inaccessible placement of a Call Bell. These examples show that failure to take due care and attention to good practice guidance[4] in relation to routine, every day activity can have serious, longer-term impact, such as physical harm, illness and hospitalisation.

4 RQIA, 2022, Nursing homes standards

COMPLIANCE WITH RELEVANT STANDARDS

As illustrated by the complaints in relation to care and treatment, there were a number of circumstances where the care provided fell below the standards expected. Evidence of care falling below expected regulatory and professional standards was found in all fully upheld complaints.

CARE PLANNING, ASSESSMENT AND REVIEW

The DoH's Regional Safeguarding policy "Prevention and Protection in Partnership"[5] emphasises the importance of care plans and risk assessments for adults with restricted mobility and limited capacity who spend most of their time in their homes. We found failures in the care planning process, such as a lack of personalised assessment, poor implementation and monitoring of care plans and failure to review/adjust care plans when resident's needs changed. We also found failures in how risk assessments to reduce possibilities of recurrence and avoidable harm were conducted.

COMMUNICATION/FAMILY INVOLVEMENT AND RIGHT TO FAMILY LIFE

Several cases highlighted examples of family members being excluded from care planning and poor communication from the Care Home. Effective communication is essential for person-centred care. Care Homes have a responsibility to be open and accountable, they must listen to and update families about incidents.

In some of the complaints the lack of communication with families and the failure to provide person-centred care impacted on residents' right[6] to a family life. In one case, the Ombudsman found that restricted visiting during the Covid-19 pandemic caused distress to a palliative care resident, impacting her right to family life. Care Homes must consider people's rights in their approach to care, treatment and complaints handling. Care Homes should demonstrate clear decision-making processes when practices interfere with qualified rights and recognise when a complaint is linked to a rights-based concern.

COMPLAINTS HANDLING

In many of the cases families' concerns were compounded by poor complaints handling by Care Home staff. This included inadequate responses to the issues raised by families, lengthy and unacceptable delays and failure to attend meetings to discuss the issues raised. In one case the Care Home threatened legal action instead of undertaking a thorough investigation.

5 DoH Adult Safeguarding: Prevention and Protection in Partnership

6 Human Rights Act 1998 outlines the rights and freedoms everyone in the UK is entitled to

POOR RECORD KEEPING

Some of the frequent failings in relation to record keeping included not keeping contemporaneous records, inaccurate care records, not keeping comprehensive records, records being changed retrospectively and excluding relevant information.

Record keeping is an important source of evidence of proper care, and incomplete records can lead to the upholding of complaints in investigations. Keeping a consistent and robust system to maintain proper records is a legal requirement for providers and is recognised as a quality indicator in RQIA inspections. *'Records Matter: a view from regulation and oversight bodies on the importance of good record keeping'*, was developed by NIPSO, the Northern Ireland Audit Office and the Information Commissioner's Office and is available on NIPSO's website from this link: Records Matter.

MEDICATION MANAGEMENT/ HEALTHCARE INVOLVEMENT

Failures were also noted in relation to medical advice not being followed and delays in seeking medical assistance for residents. This included refusals/ delays in calling for an ambulance, GP appointments not arranged, failures to follow-up on test results, medication not being administered correctly, and failure to follow medical advice.

GENERAL COMMENT ON HUMAN RIGHTS CONCERNS

It is of concern that a reoccurring theme in investigations was a failure to have appropriate regard to the rights of residents. Too often we saw a lack of person-centred care, which failed to support dignity, privacy, choice and control. This included basic privacy issues and inappropriate clothing to serious failures in relation to medical care, risk assessment and planning. Residents right to privacy, family life and access to healthcare must be fully considered at all times and decision-making processes and risk assessments must be used to provide a high standard of care and transparency for families.

A case example of a human rights based approach in assessing a Care Home complaint (page 97) is provided in NIPSO's Human Rights Manual which can be found on NIPSO's website from this link: NIPSO Information & Guidance.

