Investigation of a complaint against Cairnmartin Care Home

Report reference: 202004932

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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 care and treatment Cairnmartin Care Home (the Home) provided to the resident from April 2022 to December 2022. The complainant, the resident's daughter, stated the Home did not take steps to address the resident's declining weight. She also questioned whether the Home responded appropriately to the resident's falls and raised concerns staff had not appropriately investigated a lost mobile phone.

I partly upheld this complaint. The resident had dementia and COPD and as such was at risk of nutritional deficiency. The residents weight dropped from 49.7kg to 40.31kg in the period from April 22 to December 22. The investigation found that the failure, by the Care Home, to appropriately follow up a referral to the Community Nutritional and Dietetic Service was a failure in care and treatment and the resident suffered the injustice of not having the opportunity for an appropriate and full assessment of her dietary needs. The investigation also found the Home provided the resident with appropriate meals and fluids throughout this period.

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The investigation found the Home followed the appropriate guidance and standards regarding recording and responding to the resident's falls.

It further found the Home failed to follow the appropriate guidance and standards by not documenting or investigating the resident's missing phone.

I recommended the Home provides a written apology to the complainant for the injustices caused by the failures I identified in this report. I also made further recommendations for the Home to instigate service improvements to prevent similar failings recurring.

I wish to convey my sincere condolences to the complainant for the sad loss of her mother.

THE COMPLAINT

1. This complaint was about care and treatment Cairnmartin Care Home (the Home) provided to the resident from April 2022 to December 2022. The complainant was the resident's daughter.

Background

2. The resident entered the Home in April 2022. She sadly passed away in December 2022.

Issues of complaint

3. I accepted the following issues of complaint for investigation:

   Issue 1: Whether the care the Home provided to the resident from April 2022 to December 2022 was appropriate, reasonable, and in line with relevant standards.

   Issue 2: Whether the Home responded to the resident's missing phone appropriately and in line with relevant policy and guidance.

INVESTIGATION METHODOLOGY

4. In order to investigate this complaint, the Investigating Officer obtained from the Home all relevant documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):
   - A Registered Nurse with over twenty years of experience as a Consultant Nurse for Older People.

   I enclose the clinical advice received at Appendix 2 to this report.

6. 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 complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. In order 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[1]:

   - The Principles of Good Administration

8. 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:

   - National Institute for Health and Care Excellence (NICE): Dementia: assessment, management and support for older people living with dementia and their carers [NG97] 2018 (NICE Guidance [NG97])
   - Regulation and Quality Improvement Authority (RQIA) Residential Care Homes: Minimum Standards v1.1 2021 (RQIA Minimum Standards)
   - National Institute for Health and Care Excellence: Nutritional Support for adults [CG32] updated 2017 (NICE Guidance [CG32])
   - National Institute for Health and Care Excellence: Chronic obstructive pulmonary disease in over 16s: diagnosis and management [NG115] updated 2019 (NICE Guidance [NG115])
   - National Institute for Health and Care Excellence (NICE): Falls in older people: assessing risk and prevention [CG161] 2013 (NICE Guidance [CG161]
   - Northern Ireland Public Health Agency (PHA) Falls Prevention 2020 (PHA Falls Guidance)
   - The Home's Loss and Theft Policy

   I enclose relevant sections of the guidance at Appendix 3 to this report.

9. 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.

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

10. A draft copy of this report was shared with the complainant and the Home for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care the Home provided to the resident from April 2022 to December 2022 was appropriate, reasonable, and in line with relevant standards.

Detail of Complaint

Resident's Weight Loss

11. The complainant said the resident's weight was consistent when she was in a previous care home. She said while in the Home, the resident's weight declined every month, but staff did not act until she raised concerns in August 2022. The complainant said the Home told her the GP referred the resident to a dietitian, but her GP did not follow up due to her mother having Chronic obstructive pulmonary disease (COPD)[2]. She raised concerns about this explanation, stating the resident was receiving treatment for COPD for years and her medication never changed in all that time.

