Investigation of a complaint against Bangor Care Home

Report Reference: 202004885 & 202004886

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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.

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Listed Authorities: Bangor Care Home &
South Eastern Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment Bangor Care Home (the Care Home) provided to the complainant's 91 year old grandmother (the resident), specifically on 9 September 2021 when she fell whilst using the bathroom. The resident sadly died approximately one month after this fall.

The complaint was also about a Serious Adverse Incident (SAI) investigation the South Eastern Health and Social Care Trust (SEHSCT) subsequently carried out when the complainant remained unhappy with the Care Home's response to her complaint. The complainant raised concerns regarding the thoroughness of the Trust's investigation.

My investigation found the Care Home failed to provide appropriate care and treatment to the resident on 9 September 2021. At the time of the fall the Care Home did not have the recommended number of staff, as a care assistant had left early and had not been replaced. The resident's care plans indicated that she required assistance of at least one for toileting, and should not have been left alone for any length of time while using the bathroom. Unfortunately she was left alone and during this time she fell. This was not in accordance with the resident's care plan. The care home moved the resident following the fall, despite the resident having fractured her femur. There was no indication that the resident was appropriately checked prior to being moved, nor had advice been obtained from the Northern Ireland Ambulance Service in advance. The Ambulance Service advised that the resident should not be moved, however staff had already done so. This was poor practice and not in keeping with relevant standards.

The Care Home also failed to keep detailed and accurate records of the incident which resulted in the family not being able to obtain answers to questions regarding exactly what had happened.

Falls in the elderly can have very significant consequences. Particularly where they result in a fracture, as in this case, and where the individual has co-morbidities. The resident was taken to hospital and operated on two days after her fall. However after nearly a month in hospital she was discharged to a different care home and sadly died four days later.

My investigation found the Trust conducted its SAI investigation in line with relevant standards.

I recommended the Care Home apologise to the complainant, and provide training to its staff regarding its policies and procedures relating to the prevention and management of falls.

Falls in care homes are a significant issue, with residents in care homes much more likely to fall than those of a similar age living in the community. As individuals get older, falls become much more common, and the consequences of the fall can become much more serious. Injury caused by falls is the leading cause of death for people over 75. It is therefore imperative that care homes carry out, and adhere to, appropriate falls risk assessments for residents and ensure that the care plans devised to reduce risk are implemented.

THE COMPLAINT

1. This complaint was about care and treatment Bangor Care Home (the Care Home) provided to the complainant's grandmother (the resident) on 9 September 2021. The resident fell while using the bathroom, which required a hospital admission and surgery. The resident sadly passed away approximately one month after her fall.

2. The complaint also included concerns about a Serious Adverse Incident (SAI) investigation carried out by the South Eastern Health and Social Care Trust (the Trust) following the resident's death and the complainant's subsequent complaint to the Care Home.

3. I addressed the complaints against both authorities in this composite report because of their interdependent nature, and to maximise the opportunity for learning and system improvement for both the Trust and the Care Home.

Background

4. The resident, a 91 year old lady, lived in the Care Home from August 2019. She had several health problems and required a rollator[1] and the assistance of one to two persons when mobilising. She also required assistance for toileting. The resident had a history of falls. In particular, in December 2019 she had an unwitnessed fall in the Care Home which resulted in a fracture to her left femur.

5. At approximately 4.00pm on 9th September 2021, a staff member observed the resident walking to the toilet without assistance. The member of staff assisted the resident to the toilet. She then left, according to the Care Home to get continence products. On returning, she found the resident on the floor of the toilet. The staff member informed the Care Home Registered Nurse (RN) about the incident. The RN contacted the Northern Ireland Ambulance Service (NIAS), who advised her not to move the resident until they arrived. However, staff had already moved the resident because they reported she became agitated and expressed pain. She was subsequently admitted to hospital and had surgery for a fracture to her upper right femur.

