Investigation of a complaint against Culmore Manor Care Home and the Western Health and Social Care Trust

Report Reference: 202001889 / 202001610

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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

I received a complaint about the actions of Culmore Manor Care Centre (the Care Home) and the Western Health and Social Care Trust (the Trust). The complaint concerned the care and treatment the Care Home provided to the complainant's father (the resident). It also concerned how the Western Health and Social Care Trust (the Trust) handled the complaint.

It should be noted since the complainant's father was a resident at the Care Home, the ownership of the Care Home has changed.

The investigation established the Care Home failed to properly monitor the resident's vital signs and escalate hypotension appropriately on the morning of the patient's death. . The investigation also found a failure to escalate a new symptom of necrosis complications in the resident's final few weeks as well as gaps and ambiguity in the records relating to the repositioning of the resident to ensure skin integrity. The investigation acknowledged the Trust found failings in the care and treatment the Care Home provided regarding oral hygiene, skin integrity checks and communication with the family in its original investigation into the Care Home. This Office's investigation echoed these failings, but is satisfied the Trust took sufficient steps with the Care Home to improve those service areas. The investigation did not identify any failings in the administration of medication, or the care and dressing of the resident's pressure wounds.

The investigation also identified maladministration in the Trust's handling of the complaint. In particular a failure to fully and accurately investigate the complaint which caused the complainant to lose trust in the complaint process.

I recommended the Trust apologise to the complainant for the failures identified and I would have also recommended the Care Home apologised for the failures identified if its ownership had not changed. I made two further recommendations to the Trust to bring about service improvement and prevent future recurrence.

THE COMPLAINT

1. This complaint related to the actions of two authorities, Culmore Manor Care Centre[1] (the Care Home) and the Western Health and Social Care Trust (the Trust). The complaint concerned the care and treatment the Care Home provided to the complainant's father (the resident). It also concerned how the Trust handled the complaint.

2. I addressed the complaints against both authorities in this composite report because of their interdependent nature and to provide maximum learning opportunities.

Background

3. The resident lived in supported accommodation until he had a stroke in August 2015. The resident required 24-hour care due to a loss of mobility and entered the Care Home in October 2015.

4. A Tissue Viability Nurse (TVN) carried out an assessment on 14 June 2017. The TVN recommended heel protectors / boots due to dry and red skin on the resident's heels.

5. The resident went into hospital on 19 June 2017. During his time in hospital the Trust diagnosed a wound to the resident's right heel as necrotic[2]. The hospital prescribed the resident Oxycodone for pain relief.

6. From 4 October 2017 the resident's condition deteriorated, and the Care Home commenced clinical observations at least once per day. The resident's GP agreed with the family the treatment plan would be palliative and the resident treated conservatively.

[1] Culmore Manor Care Centre was owned by Larchwood Care (NI) Limited until October 2023.

[2] Necrosis is the death of tissues of the body. Necrotic tissue forms when tissue isn't getting enough blood.

7. The resident's overall condition deteriorated further in the week prior to his passing. The resident's GP and a specialist nurse were involved in the later stages of his life. On 11 October 2017, the family agreed a DNACPR with the resident's GP, and the GP changed the frequency of the resident's medication.

8. On 12 October 2017 the resident had a spike in his temperature and pulse rate. There was a further spike in the resident's temperature on 13 October 2017. The specialist nurse examined the resident and requested the GP review his medication and consider using a syringe pump. The GP prescribed a syringe pump on 14 October 2017. However, the patient died before the pump was fitted.

9. On 14 October 2017 at 11:40, the resident's daughter contacted the Care Home and spoke with a nurse. The nurse advised the resident was "*comfortable*". The complainant visited the resident at 13:10 and found him to be non-responsive and having trouble breathing. The complainant requested the nurse, who came to check the resident's temperature / SATS. The Care Home contacted the GP at 13:42 and they attended the Care Home. The GP spoke with the family and advised the resident was close to passing. Sadly, the resident passed away at 15:17.

10. The family submitted a complaint to the Trust on 29 November 2019. The family had concerns regarding the care and treatment the Care Home provided to the resident during his time there.

11. The Trust initially met with the family on 24 September 2020 before issuing a first stage response on 13 October 2020 (first stage response).

12. The complainant responded to the Trust on 11 December 2020 (response to the Trust). The Trust issued a second stage response on 16 June 2021 (second stage response).

13. The complainant raised a complaint with NIPSO on 23 October 2021.

Issues of complaint

The Care Home

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

Issue 1: Whether the resident's care and treatment at the Care Home was appropriate and reasonable.

The Trust

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

Issue 2: Whether the Trust handled the complaint in accordance with its policy and relevant standards.

INVESTIGATION METHODOLOGY

16. To investigate this complaint, the Investigating Officer obtained from the new Care Home owners and the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included Culmore Care Home records and information relating to the Trust complaints and investigation process.

