Investigation of a complaint against the Southern Health & Social Care Trust

Report Reference: 202001080 and 202005667

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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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SUMMARY

This complaint was about a Four Seasons Healthcare Care Home's (the Care Home) actions in response to Covid-19 guidance in the period of 23 March 2020 to 4 January 2021. It was also about how the Southern Health and Social Care Trust (the Trust) monitored the Care Home during this period.

The complainant believed the Care Home did not comply with contemporary guidance on visiting care homes or the implementation of Care Partners[1] during this period. The complainant also believed the Trust did not carry out its responsibilities in relation to providing her late mother with an appropriate level of support from a key worker during a period from March to July 2020.

The investigation identified that the Care Home did not act fully in accordance with the Covid-19 visiting care home guidance in the period of 23 to 28 March 2020. It also did not implement Care Partners within the timelines stipulated in relevant guidance.

The investigation established the Trust did not act in accordance with Department of Health guidance and directions by failing to provide assurance about the Care Home's implementation of Care Partner guidance.

The investigation found there was no evidence the Care Home was required to facilitate exceptional close contact visiting. It also identified the Trust provided appropriate key worker support to the resident in the Care Home during the period. I recommended the Care Home and the Trust each provide the complainant with a written apology for the injustices caused by maladministration.

[1] A Care Partner is a defined practical role to provide additional support to a relative or friend in care homes. A Care Partner is complementary to the care delivered by the staff in the care home. It is individualised and tailored to the needs of the resident. A Care Partner is a close family member or friend who has a long-standing relationship with a resident and plays an essential role on a regular basis on maintaining a resident's health and wellbeing. A Care Partner is in addition to visiting; however, it is not simply another opportunity to visit – A Care Partner supports their relative/friend with an identified need such as encouraging them to eat and drink.

I wish to convey my sincere condolences to the complainant and her family on the sad loss of their mother. Although I did not fully uphold the complaint, I recognise the complainant's concerns for her mother's best interests and hope this report provides the complainant with some reassurance.

THE COMPLAINT

Background and Environmental Context of the Complaint

1. On 11 March 2020, the World Health Organisation (WHO) declared the novel coronavirus (Covid-19) respiratory infection outbreak as a global pandemic. The risk of severe disease and death increased amongst the elderly and those with underlying health conditions. As a result, stringent restrictions were put in place to limit family members visiting their loved ones in hospital or care home settings.

2. This complaint related to the actions of two authorities, a Four Seasons Healthcare Care Home (the Care Home) and the Southern Health and Social Care Trust (the Trust) during the period of 23 March 2020 to 4 January 2021. The complaint concerned the Care Home's compliance with both Covid-19 Visiting and Care Partner guidance and the Trust's fulfilment of its duties in ensuring the Care Home acted in accordance with the guidance. The complaint also concerned the level of input the Trust key worker had with the complainant's late mother (the resident) during the period.

3. Within the relevant guidance, Care Partners were defined as: -
'… more than visitors. Care partners will have previously played a role in supporting and attending to their relative's physical and mental health, and/or provided specific support and assistance to ensure that communication or other health and social care needs are met due to a pre-existing condition. Without this input a resident is likely to experience significant and/or continued distress. Care homes should identify residents who will physically, mentally and/or emotionally benefit from input from a care partner and who they would like to be their care partner. In addition, consideration should be given in individual risk assessments to how the care partner was involved in supporting the resident prior to the Covid-19 pandemic period.'

4. I addressed the complaints against both authorities in this composite report because of their interdependent nature and to provide maximum learning opportunities for both the Trust and the Care Home.

Issues of complaint

The Care Home

5. I accepted the following areas of concern within the complaint about the Care Home for investigation:

Area of concern 1: Whether the Care Home operated in line with up-to-date guidance associated with visiting of the complainant's late mother (the resident) from 23 March 2020 to 4 January 2021.

Area of concern 2: Whether the Care Home appropriately implemented the Department of Health's Care Partner guidance from 23 September 2020 to 4 January 2021.

Area of concern 3: Whether the Care Home appropriately facilitated access of the Trust's key worker to the resident in the care home from 23 March 2020 to 4 January 2021.

The Trust

6. I accepted the following areas of concern within the complaint about the Trust for investigation:

Area of concern 4: Whether the Trust discharged its responsibilities in relation to oversight and monitoring of the Care Home during the period of 23 March 2020 to 4 January 2021 associated with:

i. **Ensuring the Care Home operated in line with up-to-date guidance associated with visiting of the resident during this period; and**
ii. **ensuring the Care Home appropriately implemented the Department of Health's Care Partner guidance in relation to the resident from 23 September 2020 to 4 January 2021.**

Area of concern 5: Whether the Trust discharged its responsibilities in relation to the provision of appropriate key worker support to the resident in the Care Home during this period.

INVESTIGATION METHODOLOGY

7. To investigate this complaint, the Investigating Officer obtained all relevant documentation from both the Care Home and the Trust, together with each authority's comments on the areas of concern the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

8. After further consideration of the areas of concern in the complaint, I obtained independent professional advice from an independent professional advisor (IPA) in relation to the support the Trust key worker provided to the resident. The resident's Trust key worker was a registered nurse, employed as a Nurse Key Worker within the Care Home Support Team. The clinician who provided the advice was:

- A registered nurse; RGN, BA (Hons), MSc, PGCert (HE). A registered nurse tutor and independent prescriber with more than 20 years' experience, specialising in the care of frail older people across hospital, community and care homes, within the NHS.

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

9. 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

10. 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]:

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

- The Principles of Good Administration.

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

    The specific standards and guidance relevant to this complaint are:

    - The Department of Health, Social Services and Public Safety HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance, March 2010 (DoH Care Management Guidance);
    - The Public Health Agency Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland, 17 March 2020 (PHA March 20 Care Home Visiting Guidance);
    - The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland), 28 March 2020 (NI Covid Restrictions);
    - The Department of Health Covid-19 Visiting Update HSC, 9 April 2020 (DoH April 20 Visiting Guidance);
    - The Department of Health Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland, 26 April 2020 (DoH April 20 Care Home Visiting Guidance);
    - The Department of Health Covid -19 Regional Principles for Visiting in Care Settings in Northern Ireland, 30 June 2020 (DoH June 20 Visiting Care Settings Guidance);
    - The Department of Health Rapid Learning Initiative into the Transmission of Covid-19 into and within Care Homes in Northern Ireland, Report of the Task and Finish Group, 2 September 2020 (DoH RLI Report);
    - The Department of Health Visiting in Care Settings in Northern Ireland, 23 September 2020 (DoH Sept 20 Visiting Care Settings Guidance);
    - The Southern Health and Social Care Trust Regional Residential & Nursing Provider Specification and Contract, 1 April 2020 to 31 March 2021 (Trust's Contract);

- The Department of Health Implementation of Care Partners in Care Homes in Northern Ireland, 13 November 2020 (DoH November 20 Care Partner Guidance);
- The Department of Health Letter to Health Trusts and Care Homes: Visiting and Care Partner Arrangements in Care Homes: Access to Covid-19 Testing for Visitors over the Christmas period**,** 16 December 2020 (DoH Christmas Visiting Guidance);
- The Care Home COVID-19 Care Partner Standard Operating Procedure, 23 November 2020 (Care Home's Care Partner Procedure);
- The National Health Service Guidance Communicating with Someone with Dementia (NHS Dementia Communications Guidance); and
- The Care Home Visitor Protocol-Family Members July to September 2020 (Care Home's Visiting Protocol).

12. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the Care Home and Trust's administrative actions. It is not my role to question the merits of a discretionary decision. That is, unless my investigation identifies maladministration in the bodies' process of making that decision.

13. I did not include all the 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.

14. 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.

THE INVESTIGATION

15. I have addressed the areas of concern for both authorities under the following headings:
    - **Issue 1: Compliance with Covid-19 Visiting Guidance during the period of 23 March 2020 to 4 January 2021;**

- **Issue 2: Compliance with Care Partner Guidance during the period of 23 September 2020 to 4 January 2021; and**
- **Issue 3: The Trust Key Worker's Provision of Support to the Resident during the period of 23 September 2020 to 4 January 2021.**

Detail of Complaint

Issue 1: Compliance with Covid-19 Visiting Guidance during the period of 23 March 2020 to 4 January 2021

16. The complainant said, although she repeatedly asked the Care Home to allow her '*access*' to her late mother during the period under investigation, the Care Home did not facilitate this from 23 March 2020 until 4 January 2021. She believed this did not accord with relevant guidance.

17. The complainant also believed the Trust failed to ensure the Care Home operated in line with visiting guidance. She believed this constituted a breach of both the Care Home's contract with the Trust, and the Trust's responsibilities, as specified in relevant guidance.

Evidence Considered

Legislation/Policies/Guidance

18. I considered the following guidance:
    - the PHA March 20 Care Home Visiting Guidance;
    - the NI Covid Restrictions;
    - the DoH April 20 Visiting Guidance;
    - the PHA April 20 Care Home Visiting Guidance;
    - the DoH June 20 Visiting Care Settings Guidance;
    - the DoH Sept 20 Visiting Care Settings Guidance;
    - the Trust's Contract;
    - the DoH November 20 Care Partner Guidance;
    - the DoH Christmas Visiting Guidance;

- the Care Home's Care Partner Procedure;
- the NHS Dementia Communications Guidance; and
- the Care Home's Visiting Protocol.

I enclose relevant sections of the guidance considered at Appendix six to this report.

Trust's response to investigation enquiries

19. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. A summary of the Trust's response to investigation enquiries is at Appendix two to this report.

Care Home's response to investigation enquiries

20. As part of investigation enquiries, the Care Home had an opportunity to respond to the complaint. A summary of the Care Home's response to investigation enquiries is at Appendix three to this report.

Relevant Trust/Care Home records

21. I considered a range of records both the Trust and Care Home provided. The Trust records included minutes from meetings the Trust held with independent care homes and all correspondence the complainant sent to the Trust about these matters.

22. The Care Home provided records associated with Care Partner arrangements, including correspondence with residents' families and records associated with seminars which the Northern Ireland's Chief Nursing Officer facilitated. It also provided visiting records for July to October 2020. The Care Home stated, however, because the Care Home ownership changed several years ago, archived detailed visiting records, which originated and were owned by the Care Home are incomplete.

23. I enclose relevant extracts from the records reviewed at Appendix seven to this report.

Responses to the Draft Investigation Report

24. The complainant, the Trust and the Care Home were given an opportunity to provide comments on the Draft Investigation Report. The responses to the draft of this report have been considered and, where appropriate, comments have been reflected in the report or changes have been made.

The Complainant's Response

25. The complainant said, when the Care Home offered virtual visiting and later *'internal'* visits in August and September 2020 as these did not allow contact between visitors and the resident, these were not appropriate for the resident. She said the resident's particular needs should have been considered under her individual risk assessment. Specifically, the complainant said the visits were in the Care Home porch and no touching or physical contact of the resident was permitted. She said these arrangements were not '*reasonable or proportionate*' as the resident had '*advanced dementia and relied on tactile sensory … [*she*] was also non-verbal, her eyesight had deteriorated and her arms sat in a fixed flexion'.*

The Trust's response

26. The Trust highlighted its understanding of the '*National Covid-19 Lockdown measures'*. Specifically, all care homes stopped face-to-face visiting when lockdown restrictions were first introduced. At this time, the Trust and the Regulation & Quality Improvement Authority (RQIA) also ceased face-to-face professional visiting in Care Homes to reduce footfall and opportunities for the spread of infection. The Trust referenced the '*UK Government['s]*' introduction, on 23 March 2020, of ''*stay at home*'' measures. The Trust stated this *'included all parts of the UK'* with *'the primary measures required'* that people were to stay at home '*except for very limited purposes'* and *'gatherings of more than two people in public*' no longer permitted. The Trust stated these instructions were in place for three weeks initially; however, on 16 April 2020, the '*UK Government extended the 'stay at home' period'* for another three weeks, '*running until at least 07 May 2020*'.

27. The Trust cited the NI Covid Restrictions which the Northern Ireland Executive introduced on 28 March 2020. The Trust stated this legislation made the restrictions in place mandatory, with a framework for legal enforcement. Further, this provided consistency of approach across the UK. The Trust highlighted the main provisions of the legislation. Shopping was to only be for essentials and to be as infrequent as possible; people could take one form of exercise per day, either alone or with household members only; travel only for medical needs or for work, only if you could not work from home; and gathering of more than two people other than from the same household was not allowed except for work or a funeral.

The Care Home's response

28. The Care Home accepted that it did not adhere to the PHA March 20 Care Home Visiting Guidance during the period of 23 March to 25 April 2020. However, the Care Home stated the Covid-19 pandemic was unprecedented and it considers the approach it took was appropriate to safeguard the welfare of both residents and team members. The Care Home referenced the Covid-19 guidance which followed this initial period, which it stated reflected this approach and was *'common across the wider society throughout the UK'.*

29. The Care Home explained it no longer operated in Northern Ireland; therefore, any improvement recommendations would not be applicable.

Further Independent Professional Advice Following Draft Investigation Report Responses

30. Further to the complainant's comments at paragraph 25 above, the Nurse IPA provided advice about whether the forms of visiting the Care Home offered were suitable for the resident's needs. The further advice is enclosed at Appendix five.

Analysis and Findings

31. I considered the records noted in paragraphs 21 and 22 in the context of the periods of time covered by each of the guidance documents.

i. Period one 23 March to 25 April 2020

32. There were no records of in-person visiting between the complainant and the resident in this period. I note there is evidence from the complainant's own article of 6 April 2021 that, during this time, she visited the resident each day at her window. The records confirm the Care Home also offered virtual visiting in this period.