[1] A rollator is a mobility aid that provides stable support and allows the user to sit comfortably. It is equipped with wheels and a seat, making it easier for individuals with limited mobility to walk longer distances and carry small items.

6. The hospital discharged the resident to a different care home on 12 October 2021. She sadly passed away a short time later on 16 October 2021. The death certificate recorded the cause of death as *'debility of old age'*.

7. The complainant felt that as the resident had been left unattended, despite the requirements of her care plan that assistance of 1 or 2 was provided for toileting, this indicated the resident was '*neglected*'.

8. The complainant was dissatisfied with the Care Home's response to her concerns. She felt that she had not received answers to questions she had about what occurred, and so she escalated her complaint to the Trust. The Trust undertook a level one SAI (referred to as a significant event audit) investigation into the incident on 9 September 2021, to consider what led to the residents fall and how the Care Home manged the residents care following the fall.

Issues of complaint

The Care Home

9. I accepted the following issue of complaint about the Care Home for investigation:

Issue One - Whether the care and treatment Bangor Care Home provided to the patient on 9 September 2021 was appropriate and in accordance with relevant care plans, policies and standards.

The Trust

10. I accepted the following issue of complaint about the Trust for investigation:

Issue Two - Whether the Trust conducted an adequate Serious Adverse Incident investigation into a complaint made against Bangor Care Home re an incident on 9 September 2021 appropriately and in accordance with relevant guidance.

INVESTIGATION METHODOLOGY

11. To investigate this complaint, the Investigating Officer obtained from the Care Home and the Trust all relevant documentation together with their comments on the issues the complainant raised. This documentation included information relating to the Care Home's complaints process and the Trust's SAI process.

Independent Professional Advice Sought

12. After further consideration of the first issue, I obtained independent professional advice from the following independent professional advisor (IPA):

    - A Consultant Nurse for Older People (RGN, BA(Hons), MSc, PGCert(HE)), with 21 years' experience specialising in the care of older people across hospital, community and care homes (N IPA).

    I enclose the clinical advice received at Appendix two to this report.

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

Relevant Standards and Guidance

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

    The general standards are the Ombudsman's Principles[2]:

    - The Principles of Good Administration.

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

15. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific legislation, standards and guidance relevant to this complaint are:

    - The Department of Health, Social Services and Public Safety's Care Standards for Nursing Homes, April 2015 (Care Standards for Nursing Homes);
    - The Nursing Homes Regulations (Northern Ireland) 2005, Regulation 30, (Nursing Home Regulations);
    - The National Institute for Health and Care Excellence's Falls in older people: assessing risk and prevention, Clinical Guideline 161, 12 June 2013 (NICE CG161);
    - The National Institute for Health and Care Excellence's Falls in older people, Quality Standard 86, 25 March 2015 (updated 31 January 2017), (NICE QS86);
    - The Nursing and Midwifery Council, The Code, published 29 January 2015, (The NMC Code);
    - The Health and Social Care Board, Procedure for the Reporting and Follow Up of SAIs, November 2016 (SAI guidance); and
    - The South Eastern Health and Social Care Trust, Reporting of Serious Adverse Incidents (SAIs) to the Health & Social Care Board, Policy Code: SET/H&S (07), operational date December 2018 (Reporting of SAIs).

    I enclose relevant sections of the guidance considered at appendix three to this report.

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

17. A draft copy of this report was shared with the complainant, the Care Home, and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the comments I received in preparing this final report.

THE INVESTIGATION

Issue 1: Whether the care and treatment Bangor Care Home provided to the patient on 9 September 2021 was appropriate and in accordance with relevant care plans, policies and standards.

Detail of Complaint

18. The complainant said the Care Home failed to provide the appropriate care and treatment to the resident on 9 September 2021 when she fell.

19. The complainant said staff left the resident alone and unsupervised on the toilet, despite her care plan indicating that she required the assistance of a minimum of one member of staff when toileting.

20. The complainant also questioned why staff moved the resident following the fall, given the NIAS instruction not to move her. The complainant said by moving the resident, the Care Home had breached its own protocol on falls.