Recording of Resident's Falls

12. The complainant said the resident fell on several occasions, but the Home has not provided her with the fall records. This has led her to question whether it recorded the falls or responded appropriately.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following:
    - NICE Guidance CG161
    - NICE Guidance CG32
    - NICE Guidance NG97
    - NICE Guidance NG115
    - RQIA Standards
    - PHA Falls Guidance

[2] Chronic Obstructive Pulmonary Disease (COPD) is a progressive lung condition characterized by chronic respiratory symptoms and airflow limitation. Common symptoms include shortness of breath, a persistent cough, and mucus production.

Home's response to investigation enquiries

Resident's Weight Loss

14. The Home stated the resident was in its residential unit. This unit has care staff, but they do not complete nursing assessments. Nursing assessments are the District Nursing Service's responsibility. Therefore, the Home monitored the resident's weight by recording her weight monthly.

15. The resident's weight was stable six months prior to entering the home, at a range of 49.3kg to 50kg. The records show the resident's initial weight in the Home on 14 April 2022 was 49.7kg and it declined to 40.31kg by November 2022. Staff attributed some of the weight loss in July to a diuretic medication. The Home contacted the GP on 9 August 2022. The GP referred the resident to a dietician that day, noting she was 'always a picky eater'. The GP did not prescribe supplements at that time.

16. The Home said the Dietetic Service sent it a letter on 10 August 2022, regarding the referral and seeking more information. The Dietetic Service required the resident's clinical condition and recent weight and height. The Home received this letter by mail, and stated this delayed it responding. It stated that it provided this information by phone on 18 August 2022, but did not make a record. However, the Dietetic Service made a note in the top right-hand corner of their letter confirming it had completed the referral.

Recording of Resident's Falls

17. The Home said the complainant never requested a copy of the resident's fall records. If she had requested them, staff would have provided them to her in line with the Home's policy. During stage two of the Home's investigation into the complainant's concerns, the complainant simply asked if staff completed appropriate paperwork.

Relevant records

18. I reviewed the documentation the complainant and the Home provided in response to my investigation enquiries.

Relevant Independent Professional Advice

19. The IPA provided advice about the care the Home provided to the patient. The IPA's full advice report is available at Appendix two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

Resident's Weight Loss

20. The complainant stated the Home did not take steps to address the resident's declining weight until after she raised concerns.

21. The NICE Guideline CG32 states Homes should screen residents on admission for malnutrition and when there is clinical concern. The RQIA standards require residential care homes to monitor and record resident's food and drink in sufficient detail to enable any person inspecting to judge whether the diet for each resident is satisfactory. It states, when a resident chooses not to eat a meal or is unable to eat a meal, staff should keep a record. They should discuss these occurrences with the resident and report them to the Home's senior staff. When necessary, the Home should make a referral to the relevant professionals and keep a record of any action taken.

22. The NICE Guidance NG97 states the principles of person-centred care underpins good practice in dementia care. These principles assert the human value and individuality of people living with dementia, the importance of the person's perspective, and the importance of relationships and interactions with others. The IPA advised the Home in this case should have used a person-centred approach.

23. The IPA advised as the Home was residential, rather than nursing, it was not required to carry out observations of the resident's vital signs, but was required to screen the resident for malnutrition. This involved weighing the resident and calculating her BMI. The Home should have reviewed this at appropriate intervals and taken appropriate action. If her BMI was low, it should have completed care planning and made a dietician referral via the GP and followed this through to completion. The IPA advised as the resident had COPD and associated nutritional risk, the Home should have provided her with nutritional supplements via the GP or from the hospital on discharge prescription. It should have recorded food and drink if there were concerns that she was not completing meals.

24. The IPA advised the resident's care plan dated 08 May 2022 demonstrated a person-centred approach to care which was appropriate and in line with NICE Guidance NG97. The records state the patient had difficulty in making decisions, could become confused, and had anxiety. The IPA advised these factors could contribute to poor oral intake and nutrition. She noted the Home recognised these issues in terms of the resident's overall care, and doing so constituted good practice.