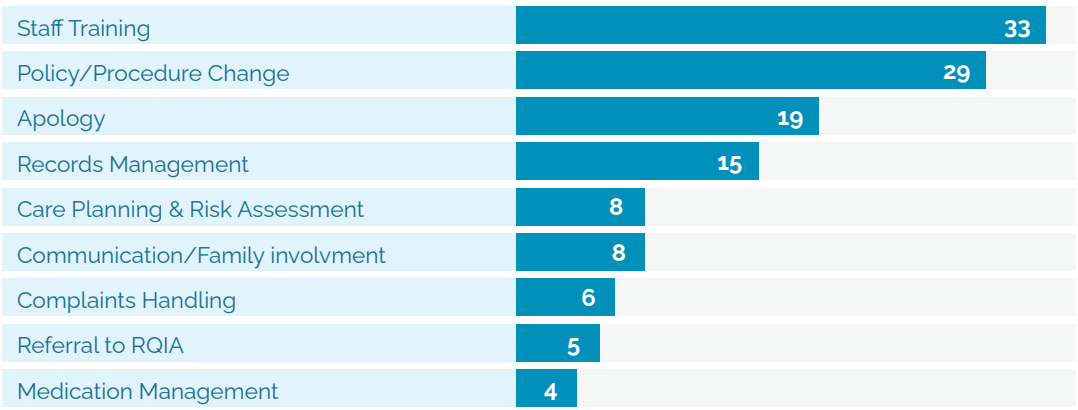
Recommendations from NIPSO

When an investigation identifies failings, NIPSO makes recommendations to identify service improvements and help prevent the incident reoccurring. The Ombudsman also has discretion to share issues with RQIA at any stage in an investigation and when appropriate, will share the findings and recommendations of the final investigation report. A final report is always shared with the relevant Trust.

In the 24 cases assessed for this Case Digest, 147 recommendations were made. The most frequent was staff training, followed by improvements to Care Home and Trust policies and procedures. An apology was recommended for 19 complainants, and 15 recommendations for improvements in maintaining accurate records were made.

Due to wider concerns, five investigation reports were shared with RQIA.

RECOMMENDATIONS FROM INVESTIGATIONS



Conclusion

Key messages for Care Homes

How Care Homes manage complaints is a strong indicator of the quality of their provision. We recognise that effective complaints handling does require time which can be challenging in a busy care home – however good communication and early resolution can prevent problems from escalating. In the vast majority of cases, the complainant's main motivation will be to ensure their loved one is receiving good care – they want the same outcome that dedicated care home staff seek to provide. Make sure that residents and visitors know how to raise an issue and provide reassurances that all feedback, including complaints, is welcome. Provide training for staff so that they can respond to complaints effectively and with compassion. Value complaints as an opportunity to learn and improve care.

APOLOGY

Receiving an acknowledgement of identified failings and shortcomings in care and treatment of loved ones can be an important step in moving forward. To assist all public bodies, NIPSO has published a resource on issuing an apology which is available on NIPSO's website from this link.

Guidance on Issuing an Apology

Complaints Handling for Care Homes

Communication

Look at ways to improve how you **communicate** with residents and families and deliver simple, compassionate and effective complaints handling.

- Ask for regular feedback/comments on services to see what is working and not working so well.
- Identify common concerns and fix them early.

Listen

When a complaint is brought to your attention:

- **Listen** carefully. Be open-minded and objective.
- Thank the complainant for sharing their experience.
- Provide reasonable and honest explanations if you cannot handle the complaint in the way the complainant would prefer.

Decisive

Be **decisive** in deciding what you can do to resolve the complaint.

- Seek the best possible outcome for everyone.
- 'Put yourself in their shoes' – when you empathise and care about problems encountered a solution can be found more quickly.

Stage 1: Frontline Response

Be responsive at Stage 1 – Frontline Response

- Let the complainant know what you will do to resolve the complaint quickly and agree a timescale for when change will happen. Take remedial action straight away if possible.
- Take responsibility and apologise for poor care services experienced by the complainant or if mistakes have been made.
- If you can't fix the issue right away, then let the complainant know what will happen next and when you will get back to them.
- Try to respond within 5 days or sooner if possible.

Stage 2: Investigation

- Complaints that can't be resolved during the frontline response stage can progress to Stage 2.
- Plan the investigation – consider ways to resolve the complaint with the complainant.
- Complete the investigation within 20 working days if possible. If not, make sure the complainant is kept updated with the anticipated timescale.
- **Follow up** with the complainant, ask if they are satisfied with the outcome and with how their complaint was handled.
- If they are content, thank the complainant for their feedback.
- Ensure you signpost to **NIPSO** in your final response to the complainant.

