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

Report reference: 202400522

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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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Appendix 1 – The Principles of Good Administration

Case Reference: 202400522
Listed Authority: Northern Health and Social Care Trust

SUMMARY

This case was about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to a patient. The patient, who was 85 years old at the time, has now sadly passed away. The complainant is the patient's son. He said the Trust provided his father with substandard care, causing him severe bed sores. He found his father in a wet state on several occasions, indicating staff did not meet his toileting needs for extended periods of time.

The investigation focused on four areas of pressure damage care and treatment. It found failings in three out of four of the areas it examined. This included a failure to reassess the patient's pressure ulcer risk appropriately; a failure to reposition the patient appropriately on several occasions; and a failure to develop an appropriate care plan for managing the patient's incontinence. I concluded these constituted failures in care and treatment.

I recommended the Trust apologises to the complainant for the failures and injustice identified. I recommended the Trust provides refresher training on certain aspects of pressure damage care and treatment to relevant staff and reviews its protocol for managing patients' incontinence. I also made an observation about the consistency of the Trust's record keeping and encouraged it to reflect upon this going forward. The Trust accepted my findings and recommendations.

I offer my sincere condolences to the complainant for the loss of his father.

THE COMPLAINT

1. This complaint was about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to a patient at Causeway Hospital between 30 December 2023 and 17 January 2024. The complainant is the son of the patient, who has since passed away.

Background

2. The Trust admitted the patient to Causeway Hospital on 28 December 2023 with a lower respiratory tract infection[1]. He was 85 years old. It transferred him to the Acute Elderly Medicine (AEM) ward on 30 December 2023. On 1 January 2024 the patient suffered a fall. The Trust transferred the patient to the Coronary Care Unit (CCU) on 13 January to investigate end stage heart failure[2]. It discharged him to his care home on 17 January 2024, where he sadly died on 16 February 2024.

Issue of complaint

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

   Whether the care and treatment the Trust provided to the patient for pressure damage during the period 30 December 2023 to 17 January 2024 was reasonable, appropriate, and in accordance with relevant standards.

INVESTIGATION METHODOLOGY

4. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

[1] Respiratory tract infections are infectious diseases involving the upper or lower respiratory tract. The upper respiratory tract is considered the airway above the throat, including the sinuses and the nose. Infections here can include tonsillitis or the common cold. The lower respiratory tract is below this, including the trachea and the lungs. Infections here can include bronchitis and pneumonia. Lower respiratory tract infections tend to be more severe than those in the upper respiratory tract.

[2] Heart failure is a syndrome caused by an impairment in the heart's ability to fill with and to pump blood. This means the heart cannot pump enough blood to meet the body's needs. Symptoms can include shortness of breath, excessive fatigue, leg swelling, and abdominal pain. End stage heart failure is the most severe form of heart failure, with no cure. A person with this condition will need medical intervention to stay alive.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisor (IPA):

   - A Consultant Nurse for Older People, BA(Hons), MSC, PGCert(HE), RGN, with 20 years' experience across hospital, community, and care home settings.

   I enclose the clinical advice received at Appendix Two 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 particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

7. 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.

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 Guidelines for Pressure Ulcers: Prevention and Management, NICE Clinical Guideline 179, 23 April 2014 (NICE CG179);
   - The Northern Health and Social Care Trust policy for Pressure Ulcers, Prevention and Management for Adults in Hospital, 16 January 2020 (the Trust's Pressure Ulcer Policy);
   - The Nursing and Midwifery Council Standards of Proficiency for Registered Nurses, May 2018 (the NMC Standards);

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

- The Nursing and Midwifery Council Code on Professional Standards of Practice for Nurses, Midwives, and Nursing Associates, October 2018 (the NMC Code).

I enclose relevant sections of the guidance considered at Appendix Three 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.

10. 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.

THE INVESTIGATION

Whether the care and treatment the Trust provided to the patient for pressure damage during the period 30 December 2023 to 17 January 2024 was reasonable, appropriate, and in accordance with relevant standards.

Detail of Complaint

11. The complainant said the Trust provided his father with substandard care, leaving him with severe bed sores[4]. He said he and his family found his father in a wet state on several occasions, indicating staff left him unattended for prolonged periods of time. He said the fall his father had on 1 January 2024 was because he was trying to get to the toilet as no one had come to toilet him.