25. The records show the Home assessed the patient pre-admission on 7 May 2022, and identified she was independent with all aspects of eating and drinking and required no assistance. It noted staff should encourage a fortified diet, and a nutritional supplement. The records from 3 November 2022 states the patient was at risk of malnutrition and the Home had included a food input chart. The IPA advised these assessments were appropriate and in line with relevant guidance and standards.

26. The records show the Home kept a Daily Food and Fluid Chart Booklet, which covers the period of 6 June 2022 to 4 December 2022. Upon reviewing this, the IPA advised the Home offered the resident sufficient full meals and snacks. She said on approximately 15% of occasions the resident only took half or three quarters of her meals. However, overall, the resident had adequate food intake. The IPA stated there is evidence to show the resident's fluid intake was adequate on the '*vast majority of occasions*'. I accept this advice.

27. The IPA noted although the evidence confirms the resident was consuming adequate food and fluids, and the Home was monitoring this appropriately, she was at risk of weight loss and low BMI due to having dementia and COPD. I note the NICE Guideline NG115 states people with COPD who have a low BMI require nutritional supplements. The records state the GP made a referral on 9 August 2022. It states the resident had COPD and advanced dementia, has always been '*a picky eater*', and has had some weight loss since last year.

28. The records show the Community Nutrition and Dietetic Service wrote to the Home on 10 August 2022 requesting further information to assess the resident and proceed with the referral. It said it could not accept this referral without further information. The Home stated it provided this information on 18 August 2022 by phone but did not document having done so in the multidisciplinary team communication records. It provided a copy of the letter, which has a note in the top right corner stating 'rereferred 18/8/2022'. Having reviewed the records, the IPA found no evidence to

show the Home provided the information the dietetic service required. The IPA said the lack of follow up is significant, as it was partly the Home's responsibility, RQIA guidance.

29. I am satisfied the Home provided appropriate care for the resident by giving her sufficient meals and fluids and monitoring her weight. I also acknowledge the Home's claim it provided the information the Dietetic Service requested by telephone. However, without a record to demonstrate this call took place, I am unable to confirm whether this was done at all or appropriately. Without adequate evidence to the contrary, I accept the IPA's advice there is no evidence of the Home appropriately following up with the Dietetic Service. I find this to be contrary to the RQIA Standards and a failure in care. I therefore partly uphold this complaint.

30. I find the failure in care caused the resident to sustain the injustice of losing the opportunity to have an appropriate and full assessment of her dietary needs. I am satisfied had the Home followed up with the dietitian appropriately and seen the referral through to completion it could have potentially contributed to addressing the resident's weight loss issues.

Resident's Falls

31. The complainant has raised concerns about whether the home had proper measures in place to prevent the resident falling, and whether it completed appropriate and relevant documentation following falls. The records show the resident fell on 1 May, 7 September, and 30 November 2022.

32. The RQIA standards state staff in homes need to have knowledge of the general health and social care needs of the residents, and basic care practices and interventions that promote the health and welfare of residents. Staff must treat residents as individuals and provide care that meets their individual needs. The need for ongoing assessment and identification of risks by staff is also necessary to ensure a proper fit between the care a home can provide and the changing needs of those living there.

33. The NICE Guideline CG161 state Care Homes should aim to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and mortality. The IPA noted there is no single fall prevention measure, but the generally principle is to adopt a multifactorial approach. This means

the Home should have carried out an appropriate risk assessment, identified the resident's mobility needs, and used appropriate aids and equipment. However, I recognise the PHA Fall Guidance states Homes cannot prevent all falls, without unacceptable restrictions to the resident's independence, dignity, and privacy.

34. The records show the Home completed an assessment of the resident's mobility on 7 May 2022. It noted the resident mobilises by using a rollator and had a low to medium risk of falls. The records show the Home completed a mobility care plan and identified the patient's fall history. The IPA advised these risk assessments and plans were appropriate. The Home recognised the fall risks and the need for supervised mobility, a rollator frame, and a fall alert mat. Having reviewed the record and the IPA advice, I am satisfied the Home completed an appropriate assessment of the resident's mobility needs per the relevant guidelines.