Learning

Promote a culture of learning among staff by ensuring they are aware of complaints issues and any action needed to prevent issues reoccurring.

Record keeping

Ensure throughout the complaints process that your record keeping is clear, accurate and provides evidence of your decision-making processes.

Key Messages for Residents and their Families

1

- To raise a concern about the care and treatment you or your loved one has received let the Care Home Manager or Person in Charge know immediately and give them the chance to put things right.
- In sharing a concern or making a complaint you are helping protect your loved one and playing an important role in potential service improvements.
- You can make the complaint yourself or ask someone to make the complaint on your behalf. If you need help, consider getting support from an advocacy organisation.

2

- You can make a complaint verbally or in writing – either way it should be acknowledged as a complaint by the Care Home.
- Explain what you are concerned about and focus on the facts.
- You may feel distressed, frustrated or angry about the matter affecting you or your loved one and keeping to the key events and facts will help the provider to better understand and assess your complaint.
- Include any dates/times or names of staff you have spoken to and their responses.

3

- Expectations - be as clear as you can about what you want as an outcome to improve the quality of care services to you or your loved one.
- You should expect to be treated fairly, with respect and feel reassured that the service you/ your loved one receives is not affected by you raising a complaint.
- Your concerns should be dealt with quickly, if possible.
- A more complex complaint may take a few weeks or longer to investigate. The Care Home must keep you updated with the anticipated timescale.

4

- Listen to the explanation that has been given by the provider.
- Consider their proposed solution and ask questions if it isn't clear.
- If you are not happy with the provider's final response to your complaint, you have a right to go to NIPSO.
- Where possible, complaints should be brought to NIPSO within six months of the Care Home's complaint procedure ending, which is when you have received their final response.
- Each complaint is assessed by NIPSO on a case-by-case basis, and we will let you know what action we can take. If we do not proceed with your complaint, we will explain the reasons why.

Case Summaries

NIPSO would like to thank every complainant who brought a complaint about a Care Home to the office. Raising a complaint, particularly about a distressing incident can be a difficult process. Many of the complainants that contact our office do so out of motivation to prevent the incident happening to someone else.

By sharing summaries of some of the cases that reached further investigation by NIPSO, we hope to highlight some of the failings the investigations found and raise awareness of the importance of the complaints process as an opportunity for learning and improvement. We also wish to emphasise that many residents and families enjoy a positive care home environment and the examples within this case digest are not reflective of the care home sector as a whole.

Multiple issues of concern

CASE 1: INADEQUATE CARE LED TO SIGNIFICANT HARM AND CONTRIBUTED TO SHORTENING MOTHER'S LIFE.

The daughter of a Care Home resident contacted us about two distressing incidents experienced by their mother which led to a deterioration in her health, resulting in pneumonia and sadly her death. The complainant's mother had dementia associated with Parkinson's Disease, she also had osteoporosis and needed assistance to move between her bed and chair.

In the first incident the resident's slipper became trapped in her bedrails as staff were moving her, the staff assessed her for injury but concluded no further intervention was necessary. However, the following day it was found she was in significant pain and had sustained a leg fracture, which necessitated a stay in hospital. The investigation found that this was a preventable injury, and the clinical assessment was inadequate. The complainant's view that the injury has contributed to the shortening of her mother's life, was shared by the independent medical advice received in the investigation.

Within two weeks of being discharged from hospital the same lady developed breathing and swallowing problems. However, despite complaining of a sore throat no action from the home was taken until the complainant asked for an oral suction procedure. This procedure led to the discovery that her mother's dentures were lodged in her throat and partially obstructing her airways. A further hospital admittance to remove the denture plate was required. The complainant's mother then developed pneumonia and sadly passed away – only four weeks after the initial leg fracture incident.

The investigation found that the Care Home had no oral and mouth hygiene policy in place. Regular oral hygiene care is well documented as a key preventative measure in reducing the likelihood of a pneumonia associated death. In this case, the Care Home was aware that the lady had loose dentures and had even asked the family to buy denture adhesive. The adhesive was found unopened after this incident.

As a result of the failings identified, a number of recommendations including a new policy on Oral Health and staff training in Moving and Handling were made, to remedy the injustice identified in this report and to improve the care provided in the future.