21. The complainant said the accounts the Care Home provided to her, her mother, and subsequently the Trust, contained inconsistencies regarding what happened to the resident on 9 September 2021. She felt the Care Home displayed a lack of clarity and integrity by providing different accounts. She explained this led her to believe the Care Home covered up what had taken place. She said she still does not know the full detail of what happened on 9 September 2021.

22. The complainant said the Care Home's written records also differed from the various verbal accounts it provided.

Care Plans and Falls Risk Assessments

23. The complainant raised concerns regarding the Care Home's care plans and risk assessments for the resident. She said that during a meeting Care Home staff

produced some of the resident's care plans which were completed in the same handwriting, leading her to believe they had been re-written following the resident's fall, to cover up any previous inaccuracies. The complainant also said she felt the resident's risk assessments were incomplete and she did not believe they fully reflected the risks the resident faced.

Evidence Considered

Legislation/Policies/Guidance

24. I considered the following legislation and guidance:

- Care Standards for Nursing Homes;
- The NMC Code;
- NICE CG161; and
- NICE QS86.

The Care Home's response to investigation enquiries

25. The Care Home stated it had been short-staffed on that day, despite trying to find cover for an unexpectedly absent staff member at short notice. It accepted staff had left the resident on her own in the bathroom, and that this was contrary to her care plan and falls risk assessments. It also accepted staff moved the resident following her fall, and that they should not have done so.

26. The Care Home stated it therefore accepted the complainant's concerns and acknowledged that there were areas of the resident's care and treatment which fell short in this instance. The Care Home said it had apologised to the complainant for these mistakes.

27. The Care Home also accepted the RN provided differing accounts of what had happened that day. In particular, the RN at one stage said she and the care assistant (CA) who assisted the resident in the bathroom used a hoist to lift the resident off the floor. The RN later said they '*assisted*' the resident '*to stand*' and '*seated her on a wheeled commode*'.

28. The Care Home stated the RN had not kept a detailed record of her actions that day. It explained the RN had also not kept a record of the verbal accounts she provided to different parties. As a result, when it, and later the Trust, investigated the incident, the RN was unable to recall exactly what had happened. The Care Home explained it has been unable to interview the CA, who had since left their job and the Care Home. It explained it could only rely on a brief written record the CA prepared at the time. The Care Home stated it had acknowledged this was unacceptable, and had apologised to the complainant.

29. In addition, the Care Home accepted it had not always ensured the resident's risk assessments were accurately completed. However, it denied it deliberately covered-up any mistakes. It explained its Quality Manager has since addressed this issue with staff as part of their supervisions.

Relevant Chronology

30. I included a chronology of actions and correspondence from documentation the Care Home provided to this office at appendix four of this report.

Relevant Independent Professional Advice

31. I included the IPA's advice at appendix two to this report. I have outlined my consideration of that advice in the analysis and findings below.

Analysis and Findings

Care Plans and Falls Risk Assessments

32. The N IPA advised the resident's care plans noted she was at risk of falls, and that she required the assistance of one to two staff for all her transfers / mobility needs (depending on her level of fatigue when using the rollator). The N IPA also advised the resident required the assistance of one for all toileting needs. The N IPA advised the Care Home's care plans adhered to relevant guidance. In particular, they provided detailed information on the resident's care needs, and made reference to appropriate risk assessments and standardised tools, specifically NICE Guidance and the Care Standards for Nursing Homes.

33. The N IPA advised Care Home records indicate the Care Home appropriately assessed the resident for the risk of falls and put preventative measures in place

34. The N IPA advised the Care Home had a detailed falls risk care plan in place for the resident. She further advised the Care Home completed the resident's risk assessment on admission, and updated it monthly. She advised the most recent review was on the date of the resident's fall, 9 September 2021. The N IPA advised the identified risks factors included the resident's previous fall history, confusion, a long term condition which may increase falls, unsteady walking, and poor vision. The N IPA advised the care plans and risk assessment records were consistent with relevant standards and guidance.