12. The complainant said this period was extremely distressing for him as his father was very ill and he was anxious about his wellbeing. He said it was particularly upsetting seeing him in an undignified, wet state.

[4] Bed sores, also known as pressure ulcers, are areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to vulnerable areas of the body. People who are immobile for long periods, such as those who are bedridden, are most at risk. This is because the weight of the body is always putting pressure on the same areas of skin, which can lead to damage. If left untreated, bed sores can become blisters or open wounds, eventually reaching deeper layers of skin, muscle, or bone. Changing position regularly, using a specially designed mattress, and checking skin frequently can help to prevent bed sores.

Evidence Considered

Trust's response to investigation enquiries

13. The Trust stated it carried out a pressure ulcer[5] risk assessment for the patient 25 minutes after his admission to the AEM ward on 30 December 2023, which identified him as at risk of sustaining pressure damage. It stated there was documentation on admission of a sinus[6] to both right and left buttocks with a history of removal of abscesses[7]. However, the Trust stated it did not note any current pressure sores. The Trust explained it immediately started a SSKIN Bundle[8] care plan for the patient to monitor and care for his skin. This included repositioning him every four to six hours and nursing him on a pressure relieving mattress. The Trust acknowledged, on the evening of his admission, staff twice failed to document skin checks and repositioning in the SSKIN Bundle. It added, on a third occasion that evening, the patient declined skin check and repositioning.

14. The Trust stated it repeated the pressure ulcer risk assessment on 7 January 2024 and found the patient still at risk, but with no current pressure damage. On 13 January 2024 the Trust stated it transferred the patient to the CCU ward and staff there ought to have repeated the pressure ulcer risk assessment. The Trust acknowledged staff on the CCU ward failed to do so. Nevertheless, it added, skin checks and repositioning continued. The Trust stated the CCU ward also put in place a pressure relieving mattress for the patient.

15. The Trust stated the patient started taking a diuretic medicine on 5 January 2024, which meant he was likely to pass more urine than usual. On 6 January 2024 it noted he was more incontinent, causing more moisture on his skin and making him more susceptible to pressure damage. It explained staff recorded this incontinence on his second pressure ulcer risk assessment on 7 January 2024.

16. The Trust acknowledged it did not correctly document one of the patient's four to six hourly checks on 9 January 2024. It explained on the same date it also increased the patient's diuretic medication. The Trust stated on 12 January 2024 it noted blood

[5] See above.
[6] A sinus to the buttocks is a small hole leading to a tunnel or tract under the skin. These most commonly develop underneath the skin in the cleft between the buttocks where the buttocks separate.
[7] A skin abscess is a painful lump on the skin that contains pus, which may leak. Abscesses are usually caused by an infection, when bacteria get into the skin, for example through a cut or hair follicle. Some abscesses go away by themselves, while others require treatment. Treatment can include draining the abscess to remove the pus. An infected sinus can become a skin abscess.
[8] SSKIN stands for "Surface, Skin Inspection, Keep Moving, Incontinence/Moisture, and Nutrition". The SSKIN Bundle chart is a means of documenting an evidence-based set of interventions that help to prevent pressure damage. It takes the form of a seven-day booklet, in which staff document and monitor skin checks and any interventions they take. At the beginning of each seven-day SSKIN Bundle chart there is a pressure ulcer risk assessment which staff ought to complete.

leakage from the sinus on the patient's buttocks. On 13 January it noted the patient's two sinuses were bleeding after using the bedpan and it encouraged him to lie on alternate sides. It stated on 14 January 2024, at 3.15, the patient declined skin check and repositioning. The Trust acknowledged staff did not record any other check or repositioning until the next morning at 9.45.

17. The Trust stated, by the 16 January 2024, the patient's mobility had significantly deteriorated from its baseline. The day prior, Physiotherapy had noted a full hoist was necessary for all transfers out of bed, and this remained the case. The Trust noted catheter bypassing and bleeding from the sinus on his left buttock. It explained it applied a dressing to this. It also noted a small pin-point hole and observed this. The Trust stated the patient reported his buttocks were sore, and nursing staff consulted medics who prescribed him medication for this. Into the night of 16 January 2024, the Trust explained it recorded bleeding or "*exudate"* from the patient's old sinus and applied a dressing. It stated on 17 January 2024 staff repositioned the patient every two hours and renewed the dressing to the patient's sacral area[9].