CASE 2:
FAMILY PROHIBITED FROM MOTHER'S END OF LIFE VISITS DURING THE PANDEMIC

A family complained about the standard of care for their mother who had dementia and could not verbally communicate. The complainant claimed that when developing their mother's care plan, the Care Home did not involve family members input regarding their mother's needs and preferences. Consequently, staff failed to recognise signs of distress and pain which led to a delay in seeking medical advice and appropriate treatment. The investigation found the resident was denied access to high quality palliative care services and pain-free, peaceful end-of-life care. In addition, medication administration records were inaccurate and only one formal pain assessment was performed by the Care Home. Sadly, the recording of the lady's death was also inaccurate.

During the resident's stay in the Care Home full Covid 19 restrictions were in place with no exceptions for end-of-life visits. The investigation found this inappropriate as the Care Home's guidance allowed visits in *'exceptional circumstances'.* Whilst recognising this was a particularly challenging time for Care Homes, the investigation identified failings that could have been prevented. The family expected their mother to receive a pain-free, dignified care delivered with compassion at the end of her life. However, their grief was compounded with the knowledge that their mother's medical needs were not met and her last days were spent alone.

The complaint was partially upheld. The Care Home was reminded of the importance of person-centred care and to ensure that care plans have respect for a resident's physical, psychological and spiritual needs. We reminded them of the importance of involving family in care planning and to provide opportunities for choice and control. The Care Home was also asked to develop plans to use a structured pain assessment tool such as the Abbey Pain Scale.

CASE 3:
UNSAFE PRACTICES AND RIGHT TO DIGNITY NOT RESPECTED FOR ELDERLY MOTHER

This complaint focused on safety concerns in the care and treatment provided to the complainant's late mother. The investigation found that the complainant's mother was incorrectly positioned in her bed for mealtimes, causing choking and vomiting. Against good practice guidance, the resident was placed at the foot of a profiling bed, propped up with pillows and out of reach of the safety buzzer. In addition, clean utensils were not used, and the same spoon was used for each meal course without washing it between courses. This lady sadly passed away during the complaints process.

The Care Home failed to apologise for unsafe practices and demonstrated a lack of candour in its response to the complainant. The NIPSO investigation found poor complaints handling and the lack of a full and honest investigation by the Care Home. A poor standard of record keeping was found and the practice of editing records clearly showed evidence of errors. We asked the Care Home to issue an apology to the family and recommended refresher staff training on care plans and risk assessments, assisting residents at mealtimes and employing appropriate manual handling techniques when moving residents. Timeliness and accuracy in record keeping was also highlighted as needing improvement.

CASE 4:
SYSTEMIC FAILURES IN FATHER'S CARE INCLUDING NOT ACTING QUICKLY UPON STROKE SYMPTOMS

A 65-year-old man with advanced Multiple Sclerosis lived in the Care Home for 10 months until he sadly passed away. His daughter had multiple concerns about her father's standard of care and treatment, believing it contributed to his significant health deterioration. Issues investigated included poor personal and oral hygiene care, poor treatment of pressure sores, and staff not following physiotherapist advice. Her father lost 21% of his body weight over a seven-month period raising concerns about weight assessments. The complainant suspected falsified care records and stated that the Care Home did not properly assess her father or call for an ambulance when he displayed symptoms of stroke.

The investigation upheld all elements of this complaint. NIPSO found a lack of person-centred care, poor standard of personal and oral hygiene care, inadequate communication with the resident's family and insufficient family input into the resident's care plan. The man did not receive adequate care and treatment of pressure sores, or the prevention of contractures. His care plan was not updated to reflect preventative care changes and the Care Home did not assess the resident for stroke symptoms.

The investigation found repeated maladministration in record keeping with some resident's records lost or mislaid and the Care Home failing to inform the complainant about missing records. On one occasion a weight assessment was falsely entered - the resident was in hospital and not present in the Care Home at the time. The professional independent nursing advisor noted *'it was common practice at the home to cut and paste records'* making them untrustworthy.

The Care Home's handling of complaints was lacking, and it failed to provide a thorough investigation. Recommendations included staff training on recognising stroke symptoms and actions to take when a stroke is suspected and a review of nursing records for oral/mouthcare plans. A key focus was placed on records management, to include training on standards, review of record management policies and processes to ensure accurate entries.