35. I note the Care Home acknowledged its risk assessments for the resident were not always fully accurate. I also note it apologised to the complainant for this in its internal complaints response. The complainant was concerned that the risk assessments did not include that the resident was deaf in one ear. She was also concerned that her weight loss had not been included. I am pleased to note that the Care Home apologised for not ensuring that risk assessments were fully accurate and that steps have been taken to improve practice in the care home. Whilst I note the complainant's concern the Care Home deliberately manipulated these documents, I have not identified evidence which supports this position. I accept the N IPA's advice that, ultimately, the standard of the resident's care plans and risk assessment were sufficient to meet relevant standards.

36. Having considered all relevant evidence, and on foot of the N IPA's advice, despite the issues identified above, I am satisfied the care plans and risk assessments were sufficient, if they had been followed, to appropriately reduce the risk of the resident falling on 9 September 2021.

The Resident's Fall

37. The N IPA referred to Care Home records and advised the CA left the resident alone in the bathroom whilst she went to fetch incontinence pads. The N IPA advised the Care Home's actions during this incident were incorrect and not in accordance with the resident's care plan and her risk assessment for falls. The N IPA advised the resident's care plan specified she required supervision with mobilising. She advised

the resident's continence plan stated that '*she required assistance with toileting needs.'* The N IPA advised that the resident therefore '*should not have been left alone in the toilet for any length of time.'* The absence of detailed contemporaneous records or a swift thorough investigation of the issue means that the complainant and her family still have questions about exactly what occurred. As a result, they have lost trust in the accounts provided, which they consider have not been consistent.

38. I considered the Care Standards for Nursing Homes which states '*Care delivered in nursing homes must be of the highest quality. Care must be delivered by the right number of appropriately trained and qualified staff in line with the most recent, evidence-based practice guidance*.' I consider the Care Home failed to adhere to this standard on this occasion.

39. Whilst I recognise the Care Home had the appropriate care plans and risk assessments for the resident in place, unfortunately it failed to act in accordance with these in this instance resulting in serious consequences for the resident. Having reviewed all relevant evidence, I accept the N IPA's advice and consider the Care Home failed to provide the resident with appropriate care and treatment on 9 September 2021. Had this failure not occurred, it is very likely the resident would not have fallen in the bathroom. This is something that the complainant and her family will always be aware of and understandably feel highly aggrieved about. There is considerable evidence about the significant consequences for elderly persons following falls. In many cases, particularly where the fall causes a significant trauma such as a fracture, the fall leads to a series of events which ultimately mean the individual loses considerable functionality and does not return to their baseline or, as in this case, does not recover leading to decline and death.

Action taken by Care Home staff prior to contacting NIAS

40. The N IPA advised when staff found the resident, they moved her from the floor and onto the commode in a sitting position. I reviewed records obtained from the NIAS and a transcript of the 999 call, during which the call handler said several times not to move the resident unless she was in danger or it was absolutely necessary. Unfortunately, by this time the staff had already moved the resident. The N IPA advised staff, including the RN, should not have moved the resident until they sought advice from the emergency services. Furthermore, the N IPA advised staff should not

have moved the resident without having first checked her for more serious injury, such as hip fracture or spinal fracture. She advised there is no evidence staff did so.

41. In this respect, the N IPA referred to NICE Quality Statement QS86 which sets out the steps to take if an older person has a fall whilst in a hospital. She advised these statements apply equally to Care Home settings. I reviewed the Guidance QS86 and noted:

- *'Statement 4: Older people who fall during a hospital stay are checked for signs or symptoms of fracture and potential for spinal injury before they are moved.*
- *Statement 5: Older people who fall during a hospital stay and have signs or symptoms of fracture or potential for spinal injury are moved using safe manual handling methods.*
- *Statement 6: Older people who fall during a hospital stay have a medical examination'.*

42. It transpired the resident had fractured her right hip in the fall, which required surgery. Having reviewed the N IPA's advice, I am satisfied that by moving the resident prior to fully assessing her for serious injury and prior to seeking direction from the emergency services, the Care Home failed to act in accordance with relevant standards and in the best interest of the resident. Standard 4 of the NMC Code requires nurses to act in the best interests of people at all times. The Code also requires nurses to '*practice effectively*'. I consider the RN failed to adhere to the Code on this occasion. I find this concerning and consider this to be a further failure in the care and treatment the Care Home provided to the resident.

