Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Ard Mhacha Nursing Home, Armagh

NIPSO Reference: 17587

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

Publication date: February 2019

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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

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.

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY

I received a complaint from a man whose father was a resident of Ard Mhacha Nursing Home, Armagh from 2 December 2016 to 14 January 2017.

Issue of Complaint

I accepted the following issue of complaint for investigation:

The care and treatment received by the resident in relation to:

- The adequacy of assessments completed on his admission to Ard Mhacha
- The medication regime with regard to pain management and the provision of laxatives
- Weight management

Findings and Conclusion

The investigation of the complaint identified a failure in the care and treatment received in respect of the following matters:

- Failure to carry out blood pressure monitoring
- Inconsistency between the falls risk assessment and the care plans and insufficient information about the resident's mental state
- Category of risk of fall
- Pain Management
- Bowel Management

Recommendation

I recommend that the resident receives an apology from Ard Mhacha Care Home for the failures in care and treatment identified together with a payment of £500 in solatium.

THE COMPLAINT

1. I received a complaint about the care and treatment of a resident of Ard Mhacha Nursing Home from 2 December 2016 to 14 January 2017. Since the date of this complaint Ard Mhacha has been renamed Orchard Lodge Care Home. It continues to be owned by Runwood Homes.

2. The resident, aged 85, was admitted to Ard Mhacha on 2 December 2016 from home. He suffered from Parkinson's disease, chronic kidney disease, hypertension, gastro oesophageal reflex, urine retention, skin cancer (lesion to his chest) and recurrent chest infections.

3. He fell from bed in the care home on 1 January 2017. Following the fall he complained of pain and discomfort and he had sustained a small bruise on his left hip. He was brought to Craigavon Area Hospital on 5 January 2017 but subsequently discharged back to the home, after x-rays identified no fracture.

4. Over the next few days he was seen by the GP and had his pain relief increased. The complainant states that on his first visit to his father in the care home on 13 January 2017 he was shocked at his weight loss. In his letter of complaint he stated that he considered that his father had suffered neglect and poor treatment. He also complained that his father had no air mattress.

5. The following day, 14 January 2017, the resident was taken by ambulance to Craigavon Area Hospital where x-rays showed faecal loading. He remained in hospital for seven weeks before being discharged and moved to a different care home.

6. A complaint was made to Ard Mhacha on 19 January 2017 and a referral was made to the Southern Health and Social Care Trust's (the Trust) Adult Safeguarding Team on the same day. An investigation by the Trust's safeguarding team found areas for improvement in relation to the resident's care plan and recommendations were shared with the Home Manager. A referral was made to the Regulation and Quality Improvement Authority (RQIA). RQIA carried out an unannounced inspection of Ard Mhacha on 9 March 2017.

Issues of complaint

7. The following issue of complaint was investigated by my Office:

1. **Whether the care and treatment received by the resident in Ard Mhacha Care Home was reasonable?**

7. It was determined that in order to fully investigate the reasonableness of the care and treatment in this case the following concerns raised would be addressed:

(i) The adequacy of assessments completed for the resident on his admission to Ard Mhacha with regards to risk of falls, prevention of bed sores and his nutritional requirements;

(ii) The care home's medication regime with regard to the management of the resident's pain and the provision of laxatives; and

(iii) The care home's management of the resident's weight.

INVESTIGATION METHODOLOGY

9. In order to investigate the complaint, the Investigating Officer obtained from Ard Mhacha all notes and records together with its comments on the issues raised. The Investigation Officer also obtained medical records from Craigavon Area Hospital and documentation from the Trust relating to its Adult Safeguarding investigation. The Investigating Officer also interviewed the complainant at his home to fully understand his concerns in relation to his father's care.

10. After further consideration of the issues and to inform my analysis, findings and conclusions on the care and treatment, I obtained independent professional advice from an independent professional advisor (IPA), a consultant nurse for older people. The IPA has clinical experience across acute care and care homes including expertise in caring for frail older people with complex needs. Her expertise includes areas such as Parkinson's disease, falls, advance care planning, safeguarding adults and continuing healthcare.