Safeguarding Procedures

CASE 5: FAILINGS IN TRUST AND CARE HOME SAFEGUARDING PROCEDURES

Trust Complaint:
The daughter of a Care Home resident complained that she had concerns about the appropriateness of her late mother's residential care placement by the Trust and its ongoing monitoring.

The complaint was partially upheld, and serious failures were found in relation to care and treatment and safeguarding procedures. The Ombudsman recommended that the Trust issue an apology and a range of service improvements to include random sampling audits of safeguarding referrals to ensure adult protection protocols are being followed. We also asked the Trust to review care plans and conduct staff training.

Care Home Complaint:
Considering the serious issues raised in the above Trust complaint, the Ombudsman exercised statutory discretion and opened an investigation into the Care Home also. The resident had a dementia diagnosis and her daughter had concerns over safeguarding investigations, claiming that her mother as a vulnerable person was not adequately protected. In addition to safeguarding issues, other concerns raised included the provision of podiatry treatment which was not requested or wanted by the resident, mislaid clothes, care and treatment, monitoring, and poor complaints handling.

The complaint was partially upheld. Failures were found in care and treatment particularly in relation to safeguarding and the Care Home was asked to establish a policy on relationships to safeguard residents' rights, privacy, wellbeing and protection.

CASE 6: TRUST FAILED TO MONITOR QUALITY OF CARE HOME CARE AND DID NOT RECORD RATIONALE NOT TO PURSUE

A daughter complained about the lack of information and choice relating to the quality and safety of care provided by a Trust for her late mother. This complaint was partially upheld, and the investigation identified that more information and assistance was needed for families of Care Home residents. Some of the Trust's actions were found to be appropriate, but failures were found in monitoring care quality, timing of information, and recording the rationale not to investigate two safeguarding concerns. Recommendations asked the Trust to conduct a 3-year audit of social care files for residents transitioning to permanent placements, to provide training on evidence gathering for safeguarding staff, and reminders of the importance of recording decision making rationales. It was also recommended that the Trust include the consideration of quality at care review meetings.

CASE 7: FLAWED SAFEGUARDING PROCEDURES AND JOINT PROTOCOL FOLLOWING THEFT OF RESIDENT'S WEDDING RING

We received a complaint from a resident's son about a Trust's investigation into the theft of his 94-year-old mother's wedding ring by a nursing home employee and the handling of an allegation regarding another resident's behaviour. The resident sadly, died before the complaint investigation was completed.

This complaint was fully upheld. The investigation found that the Trust's investigation into the theft of the resident's wedding ring was flawed, it failed to comply with Safeguarding Procedures and the Joint Protocol with the PSNI. Additionally, the Trust failed to keep adequate records to demonstrate compliance with its safeguarding policy for a separate incident. Failures were also found in the Trust's complaint handling. The complainant experienced long delays and lack of timely updates in accordance with relevant standards.

A series of service improvements to prevent reoccurrence were recommended by the Ombudsman. These included actions around staff training and learning.

Issues with medication and pain-relief

CASE 8:
FAILURES FOUND INCLUDING MEDICATION ERRORS AND OMISSIONS

A daughter complained to us about the care her mother received at a Care Home. Concerns were raised about her late mother's deteriorating swallow, medication and hygiene within the home.

The complaint was partially upheld with multiple failures found in her mother's care including the absence of a care plan, failing to record vital signs when her mother's condition was observed to be deteriorating and failures in nutrition and hydration management before and after hospital admission. The investigation also found a disregard for the risks associated with medication administration which included conflicting and inconsistent records relating to whether her mother's medication had been given. Upon hospital admission the Care Home failed to notify the hospital that her mother had already taken her medication, and failed to ensure her medicine was reviewed so it was safe to be administered following discharge from hospital. Record keeping failures were also found.

We made recommendations for staff training to ensure the fundamentals of care were delivered effectively. The Care Home was asked to establish an individualised care plan system for resident hydration and nutrition needs, including procedures to review and act when nutritional conditions change. They were also asked to maintain records according to Care Homes standards and Trust contract requirements, and to develop a system for recording staff training events. An action plan detailing the steps for implementing the recommendations was also requested, supported by evidence such as relevant meetings, training records, and staff self-declaration forms to show an understanding of policies.