Independent Professional Advice Sought

17. After further consideration of the issues, I obtained advice from an independent professional advisor (IPA) in relation to the care and treatment the Care Home provided to the resident. The clinician who provided the advice was:

    - A consultant nurse; RGN BA(Hons) MSc PGCert(HE), specialising in the care of older people.

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

18. 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

19. 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[3]:

    - The Principles of Good Administration; and
    - The Principles of Good Complaints Handling.

20. 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 of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - Nursing and Midwifery Council - (NMC) Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, March 2015 (NMC Code);
    - Regulation and Quality Improvement Authority (RQIA) Care Standards for Nursing Homes – Standard 32 – Palliative and End of Life Care, April 2015 (RQIA Standard 32);
    - Extract from National Institute on Aging online resource, High Blood Pressure and Older Adults (NIA Extract - High Blood Pressure and Older Adults);
    - Royal College of Physicians – National Early Warning Score (NEWS) 2, December 2017 (RCP NEWS 2);

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

- NICE: Pressure ulcers: prevention and management Clinical guideline [CG179], April 2014 (NICE CG179);
- Department of Health: Guidance in relation to the Health and Social Care Complaints Procedure (April 2019) (DOH Guidance); and
- The Western Health and Social Care Trust's Policy for Management of Complaints, May 2011 (The Trust's complaint policy).

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

21. The complaint against the Trust is one of maladministration. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the 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 Trust's process of making that decision.

22. 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.

23. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the detailed comments I received from the complainant before I finalised this report. It was not possible to share a draft copy of this report with the previous owners of the Care Home.

THE INVESTIGATION

24. I have addressed the issues of complaint for both authorities under the following headings:
    - **Issue 1: Whether the resident's care and treatment at the nursing home was appropriate and reasonable?**
    - **Issue 2: Whether the Trust handled the complaint in accordance with its policy and relevant standards?**

Detail of Complaint

Care Home – Care and Treatment

25. The complainant raised a number of concerns regarding the standard of care and treatment the Care Home provided to the resident – as follows:
    - Oral hygiene – the complainant was concerned the Care Home failed to take sufficient steps to ensure the resident's proper oral hygiene. She said the family spoke to the Care Home about this. However, it did not implement agreed changes;
    - Poor repositioning – the complainant said the Care Home failed to appropriately and timeously reposition the resident as required. She said this led him to develop bedsores, and exacerbated the resident's existing foot wounds;
    - Monitoring – the complainant said the Care Home failed to properly monitor the resident on the day he died, and therefore failed to provide appropriate end of life care. She said the family arrived to see him looking 'awful', 'slumped over', 'unresponsive' and with 'laboured breathing';
    - Poor communication with the family – the complainant said the Care Home failed to keep the family updated about developments in the resident's health. She said the Care Home failed to inform the family when the resident's foot wound became 'necrotic', and when his tendon became exposed. Furthermore, she said the Care Home failed to accurately communicate with the family about the resident's deteriorating condition on the day he died; and
    - Medication - the complainant said the Care Home failed to administer Oxynorm in accordance with the prescription.

Trust – Complaints Handling

26. The complainant felt the Trust did not fully address her concerns, nor had her complaint come to a satisfactory conclusion. She questioned the robustness of the Trust's investigation. She provided the following examples:
    - The Trust failed to address her query about the Care Home's administration of Oxynorm;

- The Trust provided conflicting information in responses about the date the resident's DNACPR came into effect; and
- The Trust failed to interview relevant individuals as part of its investigation into events on the day the resident died. This included family members, a male staff member on duty, and a funeral home staff member.

27. In addition, the complainant raised concerns regarding the Trust's second stage response referring to additional Care Home records. The complainant questioned why it did not reference the records in its first stage response.

Issue 1: Whether the resident's care and treatment at the Nursing Home was appropriate and reasonable.

Care Home's response to investigation enquiries

28. As part of investigation enquiries, the Care Home responded to the complaint. A summary of the Care Home's response is at Appendix four to this report. I will address key elements of the response in my analysis and findings in this report.

Analysis and Findings

Oral hygiene

29. I note the Trust's investigation into the care home found there was a "*care plan in place to assist the resident with brushing his teeth"* and evidence available to indicate this care plan was "*regularly reviewed*". However, there was "*sporadic evidence*" of record keeping to confirm the Care Home was providing oral care and records indicate the care plan "*was not being adhered to*".

30. The IPA advised the Care Home carried out oral assessments. A full care plan set out actions including daily inspection of resident's mouth and monthly care plan evaluations. She advised the care home assessed and planned the resident's oral hygiene needs in "*accordance with NICE guidance*". Having reviewed the resident's care home records, I accept this advice. I note the IPA was silent on the care home's standard of record-keeping.