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

Relevant Standards

13. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

14. The general standards are the Ombudsman's Principles[1]:

(i) The Principles of Good Administration

(ii) The Principles of Good Complaints Handling

(iii) The Public Services Ombudsman Principles for Remedy

15. The specific standards are those which applied at the time the events occurred and which governed the exercise of the professional judgement of the care home and the individuals whose actions are the subject of this complaint.

16. The specific standards relevant to this complaint are:

- National Institute of Clinical Excellence (NICE) - Clinical Guideline CG179 (April 2014)
- NICE Guidance CG161/CG21

17. I have not included all of the information obtained in the course of the investigation in this report. However I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

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

MY INVESTIGATION

18**.** The first issue of investigation relating to the care and treatment received by the patient is:

(i) Whether the assessments completed on his admission to Ard Mhacha regarding his risk of falls, prevention of bed sores and swallow function were adequate?

19. The complainant alleged there was a failure by Ard Mhacha to complete appropriate risk assessments and care plans following his father's admission on 2 December 2016. He also complained of an unwitnessed fall that his father sustained from his bed on 1 January 2017. The resident complained that his father was not provided with an air mattress by Ard Mhacha as recommended by the Trust. Further, he complained about the assertion by the care home that his father had difficulty swallowing as this was incorrect.

20**. Daily observation notes 1 January 2017 –** 'at 18.40 care assistant heard shouting for help from [the resident's] bedroom. [He] was found lying on the floor beside the bathroom door. C/o (complaining of) pain in back and bottom. Able to move and lift both legs. Able to bend his knees. Assisted to sit up on the floor, then assisted by 3 x staff members to stand up. Able to weight bear. Assisted to bed. Full body checked. No evidence of any fresh bruises or skin tears. Made comfortable in bed, watching TV at present. Incident form completed.'
Falls Log – 1 January 2017 18.40 'Found on floor- unwitnessed. Alert and cooperative on examination. Report of nil obvious injuries, uncomplaining of acute pain. Placed under observation.'

21. The IPA reviewed the records provided by the care home in order to identify whether falls risk factors were identified either as part of the resident's admission assessment or as part of a specific falls risk assessment. If an assessment had been

completed, the Investigating Officer also inquired as to whether these were interpreted into an appropriate plan of care. The IPA identified that admission assessments included continence, personal care needs, nutritional assessment, end of life care wishes, body map, moving and handling risk, falls risk, bed rail risk, Barthel choking risk were examined. The IPA also examined a number of care plans for the resident in this case.

22. The IPA stated that the risk assessment and care plan clearly identify that the resident was known to be at risk of falling, including the risk of falling out of bed, from the time of admission to the care home, and that basic prevention strategies were established. However, the IPA noted that there was inconsistency between the falls risk assessment and the care plan. There was also insufficient information about the resident's mental state. This led to a lower overall falls risk classification than is likely to have been the case. The IPA advised that the resident was likely to have been at "very high risk" rather than "high risk" of falls. The IPA stated that if this had been correctly identified, the home might well have established additional risk reduction interventions. These would have included actions such as increased frequency of checks, use of crash mat at the bedside, and use of bed sensor/movement sensor.

23. The IPA advised, on the basis of the evidence, that the resident would have presented a very high falls risk. There were a number of factors which would have contributed to this. His age, 85, which in itself is an important consideration when considering the risk of falling. There was also the fact that he had a diagnosis of Parkinson's disease. Parkinson's disease cause symptoms of slowness, rigidity and postural instability, all of which increase the risk of a sufferer falling. The resident would also be at increased risk of falling due to cognitive impairment associated with this illness. The care notes record that he was "confused", suggesting that he did have a degree of cognitive impairment. The resident also would have had associated lack of risk awareness and impulsiveness: he therefore may have been less likely to ask for help or use the call bell. A further risk factor arising from his medical condition and its treatment could be low blood pressure or a drop in blood pressure when moving from a lying position or sitting to standing.