33. The applicable guidance at this time which specifically related to visiting was the PHA March 20 Care Home Visiting Guidance. This emphasised both the use of virtual visiting for care homes and restriction of visiting. However, I note this guidance also specifically stated, '*there was no blanket ban on visits'* and while numbers of visitors should be minimal, the only specification was '*one adult visitor per day*'.

34. I refer to the Trust's comments on the Draft Investigation Report at paragraph 27 above related to the NI Covid Restrictions. Although not specifically about visiting, this legislation restricted everyone's movement from their home other than for very specific reasons. I note the permitted reasons did not include visiting care homes. The legislation stated it is an offence for an individual to be *'outside the place where they are living in contravention of'* the regulations and that person could be instructed to return or forcibly returned to their home by appropriate officials.

35. Unlike the later guidance, issued from June 2020 onwards, the PHA March 20 Care Home Visiting Guidance did not state decisions about visiting lay with care home managers. Further, I note the records indicate, when the Care Home communicated with the complainant about the cessation of visiting, it referenced the PHA March 20 Care Home Visiting Guidance. The records also indicate the complainant challenged the Care Home several times in this period about its interpretation of the PHA March 20 Care Home Visiting Guidance in her attempt to visit the resident.

36. Although the PHA March 20 Care Home Visiting Guidance did not preclude visiting at this time, I consider the NI Covid Restrictions imposed restrictions

which were wider in scope. I consider this included that, from 28 March 2020, the complainant would not have been permitted to travel to visit the resident. I recognise that, in the rapidly changing landscape in which the Covid-19 pandemic evolved, there were ongoing amendments to legislation and regulations. Consequently, changes to guidance in support of legislation took time to keep pace with legislative changes, particularly in the early stages of the pandemic. I recognise this would have caused uncertainty for both care homes and residents' families about the regulations and how best to protect residents, families and staff. However, I consider, from 28 March 2020, the Care Home's decision to cease visiting was reasonable as it accorded with the NI Covid Restrictions. I note these restrictions continued throughout this period to 25 April 2020 and beyond. Further, I consider where there are potentially conflicting requirements between legislation and guidance, compliance with legislation is pre-eminent. Therefore, I am satisfied that the Care Home's actions did not align with the PHA March 20 Care Home Visiting Guidance during the specific period of 23 to 28 March 2020. I consider this constitutes maladministration. I will expand on this finding later in this report.

37. I also considered the Trust's responsibilities during this period. The complainant raised concerns with the Trust about visiting access on 25 and 30 March 2020. At that juncture, there was no specific guidance related to requirements for Health and Social Care Trusts (HSCTs) to gain assurance from care homes about adherence to visiting guidance. However, the Trust's Contract stipulates that providers comply with '*relevant legislation or DHSSPS guidance'.* I refer to the Trust's statement that *'it would be impossible'* for the Trust to provide the necessary staffing resources required to '*ensure that compliance with [all relevant legislation and guidance] is embedded into practice'.* Although I consider this to be reasonable, I note the Trust also stated that it employed a range of measures to identify and address areas of unsatisfactory providers' performance and these measures included carer input/feedback, complaints and incident reporting. I consider the complainant's correspondence with the Trust of 25 March 2020 about restrictions to visiting constitutes feedback which the Trust should have considered as relevant to the Care Home's compliance with relevant guidance. However, I refer to my finding

at paragraph 36 above. Three days after the complainant's first correspondence with the Trust, the Care Home's policy of restricted visiting accorded with the NI Covid Restrictions legislation.

38. I refer to the Trust's comments on the Draft Investigation Report that, in the context of the overall national lockdown measures from 23 March 2020, it understood the UK Government's '*stay at home'* measures applied throughout the UK, and it took actions and decisions on this basis. I recognise the Covid-19 pandemic was unprecedented. Further, there was widespread uncertainty, particularly in this early period, and exceptional pressures on health services with prioritisation of acute services. Therefore, I consider it was reasonable the Trust did not pursue the complainant's comments about the visiting restrictions within the short period of three days from 25 to 28 March 2020, during which there was conflicting guidance from a range of sources. I also consider that, in period one, as the Care Home adhered to legislation from 28 March 2020, there was no further need for Trust intervention. This legislation was also in place when the complainant contacted the Trust on 30 March 2020.

ii. Period two: 26 April to 5 July 2020

39. As noted in paragraph 32 above relating to period one, in period two there were no records of in-person visiting between the complainant and the resident. However, the complainant visited the resident each day at her window and the Care Home also continued to offer virtual visiting. I note the guidance which applied during this period, the DoH April 20 Care Home Visiting Guidance, only permitted in-person visiting to care homes for residents at end-of-life. I therefore am satisfied that, during period two, the Care Home acted in accordance with the existing guidance.

40. Consequently, although during this period the complainant raised concerns with the Trust on 26 April and 6 May 2020, because the Care Home complied with the guidance of the time, the Trust had no need to challenge the Care Home's actions. I have not identified any maladministration in relation to either the Care Home or the Trust's actions during this period.

iii. Period three: 6 July to 22 September 2020

41. The Care Home stated internal visiting[3] began on 6 July 2020. However, the resident was unable to avail of visiting prior to 5 August 2020 because of her hospital admissions and associated isolation. The Care Home changed ownership after the period under investigation and, despite an *'extensive search of archived records'*, unfortunately the Care Home could not identify a complete set of records for the relevant period. Consequently, the Care Home could not provide contemporaneous visiting records for the period of 6 to 20 July 2020. Therefore, I cannot definitively determine if the Care Home correctly applied the DoH June 20 Visiting Care Settings Guidance during that period.

42. The Care Home's internal visiting records evidence that, from 20 July to 1 November 2020, it facilitated internal visiting for residents. This was except for a period of three weeks, during which the Care Home had designated Covid-19 outbreak status when in-person visiting stopped, except for residents at end-of-life. I note the Care Home offered this visiting in a porch area and not in residents' rooms, which accorded with the DoH June 20 Visiting Care Settings Guidance.

43. During the week of 20 July 2020, the internal visiting records evidence the Care Home facilitated visits to several other residents. The records evidence a planned visit to the resident on 23 July 2020. This was crossed out, with a note that the reason for this related to the resident's hospitalisation and isolation. In the following week of 27 July 2020, there were records of visits to a significant number of other residents. I note in the period of 6 August to 12 September 2020, the records evidence the Care Home facilitated visits to the resident from at least one of her daughters each week, with two visits during the week of 24 August 2020.