35. The records show the resident fell at 01.18 on 1 May 2022. Staff found the resident on her bottom with both elbows bleeding and skin tears. They completed a body map, administered first aid, and called 999. The staff did not witness the fall. The IPA advised this management was appropriate, and shows the Home was aware of bleeding risk and the possibility the resident could have hit her head. They therefore escalated the fall appropriately.

36. The records show the resident next fell on 7 September 2022. The staff completed a post fall observation and action form. It notes the resident fell but was not in any pain. The post fall plan included: an accident form investigation report; risk assessment and care plan; and check of footwear, continence, and medications. The staff completed follow-up notes, and informed RQIA and the District Nurse. The IPA advised this incident was similar to the May 2022 fall, in that the resident fell without any staff witnessing and sustained injuries. Staff called 999 for the first fall, but not for the second. I note the progress notes from that date state staff did not ring 999 because they did not believe the resident needed hospital care. The IPA advised there is no specific guidance on when to call 999 for falls, and the Home's response was appropriate.

    The resident fell again on 30 November 2022. The progress notes from that date state the resident's buzzer went off, and staff found her next to the bed. She had a 'gash' on the left side of her head and skin tear on her arm. Staff called 999 and an ambulance took her to hospital. The Home completed a body map the next day, and

an investigation. The follow up notes state staff had applied pressure to the residents wound, informed the complainant, and notified RQIA, and completed all relevant documents. The IPA advised these actions were appropriate and in line with the relevant standards and guidance.

37. Having reviewed the records and IPA advice I am satisfied the Home took appropriate action and kept appropriate records in relation to the falls on 1 May 2022, 7 September 2022, and 30 November 2022, per the relevant guidelines. I note the IPA also concluded the overall responses were appropriate, and noted the Home could not have prevented the falls. I accept this advice, and do not uphold this aspect of the complaint.

Issue 2: Whether the Home responded to the resident's missing phone appropriately and in line with relevant policy and guidance.

Detail of Complaint

38. The complainant stated the resident's mobile phone went missing towards the end of September 2022. She said she informed the Home manager it was missing, and staff told her they could not find it. The complainant said she does not understand how the mobile phone went missing, as her mother was isolating alone at the time. She said she does not believe the Home investigated this issue properly and thinks staff may have taken the resident's phone to stop her ringing out to complain about being hungry. During responses to our investigation the Home found the phone and it was returned to the complainant.

Evidence Considered

Legislation/Policies/Guidance

39. I considered the following:
    - RQIA Standards
    - The Home's Loss and Theft Policy

Home's response to investigation enquiries

40. The Home said it completed a record of the resident's belongings on 30 April 2022 and 13 July 2022. The first record included the resident's mobile phone. The Home is a Dementia Residential Home. The residents are all independently mobile and tend to enter each other's bedrooms. They may, on occasion, unintentionally take each other's items and place them elsewhere, and then forget. There are recorded

incidents of the resident not remaining in her room during the isolation period. The only explanation the Home Manager can provide regarding the missing mobile phone is the resident wandered out of her room with this in her hand or another resident took it from her bedroom. The Home Manager cannot provide a date but can confirm staff located the phone after the resident passed away and it was returned to the complainant.

41. The Home said there appears to be a lack of communication regarding this issue, as the Home Manager stated she was not aware the phone was missing. If she had been aware, the Home would have completed a full investigation. The Home Manager completes daily flash meetings with the team to discuss any concerns or complaints regarding residents and has set expectations regarding property management. This includes staff completing a lost property log and documenting actions taken to locate missing items. The Home said this breakdown in communication and lack of oversight of lost property does not meet its expected standard. It said during responses to this office, it discovered the location of the phone and identified a poor standard of record keeping. The Home said it was happy to offer the complainant an unreserved apology in relation to this.

Relevant records

42. I reviewed the documentation the complainant and the Home provided in response to my investigation enquiries.

Analysis and Findings

43. The complainant said she contacted the Home to enquire about the resident's missing phone and staff stated they would not be able to find it. She was concerned the Home did not investigate this issue appropriately, and felt staff may have taken the phone to prevent the resident phoning her to complain.