24. With regard to the risk of bed sores the IPA advised that the care home pre-assessment pressure area assessment document records a Braden Scale score of 18 which indicates low risk. As such an air mattress was not required.

25. The IPA advised that entries in the daily observation notes indicate that the resident ate and drank normally with no specific swallowing difficulty reported at any stage and that there was no indication that a Speech and Language therapy referral was required, or that a swallowing problem had been identified. As a point of information, the IPA stated that there is an increased likelihood of swallowing difficulty in those suffering from Parkinson's disease due to slowed swallow. Those individuals suffering from Parkinson's disease quite commonly experience sensation of food sticking in the throat or not going down well. A swallow assessment would be indicated if the resident had reported these symptoms. However there was no indication in the Ard Mhacha care records that he raised any concerns or exhibited these symptoms.

26. Overall the IPA stated that the fundamental assessments and care plans were mostly adequate but with four exceptions:

(i) The monitoring of the resident's blood pressure – Ard Mhacha should have carried out blood pressure measurement including lying and standing blood pressure (to assess for postural hypotension – a known risk factor for falls)

(ii) The care home's assessment of mental state – There is no standardised assessment of the resident's cognition. There are inconsistent entries referring to him being 'confused' without basing this on a standardised assessment of cognition or diagnostic information. This has led to potential underestimation of his falls risk and inconsistent care planning

(iii) Bowel management – The IPA stated that there is no evidence that Ard Mhacha planned care proactively to prevent constipation (Issue (ii) refers)

(iv) Pain management prior to 4 January 2017 (Issue (ii) refers)

27. In all other respects however, the care home's assessments and care plans completed by Ard Macha staff were reasonable.

28. In response to investigation enquiries Ard Mhacha stated that the resident was not assessed by a speech and language therapist (SALT) as his choking risk did not indicate the need. The resident was not provided with an air mattress as his Braden score showed a low risk. It was the care home manager's view that the movement of an air mattress could have increased the resident's discomfort due to his musculoskeletal pain.

29. In response to receipt of a copy of the IPA advice, Ard Mhacha accepted that blood pressure monitoring of lying and standing blood pressure could have been carried out. With regard to an assessment of his mental state, Ard Mhacha stated that an assessment of mental state would not have been made solely by the staff nurse and if there were concerns over his mental status then this would have progressed to requesting a multi-disciplinary approach. On the resident's pre-assessment, Ard Mhacha stated that he is described as both alert and sociable but also forgetful and vague. Ard Mhacha also stated that the bowel charts indicated regular bowel movements. As regards pain management Ard Mhacha stated that while the resident's pain was recognised, monitored and the effectiveness of the analgesia evaluated, it would have been best practice to have also used a standardised pain assessment tool, together with the pain assessment chart which was completed.

Analysis and Findings

30. There are a number of aspects concerning the complainant's father's care while resident in Ard Mhacha. The adequacy of the assessments carried out after admission, the unwitnessed fall on 1 January 2017, the provision of an air mattress and a question regarding his father's swallow function. I shall consider each of these areas in turn.

31. Assessments - The IPA has considered the adequacy of the assessments and care plans put in place by Ard Mhacha for the resident post admission on 2 December 2016. In her advice I was provided with a list of the assessments and care plans completed. Overall the IPA considered that the fundamental assessments and care plans were adequate with some exceptions. These were with regard to Blood

pressure monitoring, assessment of mental state, bowel management and pain management prior to 4 January 2017. I will comment on bowel management and pain management at a later stage of this report. With regard to blood pressure monitoring Ard Mhacha accept that lying and standing blood pressure could have been carried out and that if there were concerns over the resident's mental state that it could have progressed to there being a multidisciplinary approach to this issue.