CASE 9:
FAILURES IN CARE OF MOTHER INCLUDING NOT ADMINISTERING PRESCRIBED MEDICATIONS

This complaint related to the care provided for the complainant's late mother who had Motor Neurone Disease (MND). Sadly, the lady passed away within three weeks of her one-month period of respite. The resident took several medications, but confusion arose when her anxiety-relieving medication was mistaken for pain management medication. Despite concerns being raised, the anxiety-relieving drugs were not administered. The investigation revealed that when the resident experienced a panic attack (which the anxiety medication may have alleviated) the Care Home staff failed to provide adequate care or support, and initially refused the ambulance requested by the family.

This complaint was partially upheld. The Care Home failed to deliver person-centred care in line with the resident's care plan, there was inadequate nursing care, and inadequate record keeping and medication management. Repeated errors were found in complaint handling - the Care Home did not conduct a thorough investigation, issued inaccurate, incomplete, and adversarial responses, and failed to attend planned meetings with the Trust and the complainant. The Care Home also resorted to threats and obfuscation to conceal their failings and used legal representation to threaten legal action against the complainant.

We recommended the Care Home provide a written apology to the complainant for the range of failings identified. We also shared the investigation with RQIA to identify wider areas for action, learning and improvement.

Delay in treatment and calling ambulance service

CASE 10: 8-HOUR DELAY IN CALLING AN AMBULANCE WITH NO OBSERVATIONS UNDERTAKEN FOLLOWING A RESIDENT'S FALL

This complaint was brought by a resident's daughter regarding her late father's care and treatment after falling and sustaining a head injury in a Care Home. This complaint was upheld with a number of failures found, including – a delay of 8 hours in calling an ambulance following the fall and failing to document observations in the intervening time. However, on the basis of independent professional advice received, the investigation found that the resident's subsequent death was unrelated to the fall. The Ombudsman asked the Home to apologise for the identified failures in care and treatment. A related complaint about how the Trust had handled her complaint was not upheld by the Ombudsman.

CASE 11: DELAY IN SEEKING MEDICAL ADVICE FOLLOWING A FALL RESULTED IN DELAYED TREATMENT

A complainant raised concerns about her late sister's care and treatment in a Care Home, highlighting issues with delays seeking medical advice and the support offered following a fall. The complaint was partially upheld. The investigation found that the Care Home should not have delayed in seeking medical advice and should have requested additional assistance from other Care Home staff following the resident's fall. They did not have appropriate policies and procedures in place for staff undertaking post-fall checks which could have identified a hip fracture sooner and enabled earlier treatment for the resident. The Care Home's record keeping after the resident's fall were not of an acceptable standard and no detail was provided on the hydration, nutrition and pain relief given to the resident. We asked the Care Home to apologise to the complainant and to make service improvements, including developing a policy on falls and accidents and procedures for post fall checks. They were also asked to provide staff training on the new policies and procedures.

Cases where failings were not found

CASE 12: TRUST INVESTIGATION FOUND TO BE APPROPRIATE, THOROUGH, AND CUSTOMER-FOCUSED

This complaint was in relation to complaints handling by a Trust following concerns about the care and treatment of a Care Home resident who was the complainant's late mother. The complainant received two detailed responses from the Care Home and as they remained unsatisfied, they then wrote to the Trust.

The Ombudsman did not uphold the complaint and commended the complaints handling by the Trust. It provided a comprehensive response and demonstrated a customer focused approach.

CASE 13: TRUST'S COMPLAINTS HANDLING WAS APPROPRIATE AND THOROUGH

A daughter brought two complaints to this office, one about the care provided by the Care Home and a second about the Trust's handling of her complaint regarding her father's Care Home. The complaint about the Trust complaint handling was not upheld as the Ombudsman found the management of the Trust's investigation of the complaint to be appropriate and thorough.

CASE 14: TRUST INVESTIGATION FOUND TO BE APPROPRIATE

A resident's son complained about the care and support his father received in relation to podiatry, hygiene, food quality and concerns around how a vaccination clinic for health care workers and Care Home residents was delivered. The complainant felt the Trust should have initiated adult safeguarding procedures and a Serious Adverse Incident.

The investigation found that the Trust was not at fault, having acted appropriately and in accordance with relevant policy and guidance. This complaint was not upheld.

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