31. I note the Trust's investigation identified learning for the Care Home to ensure the accurate and timely record keeping for oral/dental care. I welcome the Trust identified this issue and made recommendations to improve standards in this area. I am satisfied the Trust identified and addressed the record-keeping failures regarding the resident's oral hygiene. I echo these failures and the Trust's findings. However, I am satisfied the Trust has apologised to the complainant for these failures, and has already taken sufficient steps to address them, to bring about service improvement, and prevent future recurrence.

Poor repositioning

32. I note the Trust's investigation found the Care Home used repositioning charts as per Tissue Viability Protocol. However, it was evident there was "*inconsistency in what was being recorded*". The TVN's review of the repositioning charts confirmed the Care Home completed the charts on a timely basis, but "*not always accurately*".

33. The IPA referred to the relevant standards and guidance, NICE CG179. NICE CG179 states *'adults at high risk of developing a pressure ulcer to change their position frequently and at least every 4 hours'*. The IPA advised the resident's assessment and care plan included "*2 hourly change of position and regular reassessment using the Braden scale (pressure sore risk assessment)".*

34. The IPA further advised the available resident repositioning charts indicate," for his final few weeks he was repositioned on a *'2 hourly basis with the exception of'*:

- 6 October 2017 – *'repositioned at a 3 hourly interval between 06:35 and 10:15.' 'Whilst this was not in line with the recommended 2 hourly turning, it is still within the parameters recommended by NICE guidance'.*
- 8 October 2017 – *'no position was recorded between 08:40 and 15:15'*; and

- 13 October 2017 – no repositioning recorded *'when the family were visiting'*. *'The resident was very frail and at risk of skin damage, care [repositioning] should have been offered in a timely way and therefore the care home should have recorded whether care was offered or not during the family visit.*

35. The IPA advised following the patient's discharge from hospital, care home records "*indicate use of airflow mattress, 2 hourly repositioning daily, the type of repositioning typically recorded as a 30 degree tilt".* The IPA advised this technique is *"commonly used in order to prevent direct pressure onto bony prominences, thereby reducing risk of pressure sores and is therefore likely to promote comfort".*

36. I obtained further advice from the IPA and she advised there was *'possible ambiguity in the care home's use of ticks in both left and right side 'tilt' checks'.* The IPA further advised *'the use of this double check does not give enough information about which side the resident was left in once care giving was complete'*. The IPA recommended *'the care home review the way in which they record 30 degree tilt so that an unambiguous record is achieved'.*

37. The IPA advised *'the vast majority of dates demonstrate adherence to specialist advice and accord with standards and guidance'* for the resident's repositioning. However the IPA further advised *'I note that there are a few gaps and inaccuracies in entries'.*

38. The IPA advised the Care Home Skin Assessment proforma includes a body map. There are 24 references to areas of broken skin recorded between October 2015 and August 2017. The Care Home recorded an anal fistula on 14 June 2017 for which it developed a care plan. She advised it completed follow up evaluations in August and October 2017.

39. The Tissue Viability Nurse (TVN) notes record an assessment on 14 June 2017 which identified a number of wounds. The IPA advised the TVN set a plan to "*manage cleansing and redressing of the wound*". The TVN also provided directions to "*off load pressure from pressure areas including use of heel devices".*

40. The TVN conducted an assessment on 7 September 2017 which identified a number of wounds including "*3 ulcerated areas to the right foot*". On 21 September 2017, the TVN diagnosed necrosis and noted "*healing potential is severely compromised".*

41. The IPA advised "*wound healing is a complex process which may be affected by numerous factors that including ageing, chronic disease and health conditions*". The IPA concluded the resident had "*multiple wounds that were assessed and documented by both the care home and the TVN. These were chronic wounds with poor healing potential*".

42. The IPA advised the care home "*followed the care plan that was set by the TVN and was in accordance with NICE guidance. Dressing changes were carried out by the care home according to guidance and were recorded appropriately*".

43. It was noted in the Care Home records on 07 September 2017, the TVN observed the resident was *"presently on an overlay mattress however would recommend when a full mattress replacement is available within the nursing home that this is allocated to patient in the event of anticipated further skin breakdown… manager today has assure me that the [xxxx] mattress that is on the patients bed today is a full mattress replacement"*

44. The IPA advised the *"records from the repositioning charts all refer to an 'air flow mattress' which is a type of high-specification pressure relieving mattress which can be either a full mattress replacement or an overlay"*. The IPA further advised the records do not provide any further details and it *"cannot therefore be verified"* if the resident was on an overlay or full mattress replacement.

45. However, the IPA further advised the TVN recommendation of a *"full replacement mattress <u>when available</u> is in line with the principle that the mattress type [overlay / full] is not the primary factor in wound care"*. The IPA further advised *"it is not possible to conclude"* on the impact of a full or overlay mattress would have had but the *"key principles of pressure sore/wound prevention and treatment are based on repositioning, as described in the NICE guidance, not on the type of mattress used"*. I accept the IPA's advice on this matter and find no failings in the Care Home's use of mattress type for the resident.