32. I accept the advice of the IPA that blood pressure monitoring should have been carried out, including lying and standing blood pressure, to assess for postural hypotension, which is a known falls risk factor. I consider the failure to carry out this monitoring to represent a failure in the care and treatment provided to the resident. I consider it to have caused him the injustice of not having a known falls risk factor included in his falls risk assessment. I also consider it to have caused the complainant the injustice of upset and uncertainty regarding the consequences to his father of the care and treatment which he received at this time. Having said that that I welcome the fact that Ard Mhacha accept that blood pressure monitoring could have been carried out. I consider recognition of this to represent good procedure on the part of Ard Mhacha. To reflect on and learn from complaints reflects the Principles of Good Complaints Handling in that omissions are acknowledged and learning derived from these situations. I trust that Ard Mhacha will have taken learning points from the advice provided by the IPA for future reference.

33. With regard to the assessment of the resident's mental state, I acknowledge that at the time of the events surrounding this complaint, he had been a patient at Ard Mhacha for just over one month. I also acknowledge Ard Mhacha's contention that if concerns over his mental state had progressed over time that assessments regarding his cognition would have taken place and that this would have entailed a multi-disciplinary approach involving professionals from the Trust working alongside Ard Mhacha. However the IPA has stated that inconsistent entries in the records referring to the resident as being confused without this being based on a standardised assessment of cognition has led to potential underestimation of his falls risk and inconsistent care planning. I accept this advice and consider it to represent a failure in the care and treatment provided to the resident. I consider it to have caused him

the injustice of a potential underestimation of his falls risk and inconsistent care planning. I also consider it to have caused the complainant the injustice of upset and uncertainty regarding the consequences to his father of the care and treatment which he received at this time. Having considered the advice of the IPA, I am satisfied that overall the assessments and care plans put in place, with some exceptions, as described above, were adequate.

34. Fall on 1 January 2017 – While resident in the home, the resident had an unwitnessed fall on 1 January 2017. Thankfully the effects of this appear to have caused no long term damage as evidenced by his discharge from hospital following an x ray which disclosed no fracture. I comment on the pain relief he received following the fall at paragraph 49 of this report. The IPA has advised me that the resident would have been assessed as being at a 'very high risk' of falling rather than a 'high risk' as assessed by Ard Mhacha. The IPA considered that this would have been a more appropriate categorisation as to his level of risk based on his age, history, medical condition and the fact that he may have had some degree of cognitive impairment.

35. It is evident from an examination of the resident's medical history that he had considerable health, mobility and balance problems and that he had fallen twice in the preceding year. I recognise that it is impossible to prevent all falls in elderly ill persons and given the resident's history, medical condition and age, I cannot state that placing him in the very high risk of falling category as suggested by the IPA rather than the high risk category would have made any material difference in whether or not he actually did experience a fall.

36. However while I am satisfied that the risk of a fall was recognised by Ard Mhacha, I am in agreement with the IPA that he should have been placed in the 'Very high Risk of falling' rather than the 'High risk of falling category' and consider that this represents a failure in his care and treatment. As referenced in the preceding paragraph I cannot conclude that this higher categorisation would have prevented the fall but it would have heightened Ard Mhacha's awareness of the risk and may have led to further measures being put in place or considered. I consider it to have caused the resident the injustice of being placed in a lesser category of risk of fall than

necessary. I also consider it to have caused the complainant the injustice of distress and uncertainty regarding the consequences to his father of the care and treatment which he received at this time.

37. Air Mattress – The complainant complained that his father was not nursed on an air mattress. He was of the opinion that such a mattress had been recommended by the Trust. I have examined Trust documents which looked at this issue and note that no recommendation was made by the Trust in this regard. The IPA has informed me that the use of high specification foam mattresses for adults is reserved for those who have been assessed as being at a high risk of developing a pressure ulcer. The tool used to asses this risk is the 'Braden Score'. The resident was assessed by Ard Mhacha as being at low risk using this score and the IPA stated that the use of an air mattress was not indicated on this basis. I do not uphold this element of the complaint.