Relevant Trust records

18. I enclose a summary of the relevant records at Appendix Four to this report.

Relevant Independent Professional Advice

19. I enclose a summary of the independent professional advice at Appendix Two to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

20. This section will assess four aspects of the pressure damage care and treatment the Trust provided to the patient. These are:
    - Pressure ulcer risk assessment;
    - Repositioning;
    - Incontinence management;
    - Response to deterioration or change.

    I will examine each of these in turn.

[9] The sacral area refers to the sacrum, which is located at the base of the spine. It is a triangular-shaped bone composed of five spinal vertebrae which are fused together, and which connect the spine to the hips. It plays a crucial role in supporting the weight of the upper body when sitting and standing.

Pressure ulcer risk assessment

21. Section 4.2 of the Trust's Pressure Ulcer Policy states staff ought to assess pressure ulcer risk for patients admitted to or transferred between wards and departments within six hours of admission. It also states staff ought to reassess pressure ulcer risk *"once a week or sooner if there is change in the patient's condition"*.

22. The patient's medical records document the Trust admitted him to the AEM ward at 18.15 on 30 December 2023. The IPA advised nursing staff carried out a Purpose T assessment[10] for the patient at 18.50. This identified he had no current pressure ulcers but was at risk. The Trust then began a SSKIN Bundle chart for the patient. The IPA advised nursing staff reassessed the patient's pressure ulcer risk on 7 January 2024. The IPA advised the *"pressure sore risk assessment was correctly carried out on admission to the ward and was reassessed according to NICE guidelines"*, and this was *"reasonable and appropriate action"*. I accept this advice. I am therefore satisfied the Trust's assessment of the patient's pressure ulcer risk on 30 December 2023 was appropriate, and it reassessed this appropriately on 7 January 2024.

23. I note on 13 January 2024, staff transferred the patient from the AEM ward to the CCU ward. As per the Trust's Pressure Ulcer Policy, staff ought to have reassessed the patient's pressure ulcer risk upon transfer between the wards. The Trust acknowledged it *"failed to complete the weekly Purpose T screening tool"* at this stage. However, it highlighted *"skin checks and repositioning continued"*.

24. The relevant SSKIN Bundles evidence staff on the CCU ward finished the patient's pre-existing seven-day booklet (which staff on the AEM ward had started on 7 January 2024) on 13 January 2024, and began a new one on 14 January 2024. The IPA advised staff on the CCU ward *"took appropriate action"* by continuing to document the patient's skin status in the SSKIN Bundle chart.

25. Although the nursing records for 13 January 2024 referenced the patient's Purpose T risk status, there is an absence of evidence that staff carried out a risk reassessment

[10] Purpose T stands for "Pressure Ulcer Risk Primary or Secondary Evaluation Tool". It is a pressure ulcer risk assessment framework intended to identify adults at risk of pressure development in hospital and community settings. It is applicable to those at risk of pressure ulcer development and those who already have a pressure ulcer. The Trust informed my Office the Purpose T assessment framework replaced the older Braden Pressure Ulcer Risk Assessment framework. The IPA advised NICE CG179 recommends the use of the Purpose T framework. However, I note the Trust's Pressure Ulcer Policy, which it confirmed was the one in place during the patient's stay at Causeway Hospital, still refers to the Braden framework throughout.

for the patient on this date. The Trust acknowledged it failed to do such a reassessment. I therefore find CCU staff did not reassess the patient's pressure ulcer risk status upon transfer from the AEM ward to the CCU ward.

26. Furthermore, the records evidence staff did not complete the pressure ulcer risk reassessment documentation upon starting a new seven-day SSKIN Bundle chart on 14 January 2024. I therefore consider staff missed two opportunities to reassess the patient's pressure ulcer risk status: upon transfer to the CCU ward on 13 January 2024 and upon starting a new SSKIN Bundle chart on 14 January 2024.

27. The Trust discharged the patient on 17 January 2024. From his last pressure ulcer risk reassessment on 7 January 2024 while on the AEM ward, until discharge, staff did not reassess the patient's pressure ulcer risk status. I am satisfied the Trust's failure to carry out a pressure ulcer risk reassessment between 7 January 2024 and 17 January 2024 breached section 4.2 of its Pressure Ulcer Policy. I am also satisfied staff failed to adhere to section 1.2 of the NMC Code which states nursing professionals must ensure they deliver *"the fundamentals of care effectively"*. I am satisfied the pressure ulcer risk reassessment constitutes a fundamental aspect of pressure damage care. I consider the Trust's failure to carry out the reassessment a failure in care and treatment. I therefore uphold this element of the complaint.