46. Having considered the evidence available, I am satisfied, in the *'vast majority of dates',* the Care Home carried out repositioning in accordance with TVN advice and provided appropriate care and treatment regarding the resident's pressure wounds. I accept there were however gaps in the resident's routine repositioning in his final weeks and the IPA's recommendations *'of accurate recording of patient positioning following care and ensuring that care is still offered as planned during family visits, are learning points for the care home'.* I therefore partially uphold this element of complaint.

Skin Integrity

47. The IPA advised that although the Care Home planned for skin integrity checks, its daily records were incomplete. As such there was "*no evidence the twice daily check was carried out as per the care plan*".

48. I note the Trust identified this concern and made recommendations to improve record-keeping standards in this area. I am satisfied the Trust identified and addressed the Care Home's record-keeping failures regarding the resident's skin integrity. I am also satisfied the Trust identified and addressed the record-keeping failures related to the care home's accurate completion of repositioning charts, I echo those failures and the Trust's findings. However, I am satisfied the Trust has apologised to the complainant for these failures, and has already taken sufficient steps to address them, to bring about service improvement, and prevent future recurrence. I do not uphold this element of the complaint because my investigation has not identified any further recommendations for the Care Home to comply with beyond those the Trust outlined.

Monitoring

49. In the Trust's original investigation outcome, it stated the Care Home's nursing notes indicated the resident "*appeared comfortable*" at 03.20am on 14 October 2017, and that there was "*no further recording of his condition until lunchtime*".

50. The IPA advised a blood pressure (BP) measurement taken at 04.20 on 14 October 2017 indicated hypotension[4] with BP70/47. A temperature reading of 37.7C was recorded at 05.30.

51. The IPA advised the temperature reading was within normal limits and action is only required if it is 38C or above. However, the BP would have triggered a score of 3 on RCP Early Warning Score (NEWS 2). She advised the Care Home should have "*escalated"* care *"appropriately"* on foot of this result.

52. The IPA advised although care homes were not obliged to use the NEWS2, this is a reference standard for escalation as it was used in hospitals in Northern Ireland at the time.

[4] Hypotension (low blood pressure) is a condition in which the force of the blood pushing against the artery walls is too low.

53. The IPA advised the care team should have responded with a "*repeat measurement of BP and discussion with the GP".* There was no record of escalation or further monitoring until 13:30.

54. The IPA advised the care team "*failed to respond appropriately following identification of hypotension during the night*", hypotension being "*a sign of clinical deterioration and is also a flag for potential sepsis"*. She further advised they "*did not carry out sufficient monitoring of the resident's vital signs between 5:30am and 1:30pm, nor did they escalate the hypotension that had been identified*".

55. I have considered RCP NEWS 2 where a BP of below or equal to 90 scores 3 on the physiological parameter. A score of 3 has a clinical grading "*low-medium*". The frequency of monitoring required is "*minimum 1 hourly*" and the registered nurse should "*inform medical team caring for the patient, who will review and decide whether escalation of care is necessary*".

56. Having considered the evidence available, I consider the Care Home's failure to properly monitor the resident's vital signs between 05.30 and 13:30, and failure to escalate the hypotension to a GP constitute failures in care and treatment. The nursing staff only checked the resident's vitals and contacted a GP following concerns raised by a family member about his breathing during a routine visit. The complainant stated in her response to the draft of this report, *'the family was not called in by the Care Home*' due to a deterioration in the resident's condition, clarifying a family member '*was on a routine visit from 1.10pm that day'* when she raised her concerns that resident's *'breathing was very laboured/shallow'*.

57. I consider had the Care Home properly monitored the resident's vital signs and escalated for medical advice, a GP may have been able to identify the resident was close to passing at an earlier stage. The Care Home could then have informed the family more promptly.

58. Following the complainant's comments to the draft report, further advice was sought on the monitoring the pressure wounds for necrosis and gangrene. The resident had been diagnosed with necrosis during his stay in hospital in June 2017. The IPA advised *"The term necrosis is a general term for cell death. Gangrene refers to a complication of necrosis"* and "*gangrene is not an alternative term for necrosis".* The IPA further advised there was "*no reference to possible gangrene in the care home or TVN record entries. However, there are references to odour and swelling, which are possible symptoms of gangrene, from 10/10/2017 [record entry]".* The IPA advised the new symptom, odour, *'should have been raised with the TVN and GP'* and there was no *"reference to this symptom having been escalated".*

59. I consider had the Care Home escalated the new symptom presented on 10 October 2017 to the resident's GP, he would have had the opportunity for the GP to assess the complications being displayed with the necrosis and for possible gangrene.