38. Swallow – The complainant stated that he was informed by Ard Mhacha that his father had difficulty swallowing. He did not consider this to be the case. I note the review of the assessments and other documentation completed by Ard Mhacha by the IPA. The Choking Risk assessment, the Nutritional assessment, dietary requirements and daily observation notes did not reveal any difficulty being experienced by the resident in swallowing. The IPA stated that from the information available there was no indication that a Speech and Language therapy referral was indicated or that a difficulty in swallowing had been identified. I do not uphold this element of the complaint and trust that the complainant will be reassured by the fact that his father did not display or exhibit any symptoms of swallowing difficulty at this time. I also note the point of information raised by the IPA that there is an increased likelihood of swallowing difficulty in people with Parkinson's disease due to slow swallow. It is perhaps a misunderstanding in the communication of this information which has caused the complainant's impression of what he was told.

39. ii: The medication regime with regard to pain management and the provision of laxatives

40. The complainant complained of inadequate pain relief for his father following the fall on 1 January 2017 and that his father did not receive laxatives or adequate care to the extent that he suffered constipation and an impacted bowel necessitating hospital admission on 14 January 2017.

Clinical Records

41. **3 December 2016 –** Initial assessment. A pain assessment chart was completed and this identified "*musculoskeletal pain ??fall related around L hip area*". This indicates to me that the nursing team were aware that the resident was already experiencing pain from a previous fall and prior to the fall on 1 January 2017.

1 January 2017 - Falls Log,18.40 'Found on floor- unwitnessed. Alert and cooperative on examination. Report of nil obvious injuries, uncomplaining of acute pain. Placed under observation.'

2 January 2017 – Daily Observation notes. *"*dyskinesia (abnormal muscular movements) more pronounced today ? musculoskeletal discomfort following recent fall. Requires analgesia ordered. Mobility slow. Rested on top of bed but requires regular observation for safety."

3 January 2017 – Daily Observation notes. 'awaiting analgesia'

4 January 2017 - Daily Observation notes indicate that analgesia was not given. The observation notes indicate that the resident was exhibiting discomfort. 'Appears quite uncomfortable around L hip area -continue to observe and GP to be informed am. If no improvement for advice after fall few days ago.' By 18:00 that day the records note that the GP had requested that Ard Mhacha send the resident to A&E for an x ray.

14 January2017 - Daily Observation Notes 'at 17:00 […] became distressed and agitated. Was shouting a lot. Suddenly c/o pain in his L ribs area / pointing to heart. Daughter […] present, very concerned. Obs checked: BP 75/41, P 67, sat 85% resp 18. 999 called, paramedics arrived at 17:20, [Resident] fully examined, ECG done, paramedics decided to transfer to CAM for further medical tests' Craigavon Area Hospital, Emergency Dept – 'sudden onset (of pain) this pm, complains of pain in left flank and abdomen' among other things noted on admission was '….. impression of faecal loading…..'

16 January 2017 - Daily evaluation of nursing care

19 January 2017 – CT Scan '….plain film describes rib destruction and pleural plaque, probable mesothelioma (cancerous tumour of the thin layer covering the lungs)..'

42. With regard to pain relief the IPA stated that the resident's pain was not assessed or managed appropriately by the care home nurses during the period prior to him attending A&E for an x-ray on 4 January 2017, because;

(i) The nursing records are not supported by any formal pain re-assessment in the period following the initial pain assessment that was carried out on admission, despite pain being identified as a problem on admission.
(ii) Pain was not further assessed using a pain scale or tool.
(iii) No analgesia was provided following the resident's fall on 1 January 2017 until he went to hospital for x ray on 4 January 2017

43. Following the resident's return to Ard Mhacha from hospital on 6 January 2017, the IPA stated that although a formal pain assessment was not used, a care plan dated 8 January 2017 outlined a plan for pain management. In the Multi-Disciplinary Team (MDT) record the same day, it was noted that analgesia had not been effective: *"GP contacted, informed about (increased) pain and that 1g of paracetamol is not effective. GP will prescribe co-codamol"* The care plan was subsequently evaluated on 13 and 14 January 2017, noting that the level of analgesia remained inadequate and responding with intention to *"refer back to GP".* This is supported by the entry in the MDT records on 13 January 3017 in which the record stated that analgesia was discussed with the GP, who increased the strength of the co-codamol. There are also entries in the daily observation notes that refer to the resident's discomfort in his legs during this period. The IPA stated that these records provide evidence that the resident's pain was recognised, monitored and effectiveness of analgesia evaluated, with GP involvement, on his return from hospital. This was appropriate basic management.