43. Exactly how the resident was moved remains a concern for the complainant and her family. She considers that the family received contradictory verbal accounts which do not match the limited written records which exist. The lack of detailed contemporaneous records has left the complainant with uncertainty as to what occurred following the residents fall.

44. I note that since this incident, and following the outcome of the Trust's SAI, the Care Home has updated its policy on Falls Management to reflect the importance of obtaining advice from the NIAS before moving any resident following a fall. I accept the Care Home has learned from this incident to improve its future practices. Further,

it has included an additional paragraph in its Falls Policy regarding the safety of a resident with a suspected serious injury and the importance of obtaining advice from the NIAS prior to moving a resident in such a situation. I am pleased to note that this updated policy is now in place throughout all the company's Care Homes following this incident.

Care Home's record of the incident on 9 September 2021

45. The N IPA advised '*the Care Home records only provide a partial account of the actions it took. It did not include a contemporary note that they had moved the resident following the fall before she had been assessed by the paramedics*.' She advised the RN should have included this information in her written record of the incident. I reviewed the care home records. I noted the RN did not record any detail regarding the decision to move the resident.

46. I considered the NMC Code, Standard 10 which states that a nurse must keep clear and accurate records relevant to their practice, specifically '*complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event.* This Standard also states that a RN must '*identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need'.* I found the RN failed to adhere to this standard, which I consider to be a failure in record-keeping and therefore maladministration. This failure impacted on the Care Home, and subsequently the Trust's, ability to fully determine exactly what happened that day, including the length of time the resident was alone for in the bathroom. However, I accept the Care Home acknowledged this concern as part of its internal complaints investigation, and correctly apologised to the complainant for this failure as part of its response. I also note it advised it had reminded the RN about the importance of accurate record-keeping.

47. I also considered the N IPA's advice regarding the Care Home's submission of a notification of the incident to both the RQIA and the Trust. In particular she advised the Care Home '*did not report the actions taken to move the resident*' in that submission. I am satisfied the Care Home informed both the Trust and the RQIA about the incident. However I consider the omission regarding having moved the resident prior to the ambulance attending, was a significant fact which the Care

Home failed to disclose on the notification form. I consider this to be a failure by the Care Home to provide a full and accurate account of the incident to these bodies and therefore maladministration.

The RN's accounts of what happened

48. I note the Care Home accepted the RN provided differing accounts of the incident to the complainant, her mother and to the Trust on different occasions. I consider it is therefore reasonable for the complainant to be unsure about exactly what happened that day. Standard 7 of the NMC Code requires nurses to communicate clearly and effectively. I find the RN failed to adhere to this standard, which I consider to be a failure in communication. The Care Home also accepted the RN did not keep a record of the verbal accounts she provided to the complainant and to her mother. I consider this to be a further failure to adhere to Standard 10 of the NMC Code, and therefore a further failure in record-keeping. I consider these failures to be maladministration. Again, however, I am pleased to note the Care Home apologised to the complaint for these failures as part of its internal complaints process, and spoke with RN about the importance of record-keeping.

Summary

49. On foot of my above findings, I consider the care and treatment the Care Home provided to the patient on 9 September 2021 was inappropriate, and was not in accordance with relevant care plans, policies, and standards. Therefore I uphold this issue of complaint.

50. There were two significant issues which contributed to the residents fall:

    (1) the care home did not have the required number of staff at the time of the fall; and

    (2) The residents care plans were not followed.