60. Standard 1.2 of the NMC Code requires nurses to "*deliver the fundamentals of care effectively".* Standard 1.4 requires "*any treatment, assistance or care for which you are responsible is delivered without undue delay*". Standard 13.2 requires nurses to "*make a timely referral to another practitioner when any action, care or treatment is required*". I find the nurses at the Care Home failed to adhere to these standards in this respect.

61. I consider the failures identified caused the resident to lose the opportunity for more timely medical input from his GP. They caused the complainant to sustain the injustice of distress regarding the speed of the resident's decline in health, as well as frustration and the time and trouble of bringing a complaint to this office. Therefore, I uphold this element of the complaint.

Communication with the family

62. I note the Trust's first stage response identified learning in the area of the Care Home's communication with families. Its review of the Care Home's daily communication sheets showed a lack of evidence of "*regular contact having been maintained*" regarding updates on the resident's foot and ankle wounds.

63. The Trust stated as a result of the complaint the Care Home introduced new documentation to record and maintain "*regular communication with families*".

64. The complainant remained concerned about this issue, so I sought advice from the IPA. The IPA advised the Care Home is "*required to keep resident's families updated on changes in condition and record the discussion in the communication section, therefore they should also have shared information on this aspect of his care*". The resident's wound care was "*under multidisciplinary management from GP, TVN and care home. The care home had a responsibility for communicating changes in the resident's condition, which included changes in condition of the wounds*".

65. The IPA referred to communication records with the resident's family. She advised the resident's family "*had been informed of the extent of the resident's wounds, and that this information had been provided by both TVN and the care home*". I note this is shown in the communication records dated 26 July 2017 and 5 August 2017.

66. Having considered the evidence available, the records demonstrate the Care Home did have some limited communication with the resident's family regarding the resident's wounds. However, having considered the IPA's advice, the communication in this area should have been more comprehensive. I therefore echo the failures the Trust identified in its investigation, and the findings it reached. However, I am satisfied the Trust has apologised to the complainant for these failures, and has already taken sufficient steps to address them, to bring about service improvement. I do not uphold this element of the complaint as my investigation has not identified any further recommendations for the Care Home to comply with beyond those the Trust outlined.

Medication

67. The Trust stated the Care Home administered Oxycodone to resident on an "*as and when required basis",* and adjusted the frequency according to need. I note the Care Home records document it increased the frequency of administration in the last week of the resident's life.

68. The IPA advised the Trust prescribed the resident Oxynorm on 29 June 2017, *5mg/5ml 2.5mg every 6 hours PRN.* The frequency changed on 11 October 2017 to "*4-hourly*". A hospice review on 12 October 2017 changed the prescription to "*2.5mg of Oxynorm pre-care 10-15mins prior to care"*. The hospice review reflects the resident was prescribed Oxynorm on a PRN basis prior to this date.

69. The IPA advised Care Home records indicate "*medication was administered to the resident in accordance with prescription, and that Oxynorm was administered to the resident regularly during the period that he was identified as at a palliative stage, but that it had not been given on a regular basis prior to that".*

70. Having considered the evidence available, I am satisfied the Care Home administered pain medication, including Oxynorm, to the resident in accordance with the prescription. Therefore, I do not uphold this issue of the complaint.

71. Regarding the administration of medications on the morning of the resident's passing specifically, the IPA advised nurses are required by the Nursing and Midwifery Council to "*exercise professional accountability in ensuring the safe administration of medicines to those receiving care*".

72. The Royal Pharmaceutical Society and Royal College of Nursing provide more detailed guidance in the Professional Guidance on the Administration of Medicines in Healthcare Settings (2019) require "*Registered healthcare professionals who administer medicines, or when appropriate delegate the administration of medicines, are accountable for their actions, non-actions and omissions, and exercise professionalism and professional judgement at all times".* It also requires *"records are kept of all medicines administered or withheld, as well as those declined*".

73. The IPA advised "*In signing the drug chart, the nurse is therefore confirming that they have given the correct medicine to the correct patient and that the medicine has been taken. It is the nurse's responsibility to check with the patient that they have taken their medicine*".

74. The IPA advised the Care Home nurse signed the medicines administration record "*as per responsibility of the Registered Nurse. By doing this the Registered Nurse was confirming that the medications were taken*".

75. Having considered the evidence available, I am satisfied the Care Home nurse administered the medication to the resident. Therefore, I do not uphold this issue of the complaint.

Summary

76. In respect of this issue of complaint, I echoed the Trust's original findings of failures in record-keeping regarding oral hygiene, repositioning, skin integrity and communication with families. I am satisfied the Trust sufficiently addressed those failures in its original investigation, and encourage the Care Home to comply with the Trust's recommendations in those respects. My investigation found failures in care and treatment regarding the Care Home's monitoring of the resident in the hours leading to his death, and its failure to seek GP input into his raised blood pressure. I found the Care Home's actions regarding repositioning and administration of medication to be reasonable, appropriate and in line with relevant standards.