44. In relation to bowel management and the resident's admission to hospital on 14 January with a sudden onset of pain, the IPA stated that she was uncertain that

she could attribute this solely to constipation. The IPA noted that the resident had mesothelionma and pathological right rib fracture according to a CT scan of 19 January 2017 and that he may also have had a chest infection. Prior to 14 January 2017 constipation had been identified and noted on the continence assessment. The resident's bowel habit was recorded to be 'alternate days' 'takes laxatives' and Senna was prescribed.

45. The resident was known to have a history of constipation and due to his medical condition of Parkinson's disease, he would be at risk of faecal impaction if the constipation was not managed. Constipation could cause abdominal pain and although it could be localised or more generalised within the abdomen, it's very unlikely to cause sudden onset of chest pain of the type described. Bowel impaction would probably cause abdominal pain, and could also cause distress, nausea/vomiting, and low blood pressure.

46. The IPA stated that bowel actions were recorded as occurring on a regular basis during 28 December to 3 January 2017. Stool type is described using the Bristol Stool Form and is Typed 1 – 7. Overall the IPA stated that there is no evidence that Ard Mhacha planned care proactively to prevent constipation and she concluded that whilst the resident's bowel movements were documented, they were not adequately managed.

Ard Mhacha response to IPA advice

47. In response to receipt of a copy of the IPA advice, Ard Mhacha responded by stating that the bowel charts indicated regular bowel movements. Prior to going into hospital, while the stool type varied, generally the resident was having stool type 4 and 5. With regard to pain management Ard Mhacha stated that while his pain was recognised monitored and effectiveness of analgesia evaluated with GP involvement, it would have been best practice to have also used a standard pain assessment tool, the Abbey Pain score, alongside the pain assessment chart that was completed.

Analysis and Findings

48. There are two elements to this area of complaint; pain management and observation, and management of bowel movements. I shall consider each in turn.

49. Pain management – The Trust's Adult Safeguarding investigation found that the resident's pain management was not appropriately managed for the period between the unwitnessed fall on 1 January 2017 and his attendance at hospital for an x ray on 4 January 2017. Thankfully this x ray revealed that he had not suffered a fracture. The IPA has also stated this to be the case and I agree with this assessment. It is evident from the records that the resident was not provided with pain relief during this time. I consider this to constitute a failure in his care and treatment. I consider it to have caused him the injustice of suffering an unnecessary level of pain between 1 January 2017 and 4 January 2017. I also consider it to have caused the complainant the injustice of distress and uncertainty regarding the consequences to his father of the care and treatment which he received at this time.

50. The IPA has considered that the pain relief and monitoring which the resident received when he returned from hospital from on 6 January 2017 was of satisfactory standard. His pain was recognised, monitored and the effectiveness of pain relief evaluated, with GP involvement. The IPA stated that this appropriate management could ideally also have been supported by the use of a standardised pain assessment tool. In response to the sharing of the IPA advice Ard Mhacha accepted that it would have been best practice to have used a standard pain assessment tool, the Abbey Pain score, alongside the pain assessment chart that was completed. I welcome the fact that Ard Mhacha accept the best practice advice provided by the IPA and consider this to represent good procedure in that learning has been derived from a complaint.

51. Bowel management – The complainant was concerned that his father's admittance to hospital on 14 January 2017 was caused by severe constipation (faecal loading). From an examination of the clinical records the IPA stated that she was uncertain that she could attribute the sudden onset of pain experienced by the resident and which necessitated his admittance to hospital, solely to constipation.