44. Due to Covid-19 outbreaks from 14 September 2020, in line with the existing guidance, the Care Home could not accommodate internal visits. I note the records evidence, in the period of the Covid-19 outbreak, the Care Home

[3] The Care Home has explained internal visiting was when family members could visit residents in-person usually indoors rather than virtual or window visits.

facilitated assisted window visiting between the resident and her family, including the complainant, on 17 and 22 September 2020. The Care Home also facilitated this form of visiting throughout the outbreak period as noted under period (iv) in paragraphs 46 and 47 below. Records indicate the Care Home also continued to offer virtual visiting. I am satisfied the Care Home acted in accordance with existing guidance during period three. I have not identified any maladministration in relation to the Care Home's actions during this period.

45. The records indicate the Trust investigated the Care Home's actions when the complainant raised concerns about visiting access with the Trust on 8 July 2020. It concluded the Care Home acted in accordance with the existing guidance. I note, in addition, the minutes of the six meetings between the Trust and care home managers, during the period of 2 July to 17 September 2020, evidence the Trust discussed visiting access at each of these meetings. This included confirming with care home managers about each home's actions when implementing the guidance. Therefore, I am satisfied the Trust discharged its responsibilities in relation to the Care Home's compliance with relevant Covid-19 visiting guidance at this time. I have not identified any maladministration in relation to the Trust's actions during this period.

iv. Period four: 23 September to 23 December 2020

46. Following the implementation of the DoH Sept 20 Visiting Care Settings Guidance, the Care Home continued in outbreak status until the week of 5 October 2020. During this period of 11 days, from 23 September to 4 October 2020, the records evidence that, in addition to virtual visiting, the Care Home facilitated assisted window visiting between the resident and her family on four occasions. This equated to two visits during week commencing 21 September 2020 and three during the week of 28 September 2020.

47. The internal visiting records evidence that, after the Care Home's release from outbreak status, over a period of four weeks from 5 to 31 October 2020, the Care Home facilitated six in-person visits between the resident and her family. I note the complainant visited each of these four weeks, with her sister visiting during two of these weeks. Further, during this period, the Care Home also

facilitated assisted window visits with the resident's family on six occasions. These visits constituted three in one week, two in the second week, and one in the last week of the period.

48. I note the records indicate, from 6 November 2020, the Care Home continued in Covid-19 outbreak status for most of the period until the resident's hospitalisation from 23 December 2020.

49. I note the DoH Sept 20 Visiting Care Settings Guidance refers to consideration of local and regional surge levels in relation to variations in the applicability of visiting protocols. Although this is of relevance in the context of the Care Home's facilitation of visiting in the resident's room, as the investigation could not identify accurate historical information about local surge levels, I am unable to determine whether the Care Home appropriately applied this aspect of the guidance. I am satisfied, however, the Care Home acted in accordance with the core guidance related to visiting in this period. I have not identified any maladministration in relation to the Care Home's actions during this period. The DoH Sept 20 Visiting Care Settings Guidance also included requirements associated with Care Partners. I consider this under Issue two below.

50. The Trust held regular meetings with managers from all care homes under contract with the Trust. The Trust required each care home to be represented at these 'hub' meetings. The minutes of these meetings on 1 and 15 October, and 10 and 17 December 2020, evidence the Trust discussed visiting in care homes in the context of the DoH Sept 20 Visiting Care Settings Guidance. It provided advice and guidance about care homes' concerns and challenges about the revised guidance.

51. I consider the Trust position that it did not have the required resources to *'ensure that compliance with each [piece of guidance] is embedded into practice'* reasonable. This is particularly because of the additional pressure the Covid-19 pandemic put on the sector. Further, I note the DoH Sept 20 Visiting Care Settings Guidance specifically stated the responsibility for decisions about visiting access lay with care home managers. Therefore, I am satisfied the

Trust discharged its responsibilities in relation to the Care Home's compliance with relevant Covid-19 visiting guidance at this time. I have not identified any maladministration in relation to the Trust's actions during this period. I consider compliance with Care Partner guidance under Issue two below.

The resident's specific requirements

52. The Nurse IPA advised she '*reviewed the available evidence … to identify'* if the Care Home and the Trust Key Worker recognised the resident *'needed tactile communication, and if so whether that could have been permitted under the legislation and guidance at the time'*. She referenced the DoH April 20 Visiting Guidance and advised, *'it is clear that exceptional visiting was restricted to people who were at end of life'.* I note her advice that she could not find evidence the resident met '*this definition at that time'*.

53. The Nurse IPA referenced the DoH June 20 Visiting Care Settings Guidance and advised that those residents with specific support and assistance needs should have been able to access this within the parameters of infection control protocols. However, such exceptions were discretionary, dependent on the Care Home Manager's decision. '*The decision should have been based on the legislation, recorded need and the clinical judgement of the Senior Nurse (which would have included safety considerations)'.*

54. The Nurse IPA advised, *'it is important to recognise that there are a number of aspects to communication with a person with advanced dementia, and these would have needed to have been interpreted into the care planning before a decision about visiting could be made'.* She referenced the NHS Dementia Communications Guidance related to non-verbal communication. She advised, *'tactile communication eg holding the person's hand, is not the same as using non-verbal cues, (which might be facial expressions, gesture or other body movements), although it can be used as part of non-verbal communication'.* The Nurse IPA advised that the resident's care plan which included '*domains of need'* indicated the resident was not able to communicate her needs verbally but her sight and hearing were good. She referenced the resident's care plan and assessment records and advised, although the complainant raised

concerns about the visiting restrictions, tactile communication is not recorded as required. The Trust Key Worker and the complainant were involved in the review which took place in August 2020. I note her advice there was no evidence of any further directions for communication care or visiting which could have been planned into the resident's care upon which '*exceptional visiting might have been considered for the resident'* at the Care Home Manager's discretion.

55. I accept the Nurse IPA's advice. I am satisfied, in the first and second period, the resident did not meet the criteria for close contact visiting as outlined in the relevant legislation and guidance. Further, I am satisfied that, although in the third and fourth periods such exceptional visiting may have been possible and I recognise the integrity of the complainant's concerns about the resident's need for closer contact, there is no evidence this was identified as needed by the resident for the Care Home Manager's consideration. Therefore, I do not uphold this element of the complaint.

Summary

56. In relation to the Care Home's compliance with Covid-19 Visiting Guidance during the period of 23 March 2020 to 4 January 2021, I refer to my findings at paragraphs 36, 39, 44, 49 and 55. I consider the Care Home's failure to act fully in accordance with the PHA March 20 Care Home Visiting Guidance during period one, specifically from 23 March to 28 March 2020, is not in accordance with the first Principle of Good Administration, '*Getting it right*' which requires public bodies to act in line with relevant guidance. I consider this constitutes maladministration. Therefore, I partially uphold this issue of complaint in relation to the Care Home.

57. In relation to the Trust's actions to ensure the Care Home's compliance with Covid-19 Visiting Guidance during the period of 23 March 2020 to 4 January 2021, I refer to my findings at paragraphs 38, 40, 45 and 51. Therefore, I do not uphold this issue of complaint in relation to the Trust.