44. RQIA Standards state staff must keep a record of all property a resident, or someone acting on their behalf, brings into a home at the time of admission. They must update this record to add or remove items. This guidance notes all homes must ensure records are legible, accurate, and up to date. It also states all homes must have a 'missing items' policy.

45. The Home's Loss and Theft policy states it will endeavour to ensure the safety and security of all personal items of its residents. Staff will complete an inventory of all resident's items on admission and reconcile it quarterly. The inventory will include identifying information such as the items type, brand, model number, serial number, colour, or size. Staff must enter all items in the inventory in ink and have the resident or their representative sign it. The Home's Loss and Theft policy further states staff will inform the resident and their family or representative of any lost item. They will document the loss, giving a description and estimated value of the item, and indicating the date and time they discovered it went missing.

46. The policy states staff will take all reasonable attempts to locate the item, and if they cannot find it, they will launch an investigation. If the item has a value above £50, the Home will report the loss to the PSNI. If the Home failed to make reasonable efforts to safeguard the resident's property, it would reimburse the resident or replace the items. The policy states it is up the Home to show it has taken reasonable steps to avoid the loss.

47. The resident's progress notes show she had Covid on 29 August 2022 and came out of isolation on 7 October 2022. On 1 October 2022, the records state the resident was 'very rude' and 'very aggressive' today and 'will not stay in her room'. The record from 2 and 3 October 2022 states staff cannot find the resident's phone. Subsequent records do not mention the resident's phone or detail when staff found it. However, the Home confirmed it had since found the resident's phone and returned it to the complainant. Based on the available records, I am satisfied the Home realised the phone was missing on 2 October 2022.

48. The records show the Home recorded the patient as having a 'black mobile phone' on 20 April 2022. Subsequent records on 30 April 2022 and 13 June 2022 state the resident still had this phone. There are no other entries in this record. The communication records the Home provided to this office do not contain any entries regarding communication between staff and the complainant regarding the phone. I note these records do not comply with RQIA Standards or the Home's Loss and Theft policy. They do not include any details about the phone, such as its brand. The records also do not contain the resident or her family's signature. They do not indicate staff at one point could not find the phone, or detail when they did find it. Furthermore, I am satisfied the complainant raised concerns about the missing phone and have found no records documenting this. I am satisfied the Home's record

keeping regarding the missing phone breached both the RQIA Standards and its own internal policy.

49. The Home confirmed it did not launch an investigation into the missing phone. Further, I found no evidence to show staff took any steps to locate the phone. I am satisfied the phone was likely worth over £50. Despite this, I found no evidence the Home contacted the PSNI. I find the Home failed to investigate the missing phone and breached its policy. I accept the complainant's explanation staff told her they would not look for the phone, as it would not be possible to find it. I find this to be a service failure and uphold this element of the complaint.

50. I note the complainant sustained the injustice of uncertainty regarding what had happened to the phone and the injustice of distress at not being able to contact her mother. I did not find any evidence to suggest the Home staff intentionally took the resident's phone. I am therefore unable to make a finding on the complainant's concern that staff had taken the phone to prevent the resident from complaining to her.

CONCLUSION

51. I received a complaint about the care and treatment Cairnmartin Care Home (the Home) provided to the resident from April 2022 to December 2022. I upheld elements of the complaint and consider these a failure in the Home's care and treatment of the resident.

52. I recognise the impact of these failures and the injustice sustained by the patient and the complainant.
53. I offer through this report my condolences to the complainant for the loss of her mother.

Recommendations

I recommend:

54. The Home provides 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 I identified (within one month of the date of this report).

55. The Home shares this report with relevant staff for future learning.

56. The Home organises appropriate and relevant training for staff regarding responding to a dietician's requests for further information.

57. The Home organises appropriate and relevant training for staff regarding recording and investigating lost items.

58. I recommend the Home implements an action plan to incorporate these recommendations and should provide me with an update within three months of the date of my final report. The Home should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARGARET KELLY
Ombudsman **September 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.