51. I consider if Care Home staff had followed the resident's care plans, the resident's fall could have been prevented, as could the trauma, pain and discomfort she experienced as a result of her fall, and due to her requiring surgery to her hip. This also caused her to sustain the injustice of distress. I consider the failures also caused the complainant the injustice of distress, as well as frustration and uncertainty

regarding exactly what happened to her Grandmother. As outlined previously, falls in the elderly can lead to very significant consequences as in this case, where ultimately the resident, given her comorbidities, was hospitalised, did not recover following her fall, and sadly died approximately one month later.

Issue 2: Whether the Trust conducted an adequate Serious Adverse Incident investigation into a complaint made against Bangor Care Home re an incident on 9 September 2021 appropriately and in accordance with relevant guidance.

Detail of Complaint

52. The complainant said she does not accept the Trust could have carried out a full and thorough investigation into the resident's fall, given the Care Home provided varying accounts of what happened to her, her family, and the Trust. She said she believes the Trust failed to challenge the variations in these differing accounts. Furthermore, the Trust disregarded the inconsistencies in the Care Home's verbal accounts, and instead accepted the Care Home's written account, which was different again. The complainant also considered the Trust were slow to react to the situation and that it was only when the inaccuracy of the notification was identified that they took action to investigate.

53. The complainant said the Trust focussed its investigation on the events after the incident, as opposed to what happened to cause the fall. In addition, she felt the Trust did not fully address the Care Home's failure to follow the NIAS medical advice about not moving the resident following her fall.

Evidence Considered

Legislation/Policies/Guidance

54. I considered the Health and Social Care Board's SAI Guidance document, and the Trust's document, Reporting of SAIs.

Trust's Response to investigation enquiries

55. The Trust stated it commenced a SAI investigation following receipt and consideration of the complainant's concerns about the Care Home's response to her complaint, and the differing accounts it provided to her about the incident.

56. The Trust denied its SAI investigation was not sufficiently thorough, or that it failed to adhere to relevant standards. It stated it conducted a thorough review of documentation and records the Care Home provided, which included witness statements, incident report, risk assessments, the resident's care plan, as well as her care records. It stated '*all relevant contributory factors were given consideration, including information from NIAS.'* The Trust explained witness statements included the RN's handwritten account of the incident as well as the brief note made by the CA.

57. The Trust stated during its SAI investigation, it noted discrepancies in the accounts of the incident the Care Home provided, and that the Care Home had offered the complainant an apology for this. It also noted the Care Home addressed the RN's record-keeping failures with that staff member directly. In particular, Care Home management spoke to the RN and reinforced the importance of keeping contemporaneous and accurate records of all actions taken following such an incident.

58. The Trust stated it met with the complainant on 21 September 2022 to discuss its SAI report. It said the complainant remained dissatisfied, so it arranged a further meeting with her, senior Care Home managers, a member of staff from the Commissioner for Old People for Northern Ireland (COPNI), to provide further clarification. The Trust acknowledged it had not provided minutes from the meeting on 21 September 2022 in advance of the second meeting on 9 January 2023. It stated it apologised to the complainant for this.

59. The Trust stated it recognised the RN on duty failed to contact NIAS to seek direction regarding moving the resident. It stated the Care Home Company has since updated its policy throughout all its care homes to emphasise the importance of seeking advice from the NIAS before moving a resident following a fall.

60. The Trust stated that when this incident occurred, the Care Home completed a Trust '*Independent Sector Incident Form'*[3] as would be normal practice. The Trust provided a copy of this document. In addition, it said the Care Home also correctly reported the incident to the RQIA on the same date.

Relevant records

61. I considered a range of records provided by the Trust in relation to its SAI investigation.

Analysis and Findings

62. The complainant said she was not satisfied that the Trust carried out a thorough investigation into the incident.

63. I reviewed the Trust's SAI report and found it to be in line with relevant standards. I am satisfied the Trust considered all of the relevant information from the Care Home. I noted the Trust held and minuted two meetings with the complainant and Management of the Care Home during its SAI investigation.