Injustice

58. I considered carefully whether the Care Home's failing caused injustice to the resident and her family. I consider the resident, and her family sustained the injustice of a loss of opportunity for continued in-person contact during this period. I also consider, because of this, the resident and her family sustained the injustice of distress about this separation and the resident's family sustained the injustice of worry about the resident.

Detail of Complaint

Issue 2: Compliance with Care Partner Guidance during the period of 23 September 2020 to 4 January 2021

59. The complainant said the Care Home failed to facilitate Care Partners as specified in the DoH Sept 20 Visiting Care Settings Guidance. The complainant also said the Trust did not carry out its responsibilities in relation to ensuring the Care Home complied with the Care Partner guidance.

Evidence Considered

Legislation/Policies/Guidance

60. I considered the DoH Sept 20 Visiting Care Settings Guidance, the Care Home's Care Partner Procedure and the Trust's Contract.

Trust's response to investigation enquiries

61. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to investigation enquiries is at Appendix two to this report.

Care Home's response to investigation enquiries

62. As part of investigation enquiries, the Care Home had an opportunity to respond to the complaint. The Care Home's response to investigation enquiries is at Appendix three to this report.

Relevant records

63. I considered a range of records provided by the Trust and the Care Home. The Trust records included minutes from meetings the Trust held with independent care homes and all correspondence the complainant sent to the Trust about these matters. The Care Home provided records associated with Care Partner arrangements. These included correspondence with residents' families and records of seminars facilitated by Northern Ireland's Chief Nursing Officer. It also provided visiting records for July to October 2020. The Care Home stated the archived visiting records were incomplete.

Responses to the Draft Investigation Report

The Complainant's Response

64. The complainant cited the Rapid Learning Initiative (RLI) as new evidence relevant to the introduction of care partners. She said the Care Home and the Trust were both represented on the RLI and this evidenced that both had prior engagement with the concept of care partners; specifically, from June 2020. The complainant said the RLI '*highlighted a need for change specifically for residents and their families and the visiting'.*

The Trust's response

65. The Trust stated the RQIA was responsible for ensuring that Covid-19 requirements were implemented in care homes. The Trust stated it considers the Trust was responsible for informing and encouraging care homes in relation to any changes in guidance, rather than to enforce guidance. The Trust stated it does not consider it did not act in line with the DoH Sept 20 Visiting Care Guidance and subsequent Department of Health (DoH) directions in relation to ensuring the Care Home's compliance with Care Partner implementation. The Trust stated, when this guidance was introduced, the Trust reconfigured its normal Monday to Friday Care Home Support Team to provide a seven-day Care Home Hub to support care homes with ongoing Covid-19 outbreaks. Further, it understood the challenges Covid-19 presented care homes. These included maintaining staffing levels, sourcing PPE, maintaining infection prevention and control measures and the COVID-19 testing programme. The

Trust stated it also understood the impact these challenges had on care homes' ability to meet the timescale for the introduction of the DoH Sept 20 Visiting Care Guidance.

66. The Trust stated it provided care homes with advice and encouragement about Care Partners, and care homes assured the Trust of progression of the implementation of this guidance. The Trust stated the Care Home itself informed the Trust it had developed a Care Partner policy and begun engagement with potential Care Partners. The Trust reiterated it discussed the DoH Sept 20 Visiting Care Guidance as a standing agenda item at all the Care Home Manager meetings. It then escalated any issues raised at these meetings to the former regional Health and Social Care Board (HSCB) and Public Health Agency (PHA) care home forums. The Trust referenced the DoH Christmas Visiting Guidance. It stated care home managers were responsible for decisions about care home visiting based on risk assessments. The Trust stated, although the Trust's contract requires providers to comply with relevant legislation and guidance, in this case, the guidance required individual care home managers to implement a risk-based assessment approach. The Trust also stated the DoH Christmas Visiting Guidance required Trusts to gain assurance of the risk-based approach and to provide '*support and advice'* when care homes experienced challenges related to individual residents.

67. The Trust highlighted the Trust's involvement in the Regional Assistant Director Forum, which also included representatives from RQIA, PHA, the former HSCB and other Trusts. The challenge associated with Care Partner implementation was a frequent topic of discussions at this forum, with regional solutions discussed and considered. The Trust stated this clearly indicates the Trust actively engaged with the Care Home, the PHA and the former HSCB during the period September to December 2020. This engagement included seeking clarity about the implementation of Care Partners. The Trust highlighted the challenges and difficulty for Care Homes in implementing Care Partners when there were ongoing queries which remained unresolved.

68. The Trust highlighted the meeting between the Care Home Manager and the Complainant on 9 December 2020, at which they discussed the implementation of the Care Partner model which was to begin on 14 December 2020. The Trust referenced the Covid-19 outbreaks in the Care Home in September 2020, in the period of 6 November and 5 December 2020 and on 8 December 2020 which impacted on the Care Home's ability to implement Care Partners. The Trust stated this demonstrates the Care Home was preparing to implement Care Partners prior to 10 December 2020.

69. Both the Trust and the Care Home highlighted that Care Partner arrangements were no longer in operation. The Trust specified that it clarified this at the Regional Care Home Leads meeting on 28 August 2024, which the PHA attended.

Further Investigation Enquiries Following Draft Investigation Report Responses

70. I refer to both the complainant's comments about the Trust's involvement in the RLI and the Trust's comments that the RQIA was responsible for care homes' compliance with Covid-19 requirements, including implementation of Care Partners. Consequently, the DoH provided clarification on these issues. Key extracts of the DoH response are enclosed at Appendix eight to this report.

Analysis and Findings

71. I refer to the DoH RLI report. There are 24 recommendations across six themes. Within these there are three which relate to visiting. Specifically, *'provide appropriate technology to enable virtual visiting'*; '*provide clear and consistent visiting guidance for care homes';* and *'provide dynamic risk assessment training that enables care homes to manage a range of areas including safe visiting arrangements and implementation of physical distancing measures underpinned by a rights based approach'*. Further, the report states the PHA will be asked to *'co-ordinate the implementation of the recommendations'*, working with the HSCTs and care homes and report back to the Chief Nursing Officer (CNO) *'within 3 months'.* I note, beyond improving support for virtual visiting, there is no reference to any specific arrangements

related to visiting; this includes no reference to Care Partners or any similar proposal.

72. I refer to the DoH's response to enquiries. I note the DoH's statement that the RLI report recommendations were related to '*policy and practice to prevent/mitigate the impact of further transmission of Covid-19 into and within care homes'.* Further, the PHA and the RQIA, and not HSCTs, were responsible for taking forward and coordinating different aspects of the recommendations.

73. I refer to the DoH Sept 20 Visiting Care Settings Guidance and the DoH November 20 Care Partner Guidance. I note these state that HSCTs should seek assurance that care homes were acting in accordance with the visiting guidance. In the DoH November 20 Care Partner Guidance, suggested actions included provision of support and advice; consideration as to whether bespoke arrangements were in place for individual needs while balancing the risks of infection; consideration of whether arrangements were in place to *'recognise and facilitate the role of care partners'*; and ensuring families were involved in agreeing visiting arrangements.