Repositioning

28. Section 6.1 of the Trust's Pressure Ulcer Policy states staff ought to establish an individual repositioning schedule for patients at risk of pressure sores. It specifies it is *"essential to document the frequency required and the position adopted clearly on a SSKIN Bundle form. NB. In order to be effective a patient should be in a different position at each time interval"*[11]. It further specifies, *"any variances to the recommended repositioning frequency requirements must be recorded in the SSKIN Bundle variances"*. It recommends staff reposition *"at risk"* or *"high risk"* patients at least every six/four hours, respectively.

29. The IPA advised, on 31 December 2023, the patient's prescribed repositioning frequency was *"six hourly"*. However, the IPA highlighted, the SSKIN Bundle chart evidences staff recorded the patient's position code as *"B"* at 10.00, 13.45, 18.30,

[11] The *"position code"* field of the SSKIN Bundle charts contains four options: *"B"* (meaning *"on back"*), *"L"* (meaning *"on left side"*), *"R"* (meaning *"on right side"*), and *"other"* (where staff can record an alternative position. For example, *"sitting in a chair"*).

and 22.30. I note the records evidence the patient's position code remained *"B"* throughout the night on 31 December 2023 and into 1 January 2024 (at 2.00 and 6.00). Therefore, from 10.00 on 31 December 2023 until 11.20 on 1 January 2024, when staff recorded the patient was sitting on a chair, the patient's position code did not change.

30. The IPA highlighted, during the night of 5 January 2024, into the day of 6 January 2024, staff recorded the patient's position code as *"B"* at 2.00, 6.00, 8.10, and 13.45. The patient's repositioning frequency during this period was *"six hourly"*. However, from 2.00 in the early morning of 6 January 2024 until 19.15 that evening the records evidence staff did not note a different position code for the patient.

31. The IPA advised, when the position code remained the same at repositioning intervals, the Trust ought to *"have provided a rationale for the patient remaining on his back at each position check"*. I note the relevant nursing records for the occasions previously described do not contain this rationale. The IPA explained, although the patient was entitled to decline assistance with repositioning, *"that should have been documented"*. As this was not documented, *"this may have been an omission of care, and potentially increased pressure sore risk (even though no ensuing pressure damage is recorded)"*. I accept this advice. Due to the absence of an accompanying rationale to justify why staff did not reposition the patient appropriately on the occasions previously described, I conclude there was no valid reason for not doing so.

32. Based on the evidence available and the IPA's advice, I find the Trust's failure to reposition the patient on the occasions previously described breached section 6.1 of its Pressure Ulcer Policy. I am also satisfied staff failed to adhere to section 1.2 of the NMC Code, which outlines nursing professionals must deliver *"the fundamentals of care effectively"*. I am satisfied repositioning constitutes a fundamental aspect of pressure damage care. I consider the Trust's failure to reposition the patient appropriately to be a failure in care and treatment. I therefore uphold this element of the complaint.

Observation

33. Furthermore, after reviewing the patient's SSKIN Bundle charts, the IPA highlighted *"some gaps in charting"* on 5 January 2024. In correspondence with my Office, the Trust also acknowledged gaps in documentation on 30 December 2023 and 14 January 2024. The IPA identified this as *"a learning point for the Trust, because if a pressure sore had occurred, this could have been attributable to one of these episodes"*. The IPA added, *"the Trust should ensure that staff, especially Health Care Assistants, who provide much of this pressure area care, record…skin check evidence"*. I accept the patient did not develop a pressure sore during that period. However, having reviewed the SSKIN Bundle charts, I agree with the IPA's observation about the importance of consistent record keeping, in line with the NMC Code. I encourage the Trust to consider this observation in its practice going forward.

Incontinence management

34. The IPA advised the patient did not have any pressure damage upon admission to Causeway Hospital on 28 December 2023 nor upon discharge on 17 January 2024. However, the IPA stated, the records evidence the status of an old sinus on the patient's buttocks did change during admission *"and a moisture lesion developed on 16 January 2024"*.