64. A review of documentation the Trust provided established that Trust staff also visited the Care Home to make enquiries, and to speak with staff. My investigation established that the Trust fully documented its communication and meetings with both the complainant and the Care Home during its SAI investigation.

65. I reviewed the Health and Social Care Board's '*Procedure for the Reporting and Follow up of Serious Adverse Incidents'* and noted the Trust undertook a Level One Significant Event Audit (SEA) of the incident. The guidance states a SAI investigation process *'aims to provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users.*' The Guidance also states that the SAI process aims to '*recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs.'*

[3] This is a form for use by all Independent Sector Providers that hold a contract with the SEHSCT to report an incident involving a service user/resident.

66. Paragraph 5.1 of that guidance relates to a level one SEA and states:

'*Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:*

- *assess what has happened;*
- *assess why did it happened;*
- *what went wrong and what went well;*
- *assess what has been changed or agree what will change;*
- *identify local and regional learning.*'

67. I am satisfied, following a review of the Trust's SEA final report and recommendations it made to the Care Home following its review of the full circumstances in this instance, that its investigation was sufficiently thorough to meet this requirement.

68. I also noted the complainant said the Trust focussed on what happened after the incident as opposed what caused the resident to fall. I reviewed the Trust's SAI report. It referred to the staffing levels on the day the resident fell being '*below what would be normal for the unit at the time of the incident.'* It identified that the Care Home had a '*lack of contingency planning / risk management / escalation process for staff members leaving shifts at short notice'.* The report recommended that '*the Care Home process of escalating staffing levels were [sic] it is deemed resident's health and safety may be at risk to be reviewed*.' The report noted that this learning would ensure that '*all nurses, when addressing staff shortages … know how to escalate to the Regional Manager if they are unable to resource the required number of staff for each shift.'*

69. Regarding the incident itself the SAI report identified that the CA should not have left the resident alone in the bathroom. It also said it had not been possible to establish why the CA '*did not alert another staff member to bring the required incontinence products allowing her to remain with [the resident] as per [the resident's] care plan*.' The SAI report noted that the member of staff had since left their post '*which has prevented further clarity being sought.'* However following my review of the SAI

report, I am satisfied the Trust investigated what happened before, during, and after the resident's fall, and that it made a recommendation regarding staffing levels required in the Care Home to ensure resident safety.

70. I also noted the complainant said the Trust failed to challenge variations in the accounts of what happened the Care Home provided. On reviewing the SAI report, I noted the Trust gave its account of what happened. Whilst the report does not specifically address variations in accounts, I am satisfied the Trust spoke to members of staff about what had happened, and it also identified the poor record-keeping by Care Home staff. I concur with the Trust's finding regarding this failing, and note it made a recommendation to the Care Home that '*learning from the incident investigation to be shared with all care home staff regarding incident reporting and providing accurate and timely reports'*. I appreciate it was frustrating for the complainant and her family that the Care Home provided differing accounts of what took place at the time of the resident's fall. It is understandable the complainant wanted the Trust to consider this. Having reviewed the Trust's SAI Report, I am satisfied the Trust acknowledged the inaccuracies within the accounts provided, and it made recommendations to address poor record keeping. Given the lack of records and the delay in commencing the SAI, it is unlikely that any further investigation by the Trust would have provided increased clarity on what occurred.

71. The Trust's SAI report identified that the RN on duty '*failed to contact NIAS to discuss [the] decision to move [the resident] from the toilet floor to the commode.'* The report recommended the Care Home should '*review their [sic] Falls Policy and procedure, with specific reference to moving or transferring a resident following a fall were [sic] serious injury is suspected.'* The report noted that this learning would ensure that all staff would '*adhere to policy, guidance and training to maintain patient safety at all times.'* I noted the complainant said the Trust did not fully address the Care Home's failure to follow the NIAS medical guidance regarding moving the resident following her fall. However, I am satisfied that the Trust addressed this within its recommendation. I also noted the Care Home have since updated its policy regarding this point as a result.