74. I refer to the DoH's response to enquiries in relation to Care Partners. The DoH stated it expected Care Partners to be introduced in care homes by early November 2020; however, Care Partner arrangements were *'not mandatory or underpinned in legislation'*. I note the DoH stated that the DoH November 20 Care Partner Guidance assigned responsibility for the assessment of visiting approaches in care homes to the RQIA, with this requirement material to the RQIA's inspection and regulation of care homes. Further, the RQIA reported to the PHA weekly on compliance and, where the RQIA identified compliance issues, the CNO's team worked with the relevant HSCT and the PHA to engage with the care home's management to identify solutions and encourage compliance. The DoH stated, *'the rates of infection and consequent rates of deaths was a matter of serious concern to care home managers'*. Consequently, some care home managers were reluctant to increase the footfall which would result from the introduction of Care Partners. This led to

necessary intervention from the DoH, HSCTs, the PHA and the RQIA with some care homes to encourage compliance.

75. The minutes of the Trust's meetings with care home managers indicate it discussed Care Partners during all seven meetings held during the period from 1 October to 17 December 2020. These minutes clearly indicate care homes faced challenges to the implementation of Care Partners, including a lack of clarity about the role. The records also evidence that the Trust and care homes discussed these difficulties, with the Trust escalating concerns to other agencies outside these meetings, while encouraging care homes to also direct concerns to other forums on their own behalf. I note, however, the minutes of these meetings evidence care homes and the Trust understood the DoH expected the implementation of Care Partners by 5 November 2020.

76. The minutes of the Trust's meeting with care home managers on 26 November 2020 documented, *'[ ] advised that Trusts have been asked to seek an assurance from the Care Homes that Care Partners will be implemented by each Care Home. [ ] is working with [ ] Head of Contracts to draft a letter to go out to all Care Homes'.* I note, however, the minutes of the meeting of 10 December 2020 also stated, *'the Trust was asked to get an assurance from Care Homes that Care Partners are being implemented. [ ] advised that a letter is being drafted by the Trust to share with Care Homes'.*

77. I note the DoH issued further guidance and carried out engagement with care homes about the Care Partner concept after the date of expected implementation, specifically on 13 and 16 November 2020 respectively.

78. The records indicate, following the issue of the Care Home's Care Partner Procedure, the Care Home initiated arrangements with potential Care Partners to discuss the proposed process on 27 November 2020. The discussion with potential Care Partners took place on 1 December 2020 and included the complainant. The Care Home provided a response to further queries about the Care Partner process from the complainant on 2 December 2020. I note, in this response, the Care Home stated, '*the Home Managers will commence*

engagement [with] potential Care Partners week commencing 7th December 20'.

79. I refer to a letter from the Care Home to residents' families, undated but which appears to have issued in the first half of December 2020. In this letter the Care Home referenced the DoH Sept 20 Visiting Care Settings Guidance and stated, *'we … are ready to introduce the Care Partner role into the Homes, where this is applicable'.* I note it also stated, *'our Managers are currently identifying relatives/friends whom they believe would have fitted into the above-mentioned role previously and will be in touch to talk through the process required to enable the role to be implemented within each individual Home'.*

80. I note, on 18 December 2020, in response to an email from the complainant of 9 December 2020, the Care Home referenced the Covid-19 outbreak at the Care Home. It stated the outbreak suspended the introduction of the Care Partner role.

81. I consider the DoH's guidance and subsequent correspondence from 23 September 2020 onwards to care homes and HSCTs clearly indicated 5 November 2020 as the date for implementation of Care Partners. I consider the DoH's response to investigation enquiries confirms that it expected implementation of Care Partners by early November 2020, with the caveat these arrangements were not *'mandatory or underpinned by legislation'.* Although the specific phrasing of this requirement varied slightly across individual DoH documents, I consider even the most flexible wording that care homes should *'have implemented, or be progressing the implementation of, care partners in their care home'* indicates care homes should have completed any preparatory work by 5 November 2020.

82. I refer to both the Care Home's response to enquiries, in which it stated preparatory work included *'developing new policies, protocols, documentation and dynamic risk assessments',* and the Care Home's engagement with potential Care Partners from 29 November 2020. I consider the evidence confirms the Care Home did not complete its preparatory documentation before 23 November 2020, with other preparatory work with residents' families

ongoing in early December 2020. I also consider the minutes of the Trust's meetings with care home managers confirm the Trust and care home managers clearly understood the DoH requirement of 5 November 2020 implementation.

83. Both the Trust and the DoH have stated the RQIA was responsible for monitoring care home compliance with visiting arrangements. However, I consider there are clear references in the DoH Sept 20 Visiting Care Settings and the DoH November 20 Care Partner Guidance to HSCTs' role in providing assurance around the guidance. Further, the correspondence of 12 November 2020 indicates HSCTs should have been urgently and actively seeking this assurance. 'Compliance' is defined as acting in accordance with a requirement and 'assurance' is defined as providing confidence in the effectiveness or quality of the system or arrangements in place. I consider, within both the DoH Sept 20 Visiting Care Settings and the DoH November 20 Care Partner Guidance, the specific differences in the roles and responsibilities for HSCTs and the RQIA in relation to 'compliance' monitoring and 'assurance' of the implementation of visiting arrangements in care homes, including Care Partners, are not clearly defined. I consider it is evident from the records that the Trust engaged with care homes about the visiting guidance and provided support and advice in relation to issues raised. However, although the Trust stated the RQIA was responsible for ensuring compliance, I consider the minutes of the Trust's meeting with care home managers on 26 November 2020 evidence the Trust understood the DoH required it to issue a letter to care homes about assurance. Despite this, ten working days after this meeting, and approximately five working weeks after the implementation date of 5 November 2020, at the meeting on 10 December 2020, the Trust had not yet issued the letter.

84. In reviewing the minutes of the Trust's meetings with care home managers, I recognise care homes faced challenges in implementing Care Partners. I also refer to the DoH's response to enquiries which supports this. However, the DoH correspondence of 12 and 13 November, and 16 December 2020, indicates

that there were care homes which were able to implement Care Partners in line with the specified timelines.

85. The Care Home had a Covid-19 outbreak status from 6 November to 4 December 2020, and then again from 8 December 2020. I consider this would have prevented active Care Partners' access to the Care Home. However, I consider the Care Home failed to act in line with the DoH Sept 20 Visiting Care Settings Guidance and subsequent DoH directions in relation to Care Partners from 5 November 2020 to 10 December 2020. This is because the DoH guidance and the DoH's response to investigation enquiries clearly indicate that care homes should have implemented Care Partners by 5 November 2020. The Care Home had not completed even the required preparatory work before 27 November 2020 and did not confirm potential Care Partner arrangements with residents' families before 1 December 2020, at which point the Care Home indicated planned implementation of Care Partners from 7 December 2020. Although the Covid-19 outbreaks in the Care Home referenced above affected potential Care Partner involvement during the expected period of Care Partner implementation, if these had not occurred, the Care Home would have been unable to implement the scheme by the required date. The resident was admitted to hospital on 23 December 2020 where, sadly she died on 4 January 2021.