77. I therefore partially uphold issue one of the complaint.

Issue 2: Whether the Trust handled the complaint in accordance with its policy and relevant standards.

Trust's response to investigation enquiries

78. As part of investigation enquiries, the Trust responded to the complaint. A summary of the response is at Appendix four to this report. I will address key elements of the response in my analysis and findings in this report.

Analysis and Findings

79. Upon review of the Trust's investigation into the original complaint, I identified a number of areas where the Trust fell short of standards set out in the DOH Guidance, the Trust's complaint policy and the Principles of Good Complaint Handling. I will address these areas in separate sections below.

The Trust's response to each issue of complaint

80. The complainant said the Trust failed to address her concern that the Care Home withheld information from the family about the extent of the resident's pressure sores in its investigation into her complaint and in its responses.

81. I reviewed the Trust's responses. Having done so, I note the Trust did not address if the pressure sores, in particular the 'necrotic' pressure sore on the resident's right heel, contributed to the resident's death, nor did it address why the extent of this wound was not discussed with the family.

82. I considered section 7.4 of the Trust's Complaints Policy which outlines the role of the Complaints Manager. This includes, "*ensuring all issues raised in the formal complaint have been addressed*". In addition, Standard 6 of the DOH Guidance required the Trust to address all issues raised as part of a complaint. Furthermore, paragraph 3.44 states the Trust's response letter should "*address the concerns expressed by the complainant and show that each element has been fully and fairly investigated*". Having reviewed the Trust's response, I find it did not give a full and thorough response to this issue of complaint, and therefore failed to adhere to these standards in this respect.

83. The First Principle of Good Complaints Handling, '*getting it right*', requires public bodies to act in accordance with relevant guidance. The Fourth Principle, '*acting fairly and proportionately*' requires public bodies to ensure they investigate complaints thoroughly and fairly. I find the Trust also failed to adhere to these Principles.

84. This failure in complaint handling constitutes maladministration, and I uphold this element of the complaint. I will address the matter of injustice later in my report.

Administration of Oxynorm

85. The complainant said the Trust failed to address her concern the Care Home was not administering Oxynorm in accordance with prescription. The Trust's response concentrated on the withholding of Analgesia.

86. The Trust stated their first stage response includes the resident "*received analgesia on a regular basis, and also as required*". Having reviewed Care Home records it is evident the resident was "*receiving analgesia which included Oxycodone (Oxynorm)".*

87. The IPA advised Oxynorm was "*administered as per prescription".*

88. I have considered NICE guidance which defines an analgesic as a "*drug used to relieve pain*". I am satisfied the Trust were referring to different types of pain medication within its response which included Oxynorm.

Conflicting information in the Trust's responses

89. Having reviewed the Trust's complaints file, and its response to this Office, I identified the following inaccuracies:
    - the date the DNACPR was put in place;
    - the number of baths when it should have referred to showers;
    - inferring the resident used a specialised sling to assist with bathing; and
    - the time the care home administered paracetamol.

90. Paragraphs 3 and 21.2.5 of the Trust's Complaints Policy requires the Trust to provide "*accurate*" responses to issues of complaint. In addition, the guidance to staff in Appendix 7 sets out the importance of providing an "*accurate and full description of what happened, giving precise dates and times*". In addition, Standard 6 and paragraph 3.44 of the DOH Guidance requires Trust responses to be accurate in its responses.

91. I acknowledge public bodies can, at times, make mistakes in their response to complaints. However, given the number of inaccuracies found in the Trust's responses, and the nature of some of those inaccuracies, I consider, in this instance, it indicates a lack of attention to detail that caused me to question the thoroughness of the investigation. I consider, therefore, the Trust failed to adhere to these standards in this respect.

92. I refer to the First Principle of Good Complaints Handling set out above. I also refer to the Third Principle, '*being open and accountable*', that emphasises the importance of accuracy in complaints handling. I consider the Trust also failed to adhere to these Principles in this respect.

93. I consider this failure constitutes maladministration that undermined the complainant's confidence in the rigour of the Trust's investigation. I therefore uphold this element of the complaint. I will address the matter of injustice later in my report.

Interview of Care Home staff

94. My investigation found the Trust should have interviewed Care Home staff members during its first stage investigation. The DOH guidance outlines the purpose of the investigation is to "*ascertain what happened or what was perceived to have happened*" and "*establish the facts*". Section 5.4 of the Trust's complaint policy outlines the role of the investigator which includes "*reviewing the complaint and highlighting the issues to be addressed*" and "*identifying staff members to be interviewed or statements required if applicable*".

95. The Trust had two options available to them, to interview the staff in person, or request written responses to the complaint. In determining the interview method, the Trust should have considered the type and seriousness of the issues of complaint to which the staff member was subject.

96. The Trust did not conduct staff interviews until its second stage investigation and only on the basis the family raised staff on duty at the time of the resident's passing "*be invited to outline their version of events which occurred that day*".