35. Section 4.3.4 of the Trust's Pressure Ulcer Policy states *"a moisture lesion is damage to the skin caused by urine/faeces, perspiration which is in contact with intact skin of the perineum, buttocks, groins, inner thighs, natal cleft or in skin folds where skin is intact with skin"*. The IPA advised a moisture lesion is also known as incontinence-associated dermatitis (IAD). Section 4.3.4 of the Trust's Pressure Ulcer Policy further defines IAD as *"erythema[12] and oedema[13] of the surface of the skin, sometimes accompanied by bullae[14] with serous exudate[15], erosion[16], or, secondary cutaneous infection[17]. It can often occur in patients with faecal and/or urinary incontinence"*.

36. Section 4.3.4 of the Trust's Pressure Ulcer Policy goes on to specify *"care must be directed to limiting the damaging effects of urine and faeces through the promotion of*

[12] Erythema is an abnormal redness of the skin caused by increased blood flow due to injury or irritation.
[13] Oedema is swelling caused by a build-up of fluid in the body, most often seen around the feet and ankles.
[14] A bulla (plural: bullae) is a fluid-filled sac, lesion, or blister that appears when fluid is trapped under a thin layer of skin.
[15] Exudate is fluid which is slowly discharged from wounds. Serous exudate means that the exudate is a clear, thin, and watery fluid.
[16] Erosion is the breakdown of the outer layers of the skin. It can happen due to prolonged exposure to a source of moisture.
[17] Cutaneous infection refers to an infection affecting the skin.

continence, the management of incontinence, and the diligent and appropriate use of skin-care products".

37. Annexe 3.6 of the NMC Standards outlines what nurses ought to do to support patients' bladder and bowel health. It states nurses ought to *"observe and assess level of urinary and bowel continence to determine the need for support and intervention assisting with toileting, maintaining dignity and privacy and managing the use of appropriate aids"*. Section 1 of the NMC Code also stresses the importance of upholding patients' dignity through appropriate bladder and bowel care.

38. The IPA advised the patient's transfer letter upon admission to hospital on 28 December 2023 described him as *"continent"*. However, the nursing notes from 4 January 2024 to 8 January 2024 consistently recorded *"can be incontinent"*. Furthermore, the IPA highlighted, historical nursing records for the patient from 31 May 2023 noted *"the patient had a history of incontinence"*. The IPA therefore advised, the patient *"exhibited periods of incontinence"* during his time at Causeway Hospital, until staff inserted a urinary catheter on 9 January 2024 to monitor his urine output. The IPA explained the catheter reduced the patient's *"chance of prolonged contact with urine"*. However, the IPA added, *"it is possible that urine had leaked (known as 'bypassing'…), or that the patient had been incontinent of faeces"*.

39. The IPA advised, *"for this patient, who reported feeling weak, had a history of occasional incontinence and was on diuretics, it would have been important for a plan of care to be developed to ensure his continence needs were met"*. From the evidence available and the IPA's advice, I consider the patient required incontinence management during his stays on the AEM and CCU wards. As per, section 4.3.4 of the Trust's Pressure Ulcer Policy and annexe 3.6 of the NMC Standards, I am satisfied staff ought to have provided an appropriate care plan to manage urinary and bowel incontinence. However, the IPA advised, *"I did not find any evidence of care planning for this need"*.

40. I note section 6.0 of the Trust's Pressure Ulcer Policy states staff ought to provide patients classified as *"at risk"* of pressure ulceration with a *"management plan of care"* which should consider *"incontinence – skin care interventions"*. I further note this section of the policy also states, *"this is included on the updated SSKIN Bundle (Version 2.0)"*.

41. However, the IPA advised, *"the SSKIN Bundle proforma does not constitute a plan of continence care as it has not dedicated continence items. Any references to incontinence or passing urine are incidental".* The IPA added, *"the nursing records imply the patient needed full assistance with toileting…there are insufficient records of how he was assisted, or how frequently he was incontinent, or how incontinence was managed (e.g. with pads)"*. The IPA also highlighted an incontinence plan of care ought to have included *"how the patient's dignity would be promoted"*, but consideration of this was lacking in the patient's SSKIN Bundle charts. The IPA concluded, "*I could not find sufficient information or evidence that the patient's incontinence was managed appropriately"*. I accept the IPA's advice that the SSKIN Bundle chart did not constitute an appropriate means by which to care for and manage the patient's incontinence.