72. The Trust's SAI report identified that '*staff provided a lack of records to evidence their rationale after they moved [the resident] from the toilet floor to the commode'.* The report recommended that '*learning from the incident investigation to be shared with*

all Care Home Staff regarding incident reporting and providing accurate and timely reports in line with contracts policy and procedure with the South Eastern Trust.' The report noted that this learning would ensure that '*comprehensive post fall reviews… after each incident to investigate how the event occurred and identity lessons learned.'*

73. The Trust also recommended that all shared learning from the investigation '*to be disseminated widely within the South Eastern Trust'* in an effort to prevent such incidents occurring in the future.

74. I am satisfied based on my review that the Trust's SAI investigation was appropriate and conducted in line with relevant standards. I am also satisfied that the SAI investigation clearly identified areas for improvement, and included recommendations to improve resident care and safety. I therefore did not uphold this issue of complaint.

CONCLUSION

75. I received a complaint about the care and treatment the Care Home provided to the resident on 9 September 2021. For the reasons outlined in this report, I found failures in the care and treatment the Care Home provided to the resident prior to, during, and after her fall. I also found failures in communication and record-keeping that constitute maladministration. I therefore upheld this issue of complaint. I wish to highlight my concern about the record keeping failures identified and express my surprise that such a significant event was not accurately documented by Care Home staff. I find this to be very poor practice.

76. I consider if Care Home staff had followed the resident's care plans, the resident's fall could have been prevented, as could the significant pain, discomfort and distress she experienced as a result of her fall, and due to her requiring surgery to her hip. I consider the failures by the Care Home also caused the complainant the injustice of distress, as well as frustration and uncertainty regarding exactly what happened to her Grandmother. The Care Home did not have sufficient staff at the time of the fall, the CA did not follow the documented care plan for the resident, which was designed to reduce the risk of her falling. The care home also did not manage the resident appropriately following the fall, and did not create detailed contemporaneous records. Falls in the elderly can have very significant consequences as in this case, where the

fall, the trauma from a fracture, the patient's comorbidities and subsequent operation to repair the fracture alongside an extended period in hospital meant the resident did not recover and subsequently died.

77. I also received a complaint about the thoroughness of the Trust's SAI investigation. For the reasons outlined in this report, I found the Trust's investigation was appropriate and conducted in line with relevant standards. Therefore I did not uphold the second issue of complaint.

78. I wish to take this opportunity to offer through this report my sincere condolences to the complainant and her family for the sad loss of her Grandmother, and to thank her for bringing her concerns to my office in an effort to prevent such occurrences in the future.

Recommendations

The Care Home

79. I recommend that the Care Home restates its written apology to the complainant, this time with detail in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019) for the injustices caused as a result of the failures identified within **one month** of the date of this report. A copy should also be forwarded to NIPSO.

80. I further recommend that, for service improvement and to prevent future recurrence, the Care Home:

    (i) brings the content of this report to the attention of all staff employed at the Care Home;

    (ii) provides refresher training to all staff about the importance of adhering to mobility and personal care plans for residents;

    (iii) provides refresher training to all staff about how they should respond to a fall. This should include the importance of detailed and contemporaneous record keeping regarding any incident involving a resident in the Care Home.

(iv) implements an action plan to incorporate these recommendations and provides me with an update within **six months** of the date of my final report. The Care Home should support its action plan with evidence to confirm it took the recommended action (including, where appropriate, records of training records and/or self-declaration forms which indicate that staff read and understood any new and updated policies).

Whilst I recognise that to some extent my recommendations may have already been addressed within the Trust's recommended Action Plan following its SAI investigation, I wish to see evidence from the Care Home that it has carried out all of the recommendations evidenced by relevant records and documentation.

SEAN MARTIN
Deputy Ombudsman **March 2025**

Appendix 1 - PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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