97. The investigation identified there were numerous references to the actions and statements made by Care Home staff which the Trust could only fully address through approaching those staff members and obtaining a written or oral response to the complaint.

98. For example, the Trust's first stage response includes "*The trust cannot provide comment on the conversations you highlight in your correspondence that you state took place between Care Home manager and staff nurse and family, as there is no record of same in the nursing notes*". It also includes "*With regard to your concerns that timeframes aren't matching up in relation to one carer having to comfort another, I have to advise you that the Trust cannot substantiate or refute your comments, as there is no record in the nursing notes in relation to this incident*".

99. Given there are no records I consider it would have been reasonable for the Trust to approach the named staff members, put the issue of complaint to them and record a response. The fourth Principle of Good Complaint Handling requires a public body to "*establish the facts of the case*" and to ensure the investigation was "*proportionate, appropriate and fair*". I find the Trust failed to adhere to the Principle in this respect.

100. In addition, I consider the Trust failed to speak with staff members to investigate the following allegations the complainant raised:
    - A nurse informing the resident "*we are not in the habit of hoisting resident's out of bed at this time of night"* and reminding the resident he *"had a pad on*".
    - A nurse saying, "*he's pulling on your heart strings when you come in*" in response to the family's concern in a care review on 23 June 2017 that the resident was "*definitely in pain*".
    - Statements made by the nurse on the day of the resident's passing, namely: (1) that the resident "*appeared comfortable*"; (2) regarding equipment that "*I don't' even think this is working*"; (3) the nurse informed the undertaker to "*leave the bandages in situ"* and instructed her "*do not remove*"; (4) the complainant's account the nurse did so to try "*to cover up the severity of his foot wounds*";
    - The female carer's account on the day of the resident's passing which referenced the male carer;

- The complainant asking "*were staff members in with dad during the night of 13th October to turn him as per his 2 hourly turning chart? How was he then*"; and
- Issues raised regarding the Care Home manager, namely: (1) no communication with the family; (2) a lack of empathy; (3) being unapproachable; (4) lack of compassion; and (5) was argumentative.

101. The Trust's first stage response noted the concerns raised regarding the Care Home manager and passed those concerns onto the owners of the Care Home for their "*learning and action as appropriate*". I conclude the Trust should have investigated the issues raised and interviewed the Care Home manager to ensure they complied with relevant standards.

102. Regarding the interview of Care Home staff, the Trust stated it "*felt the validity of events recollected three years later would be questionable*". Whilst it is recognised the recollection of witnesses diminishes over time an investigator cannot make assumptions on the validity of any account provided due to the passage of time. Every individual person's recollection is different and can be affected by varying factors such as the degree of impact the event had on the individual.

103. There is a likelihood Care Home staff would have had a better recall of events if the Trust had interviewed them soon after the complaint arrived in November 2019. Even if Covid restrictions came into place in March 2020 the Trust could have availed of written responses or interviewed staff via video conferencing software.

104. The Trust did not interview staff members until 16 March 2021 / 1 April 2021. The Trust provided no records which explain why it took from September 2020 until March / April 2021 to conduct the interviews.

105. The minutes of the meeting held on 24 September 2020 list follow-up actions which state the Trust was "*to contact a current employee and a former employee who were members of staff*". The Trust response to NIPSO confirms it did not interview the male carer because "*at the time of our investigation he was no longer an employee",* as such he was "*therefore not available*".

106. A witness being no longer in the employment of the Care Home does not preclude the Trust from interviewing them on a voluntary basis. The Trust should have attempted to contact the witness and asked them to attend an in-person interview or provide a written response. If the witness did not respond to the request or refused, the Trust should have included this detail in its second stage response.

107. The Trust's second stage response confirmed there was no record of the Care Home completing a body map when the resident returned from hospital on 29 June 2017. They also identified no records of fluid or food intake. The Trust's response includes "*The skin integrity chart records that your father was turned on 29 June 2017 at 9:00pm. The timing contradicts with what the family have reported*".

108. I consider the Trust should have identified all of the staff on duty responsible for the care of the resident in the above time-period and interviewed or sought statements from them. Further, given the nature of the complaint and the Trust's other findings, it should have identified which staff member completed the Skin Integrity Repositioning Chart which recorded repositioning took place at 9pm and sought to properly ascertain the accuracy of this statement.

109. Conducting such reasonable enquiries may have identified gaps in the processes around communication between staff and / or training needs for individual staff members.

110. I find the Trust failed to take sufficient steps to obtain all potentially relevant information in its investigation into the complaint when it failed to timeously either to interview or seek written statements from key staff. This impacted the thoroughness of the investigation, the accuracy of the evidence it relied upon, and therefore the overall accuracy of its response. As a result, the Trust failed to adhere to its own Complaints Policy, the DOH Guidance, and therefore the First Principle of Good Complaints Handling (set out above). It also failed to adhere to the Fourth Principle, as set out above.