42. Although incontinence did not cause the patient to sustain pressure damage during his time on the AEM and CCU wards, the IPA advised *"it is possible that it contributed to other skin damage (specifically moisture lesion) during his stay in hospital"*. The IPA added, *"had care planning specifically addressed this, the risk of a moisture lesion developing might have been reduced"*. As per section 4.3.4 of the Trust's Pressure Ulcer Policy, the NMC Standards, the NMC Code, and the IPA's advice, I consider the Trust's failure to develop a specific plan of care to manage the patient's incontinence constituted a failure in care and treatment. I therefore uphold this element of the complaint.

Response to deterioration or change

43. As already highlighted, the IPA advised the patient developed a moisture lesion on 16 January 2024. The records evidence nursing staff took steps on 16 January 2024 and 17 January 2024 to treat the lesion. This included continuing to monitor him via the SSKIN Bundle chart, repositioning every two hours, applying various dressings, consulting with the doctor, and checking the status of the patient's pain. The IPA advised the nursing records confirm *"the Trust acted appropriately in responding to skin damage risk and change in [the patient's] condition"*. I accept this advice. Whilst the absence of an incontinence care plan may have contributed to the development of a moisture lesion, I am nevertheless satisfied the Trust's response to the patient's changing skin condition during this period was reasonable, appropriate and in line with relevant standards. I therefore do not uphold this element of the complaint.

Summary

44. This report assessed the care and treatment the Trust provided in terms of pressure damage through an analysis of four aspects. These were:
    - Pressure ulcer risk assessment;
    - Repositioning;
    - Incontinence management;
    - Response to deterioration or change.

45. I concluded the Trust appropriately carried out a pressure ulcer risk assessment during the patient's admission to the AEM ward on 30 December 2023, and reassessed this as per policy on 7 January 2024. However, I also concluded the Trust failed to reassess the patient's pressure ulcer risk status upon transfer to the CCU ward on 13 January 2024 and failed to carry out a reassessment throughout his stay there.

46. I concluded the Trust failed to reposition the patient appropriately on 31 December 2023 to 1 January 2024, and on 6 January 2024, and failed to document its rationale for not doing so. I also encouraged the Trust to reflect upon the importance of consistent record keeping in its practice going forward.

47. I concluded the Trust failed to develop an appropriate plan of care for managing the patient's incontinence throughout his stays on the AEM and CCU wards.

48. I concluded the Trust's response to the patient developing a moisture lesion on 16 January 2024 was reasonable and appropriate.

49. I consider the failures identified above to be failures in the care and treatment the Trust provided to the patient. I therefore partially uphold the complaint. I am satisfied this caused the patient to experience the injustice of loss of opportunity, indignity, and discomfort. It also caused the complainant, the patient's son, to experience the injustice of distress.

50. The patient passed away on 16 February 2024, approximately one month after discharge from Causeway Hospital. The complainant's visits to his father on the AEM and CCU wards were some of the final moments he shared with him. I offer my

sincerest sympathy to the complainant that these moments were marked by the failings identified in this report.

CONCLUSION

51. I received a complaint about the Northern Health and Social Care Trust. I partially upheld the complaint for the reasons outlined in this report. I consider the failures identified constitute failures in the Trust's care and treatment of the patient.

52. I recognise the failures caused the patient loss of opportunity, indignity, and discomfort, and caused the complainant distress.

Recommendations

53. 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 failures identified (within one month of the date of this report).

54. For service improvement and to prevent future recurrence, I recommend the Trust:
    - Provides refresher training to relevant staff about the circumstances under which a pressure ulcer risk reassessment must be carried out, including at least weekly and upon transfer to a new ward or department.
    - Provides refresher training to relevant staff to emphasise a patient's position code ought to change after every repositioning check. If there is a legitimate reason for not doing so, staff must clearly record this reason.
    - Carries out a review of how it assesses and manages patients' incontinence.

55. I further recommend the Trust carries out a review of its Pressure Ulcer Policy to consider replacing outdated references to the Braden Pressure Ulcer Risk Assessment with references to the Pressure Ulcer Risk Assessment – Purpose T.

56. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within six months of the date of my final report. The Trust 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 read and understood any related policies).

57. The Trust accepted my findings and recommendations.

MARGARET KELLY

Ombudsman

July 2025

Appendix 1 – PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and 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.