86. Although the RQIA and HSCTs' specific roles and responsibilities and the scope of these are not clearly defined in relation to the implementation of Care Partners, I am satisfied the DoH Sept 20 Visiting Care Settings and the DoH November 20 Care Partner Guidance specify that the Trust had a role in this. I am also satisfied there is evidence the Trust understood this in November 2020. I also consider, if the Trust was unclear about its role and responsibilities, it would have been reasonable to have sought clarification from the DoH. Therefore, I am satisfied that, from 5 November 2020 until, at minimum, 10 December 2020, the Trust failed to act in accordance with the DoH Sept 20 Visiting Care Settings Guidance and subsequent DoH directions in relation to ensuring the Care Home's compliance with Care Partner implementation.

87. I refer to my findings at paragraphs 85 and 86. I consider the Care Home and the Trust both failed to act in accordance with the first Principle of Good Administration, '*Getting it right*' which requires public bodies to act in line with relevant guidance. I consider these failings constitute maladministration and uphold this issue of complaint in relation to both the Care Home and the Trust.

Injustice

88. I considered carefully whether the failings caused injustice to the resident and the complainant. The first of the Covid-19 outbreaks in the Care Home, from early November to early December 2020, coincided with the period during which the DoH expected care homes to have implemented Care Partners. The further Covid-19 outbreak occurred a short time later. However, there was a short period of three days between these outbreaks from 5 to 7 December 2020. I consider, during this period, if the Care Home had implemented Care Partners within the required timescales, the resident and her family would have had the opportunity to avail of the benefits of the Care Partner scheme. Therefore, I consider the resident and the complainant sustained the injustice of a loss of opportunity of benefiting from the in-person contact which a care partner would have provided. I also consider the resident sustained the injustice of a loss of opportunity to benefit from the additional support of an assigned care partner. I also consider, because of this, the resident and the complainant sustained the injustice of distress about their separation and the complainant sustained the injustice of worry about the resident.

Detail of Complaint

Issue 3: The Trust Key Worker's Provision of Support to the Resident during the period of 23 September 2020 to 4 January 2021.

89. The complainant said the Trust Key Worker did not provide sufficient support to and monitoring of the resident during the period of investigation

Evidence Considered

Legislation/Policies/Guidance

90. I considered the DoH Care Management Guidance, the DoH RLI Report and DoH Sept 20 Visiting Care Settings Guidance.

Trust's response to investigation enquiries

91. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to investigation enquiries is at Appendix two to this report.

Care Home's response to investigation enquiries

92. As part of investigation enquiries, the Care Home had an opportunity to respond to the complaint. The Trust's response to investigation enquiries is at Appendix three to this report.

Relevant records

93. I reviewed the Trust key worker records for the period from 23 March 2020 to 4 January 2021.

Relevant Independent Professional Advice

94. The Nurse IPA provided advice on the requirements of both the DoH Care Management Guidance and DoH Sept 20 Visiting Care Settings Guidance related to the resident's key worker responsibilities and how the Trust Key Worker complied with these requirements. The Nurse IPA's full advice is at Appendix four to this report.

Responses to the Draft Investigation Report

The complainant's response

95. The complainant queried the Nurse IPA's inclusion of Trust actions which occurred prior to the period under investigation. She also queried the Trust Key Worker's role and responsibility in relation to the safeguarding incident.

The Trust's response

96. The Trust referenced its previous response to this office and reiterated that the key worker worked with the Care Home and the complainant to support the Care Partner implementation in November and December 2020. The Trust stated this work was then suspended because of the Covid-19 outbreaks in December 2020; however, it *'confirmed'* the Key Worker was involved in the Care Partner implementation process.

Further Independent Professional Advice following Draft Investigation Report responses

97. Further to the complainant and Trust's comments on the Draft Investigation Report and receipt of additional information and evidence from the DoH, the Nurse IPA provided further advice and clarification in relation to several aspects of the Trust Key Worker's involvement with the resident and her family. This included clarity about the Key Worker's role and responsibilities, including that related to support in the Care Partner process and monitoring and reporting of potential neglect and review of the Key Worker and other health professionals' specific involvement and engagement within the period of investigation. The further advice is included at Appendix five.

Analysis and Findings

The Trust Key Worker Provision of Support in line with DoH Care Management Guidance

98. I note the DoH Care Management Guidance states the Trust case manager, in this case the resident's key worker, should '*make sure that reviews take place … no less than annually and ensure that reviews are person-centred and inclusive, take into account the experience/views of service users and carers, and service providers'.*

99. I note the records indicate, during the period under investigation, the Trust Key Worker carried out one 'person-centred review' in which they addressed all aspects required. This took place on 3 August 2020. The records also indicate, in line with the requirements of the DoH Care Management Guidance, the

service provider (the Care Home), the resident's family, who represented both themselves and the resident as she did not have capacity, participated in this review.

100. The Nurse IPA referenced the DoH Care Management Guidance as the applicable standard and guidance related to the role and responsibilities of the resident's key worker. The role incorporates the responsibilities of a *'case manager'* who should maintain an overview of the resident's needs, *'embedding a common language of assessment; care planning; response; and improving trust, communications and information sharing'* between the resident, carers and service providers. An annual '*formal review'* is required. *'The key worker would not necessarily be required to visit the resident in person outside of any review meetings, unless indicated'.* The Nurse IPA concluded, the Key worker's role was to apply and document the NISAT stages, referring to other health professionals or service providers 'where appropriate' and respond to and document any issues and queries from the resident's family. I note her advice there were no stipulated changes related to the Trust key worker's role during this period of the Covid-19 pandemic.

101. I note the Nurse IPA advised the Trust key worker carried out the review on 3 August 2020 in accordance with the DoH Care Management Guidance. The review included *'person-centred information recorded in all domains,'* and which '*the Key Worker, the resident's daughter and others' 'signed-off.'* Further, she explained her inclusion of engagement records which pre-date the period of investigation. Specifically, the specialist reviews of an Occupational Therapist, Speech and Language Therapist, Dentist and podiatrist *'were likely to include prospective care planning elements relevant'* to the Key Worker's annual review. The review on 3 August 2020 *'needed to acknowledge whether the earlier specialist reviews continued to have currency'*.

102. In providing further advice the Nurse IPA confirmed that the *'resident's reviews were carried out in line with standards and guidance. Communication with the resident's family was logged appropriately with responses to all correspondence also logged … The resident's daughter was involved in the*

review meetings.' I note her advice the care plan did not require amendment at the resident's review in August 2020. Therefore, the care plan continued to meet the resident's needs, with no further specialist referrals indicated at that time.