111. I consider the Trust's failure constitutes maladministration and so I uphold this element of the complaint. I will address the matter of injustice later in my report.

Methodology of Care Home staff interviews

112. Having reviewed all relevant records, I note the Trust interviewed Care Home staff during the second stage investigation. My investigation concluded there was a lack of methodology in the interview process. The Trust's interview records demonstrate a number of staff interviewed did not work on the same floor on which the resident resided, or work with the resident at all. Numerous staff had no recollection when asked questions specific to the resident.

113. Apart from providing responses to generic scenario-based questions, which the Trust reported on, the interview of several staff members added little of substance to the Trust's investigation.

114. The Trust questioned Care Home staff about whether the resident was wearing heel boots when transferred to the hospital on 29 June 2017. The Trust stated, "*I can confirm that none of the staff could remember the incident in question*".

115. My investigation found a lack of methodology in the Trust's interview planning regarding this issue. The Trust's investigation should have established who was on duty and responsible for the care of the resident and interviewed those particular staff members.

116. I consider the Trust's approach to the interviews it did conduct impacted the accuracy and thoroughness of its investigation. I consider the Trust failed to identify the correct staff members to interview, and failed to ask sufficiently probing questions. As such, it lost the opportunity to gather all information relevant to the complaint. Its actions were therefore contrary to the Trust's Complaints Policy and the DOH Guidance, which required the Trust to establish the facts of what happened. It also failed to adhere to the First and Fourth Principles of Good Complaint Handling, set out above.

117. I consider this failure constitutes maladministration and so I uphold this element of the complaint. I will address the matter of injustice later in my report.

The Trust's second stage response referencing additional Care Home records

118. The complainant questioned why the Trust referred to additional care home records in its second response, when it could have had access to those in completing its first stage response. I note the minutes of the meeting held on 24 September 2020 state: "*although there were no nursing notes within this period there may be other notes available such as carer's notes and medication charts*".

119. The Trust stated the notes referred to in its first stage response were not the "*only notes available in their review*". The notes referenced were relevant to the issues raised in the complaint. The Trust stated its second stage response referenced additional records to answer "*more specific questions*" raised by the complainant.

120. Having considered the evidence available, I am satisfied the Trust referred to the additional Care Home records to provide a response to the further issues the complainant raised. I am satisfied this was reasonable and appropriate to allow the Trust to respond to the complaint as it developed. Whilst my investigation found failures in the Trust's standard of complaint handling, there is no evidence to suggest the Trust intentionally chose to ignore these additional records when it issued its first stage response. I therefore do not upheld this element of the complaint.

Summary

121. I found a number of failures in the Trust's handling of this complaint. The Trust failed to address all elements of the complaint in its investigation and response, and failed to ensure its response was accurate. It also failed to ensure it took all reasonable steps to obtain robust and accurate information that was potentially relevant to its investigation. However, I was satisfied the Trust in only referring to additional Care Home records in its second stage response was reasonable. Nonetheless, given the failures identified, I uphold issue two of the complaint.

122. I found these failures constitute maladministration. They caused the complainant to sustain the injustice of frustration and uncertainty regarding the investigation and its outcome. The complainant lost the opportunity to have her complaint fully investigated in line with relevant standards. The failures also caused her to take the time and trouble to bring this complaint to my Office.

CONCLUSION

123. I received a complaint about the actions of two authorities, Culmore Manor Care Centre (the Care Home) and the Western Health and Social Care Trust (the Trust). The complaint concerned the care and treatment the Care Home provided to the complainant's father (the resident). It also concerned how the Trust handled the complaint. I upheld elements of issue one, and upheld issue two of the complaint for the reasons outlined in this report.

The Care Home

124. I am satisfied the failures identified caused the complainant to sustain the injustice of distress, frustration and loss of opportunity as a result of the inappropriate care and treatment provided.

The Trust

125. I am satisfied the failure caused the complainant to sustain the injustice of frustration, uncertainty, loss of opportunity and the time and trouble of bringing a complaint to this office.

126. I offer through this report my condolences to the complainant and her family for the loss of their father.

Recommendations

127. If the ownership of the Care Home had not changed, I would have recommended it provided to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified.

128. To maximise the learnings from this report, I am sharing it with the current owners of the Care Home and I recommend it highlights to staff the need for accurate recording of patient positioning following repositioning and ensure care is still offered as planned during family visits.

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

130. I recommended that the Trust reminds staff charged with the responsibility of investigating complaints of the need to provide full and accurate responses to each of the issues of complaint. I also recommend the Trust reminds staff of the importance of robust interviewing as part of investigating complaints.

MARGARET KELLY
Ombudsman

August 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.

Appendix 2 - PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.

- Publishing service standards for handling complaints.
- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions and actions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.