103. The Nurse IPA also advised, at the time of the resident's review, the safeguarding referral was ongoing, and the Trust Key Worker documented this in the resident's records. Specifically, this included the safeguarding concern and progress of the associated investigation. I note she concluded the Trust engaged with the complainant about the safeguarding concerns and *'this included Key worker involvement'.*

104. I note the Nurse IPA's advice about the complainant's correspondence with the Trust from early in the period of lockdown. Specifically, the correspondence was not directed to the Trust Key Worker and there is no evidence of the Trust Key Worker's involvement in these enquiries.

105. The Nurse IPA advised that the *'guidance does not require the Key Worker to visit in person in order to assess the resident's standard of personal hygiene'* nor are they responsible for either *'the actions of the care home staff'* or to *'directly monitor the care given at the bedside*'. I note this included consideration of issues related to the Care Home's infection prevention control measures and the use of personal protection equipment.

106. I note the Nurse IPA concluded the Trust Key Worker *'discharged their responsibilities appropriately'*.

107. I consider the records indicate the Trust key worker conducted a 'person-centred' review in accordance with relevant guidance and documentation. I also accept the Nurse IPA's advice and am satisfied the Trust key worker provided appropriate support and monitoring of the resident. I have not identified a failure in the care and support provided.

The Trust Key Worker Support for Care Partner Arrangements in line with DoH Sept 20 Visiting Care Settings Guidance

108. I note there are no specific references to HSCT Case Manager or Key Worker in the DoH Sept 20 Visiting Care Settings Guidance.

109. I note there are no records which indicate the Trust key worker's involvement in the arrangements for a Care Partner for the resident.

110. The Nurse IPA referenced the DoH Sept 20 Visiting Care Settings Guidance and the DoH November 20 Care Partner Guidance. She advised these documents '*set out the role and requirements relating to Care Partners. Care Partner arrangements are in addition to the normal visiting arrangements*' which contemporaneous DoH visiting guidance define. I note the Nurse IPA advised that the role of a Care Partner is '*a defined practical role to provide additional support to Hospital/Hospice patients and Care Home residents.'* Further, '*Care Partner arrangements are not for everyone. A Care Partner is complementary to the care delivered by the staff in the care setting.'* The DoH November 20 Care Partner Guidance required risk assessment of Care Partners, as well as Covid-19 testing, social distancing and agreement about the frequency and length of visits.

111. The Nurse IPA also advised that, in meeting HSCTs' responsibilities within the DoH Sept 20 Visiting Care Settings Guidance, HSCTs might need to provide support to care homes in the Care Partner process. However, this is not specifically attributable to a key worker or case manager. She referenced the statement in the DoH guidance related to Care Partners, "*where a resident is unable to indicate for themselves if they would wish to have an identified individual act as a care partner' and which was applicable for the resident … discussions [about a Care Partner] should involve all relevant persons, which might include … a number of HSCT professionals".* She advised this was applicable to the resident, and from which she concluded, the Trust key worker was a "relevant person".

112. The Nurse IPA advised that the Trust Key Worker's role included case management. In relation to Care Partners, if the complainant was to become a care partner, this role could incorporate providing support in the process. Specifically, providing responses to and recording the complainant's issues and queries related to her role as Care Partner. She referenced the information the DoH provided and advised the Care Partner arrangements were neither mandatory nor underpinned in legislation. However, it was expected Care Partners would be implemented and that relevant HSCT staff would provide support for this. I note her advice, the Trust Key Worker should have provided support *'if indicated';* however, there was no evidence that the support was required.

113. I consider there is no evidence of the Trust key worker's involvement in arrangements for establishing a Care Partner for the resident. However, I accept the Nurse IPA's advice and am satisfied there was no evidence there was a need for the Trust Key Worker's support. I consider, therefore, there was no failure in care and support.

114. I refer to my finding at paragraph 113 above. Therefore, I do not uphold this element of the complaint.

115. I refer to paragraphs 85 to 87 above, related to Issue two, for my findings about the Trust's overall role in the Care Partner process.

CONCLUSION

116. I received a complaint about both the Care Home's compliance with Covid-19 visiting guidance, including Care Partner guidance and how the Trust monitored the Care Home's compliance with same during the Covid-19 pandemic from 23 March 2020 to 4 January 2021.

117. I upheld one element and partially upheld another element of the complaint in relation to the Care Home. Specifically, the Care Home did not act fully in accordance with the PHA March 20 Care Home Visiting Guidance in the period of 23 to 28 March 2020 and did not implement Care Partners in line with the

timelines in the DoH Sept 20 Visiting Care Settings Guidance. I consider these failures constitute maladministration.

118. I upheld one element of the complaint related to the Trust. Specifically, the Trust failed to act in accordance with the DoH Sept 20 Visiting Care Settings Guidance and subsequent DoH directions related to assurance that the Care Home had implemented Care Partners. I consider this constitutes maladministration.

119. I recognise that the events occurred during a period when health services throughout Northern Ireland were experiencing pressures dealing with the consequences of the Covid-19 pandemic and which impacted on all areas of health provision. While accepting the pressure on services, it also is important to recognise the difficult circumstances patients and their families faced at the time, and the impact the constantly changing visiting restrictions had on all parties.

120. I recognise the Care Home and Trust's failures caused the resident and the complainant to sustain the injustice of the loss of opportunity for to benefit from the in-person contact afforded by a care partner and the injustice of distress about their separation. I also recognise this caused the resident to sustain the injustice of the loss of opportunity to benefit from the additional support of a care partner and the complainant to sustain the injustice of worry about the resident. Through her contact with my office, the complainant has clearly articulated the impact this loss of opportunity to spend time with her much-loved mother had on her.

121. The investigation also identified: -

- there was no evidence the Care Home was required to facilitate exceptional close contact visiting for the resident; and
- the Trust provided appropriate key worker support to the resident in the Care Home.

122. Throughout my consideration of this case, the complainant's desire to ensure her mother's needs and best interests were met were clearly evident. I hope this report provides the complainant with some reassurance.

Recommendations

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

124. There is no current legislation or guidance related to Covid-19 visiting. However, I recommend the Trust should carry out a review of the processes associated with the implementation of guidance and directions from the DoH to ensure there are robust mechanisms in place to: -

- implement any necessary actions in a timely manner; and
- seek clarification where the Trust's role and responsibilities are not clearly defined and/or where there are shared or overlapping responsibilities with other bodies.

The outcome of this review, together with details of any required improvement actions, should be provided to this office within **three months** of the date of this final report.

125. In addition to the relevance to the Care Home of the absence of any existing legislation or guidance about Covid-19 visiting as noted in the paragraph above, as the Care Home no longer operates in Northern Ireland, recommendations for future improvement are not applicable.

126. I offer, through this report, my condolences to the complainant and her family on the sad loss of their mother.

MARGARET KELLY
Ombudsman **July 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 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.