The IPA noted that the resident was subsequently diagnosed with having mesothelioma (a cancerous tumour of the thin layer covering the lungs), a pathological rib fracture (that is a fracture related to this disease) and a possible chest infection. She considered that these factors would be more likely to have contributed to the sudden onset of pain experienced, though the addition of constipation may have contributed. I accept the IPA advice and conclude that the faecal impacting and constipation was not the sole cause of the resident's pain.

52. In any event, the IPA commented on the resident's bowel management while resident at Ard Mhacha. The resident was known to have a history of constipation and due to his medical conditions and medication would be at risk of faecal impaction if the constipation was not managed. The resident's bowel actions were recorded by Ard Mhacha as occurring fairly regularly and being most frequently of the stool type 5, just one marking up from the Bristol Stool Form type 4, which is a 'normal' stool. On two occasions the stool was described as Type 7 which can be an indication of underlying constipation. The IPA advised that whilst the resident's bowel movements were documented, they were not adequately managed in that there is no evidence that Ard Mhacha planned care proactively to prevent constipation. I also note that a laxative Senna was prescribed, PRN (as required) but that he was only given it on one day, 14 January 2017. I accept the IPA advice and conclude that the failure in planned care proactively to prevent constipation constitutes a failure in the care and treatment which the resident received from Ard Mhacha. The resident's medical condition and the impact of co-codamol would, as the IPA has advised, have increased his risk of constipation. The resident's bowel movements and underlying constipation was managed reactively rather than proactively to prevent this. I consider this to be a failing of care and treatment which caused the resident the injustice of suffering an increased constipation and faecal impaction during his stay in Ard Mhacha. I also consider it to have caused the complainant the injustice of distress and uncertainty regarding the consequences to his father of the care and treatment which he received at this time.

(ii) Weight management

Details

53. The complainant complained that his father suffered severe weight loss while a resident in Ard Mhacha as a result of a failure to meet his nutritional requirements.

Evidence Considered

Trust review of documentation as part of Adult Safeguarding process

54. The Trust considered the resident's weight as part of its Adult Safeguarding investigation. Its report reveals that Ard Mhacha's manager explained that due to discrepancies identified with the weights of other residents, the home's weighing machine was recalibrated. As a result the resident's weight was rechecked and recorded as 64.45 on 26 December 2016 rather that the weight of 61.1 recorded for earlier that day. The Trust calculated that overall, while a patient in Ard Mhacha, the resident had lost less than 5% of his body weight. This level of weight loss does not warrant a dietitian referral.

55. The resident's weight was recorded pre admission to Ard Mhacha, while resident in Ard Mhacha and in Craigavon Area Hospital as follows;

Date	**Weight (kg)**	
21 October 2016	68.8	
29 November 2016	66.8	
4 December 2016	66.05	Ard Mhacha (admitted 2 December 2016)
10 December 2016	66.40	Ard Mhacha
18 December 2016	62.7	Ard Mhacha
26 December 2016	61.1	Ard Mhacha
26 December 2016	64.45	Ard Mhacha (after scales recalibrated)
18 January 2017	64.2	Craigavon area Hospital

56. The IPA advised that, using weight measurement tools (MUST) any unplanned weight loss greater than 5% over a 3-6 month period triggers a risk score. Calculating the weights recorded, the IPA advised that the resident's weight loss between 4 December 2016 and 18 January 2017 was 1.85kg which is 2.8%. The IPA advised that the rate of weight loss would not have triggered a concern or required referral to a dietitian.

Analysis and Findings

57. The complainant alleged that his father suffered weight loss following his admission to Ard Mhacha on 2 December 2016. He stated that he was shocked at the extent of this weight loss when he first visited his father on 12 January 2017. This issue has been carefully considered and I note the recorded weight measurements for the resident before he was admitted to Ard Mhacha, during his time there and after his admittance to Craigavon Area Hospital. The recorded weights are fairly consistent from October 2016 to 10 December 2016 at around 66/68kg. A noticeable drop in weight is recorded, with the two following weight measurements on 18 and 26 December 2016 being in the range 61/62kg. In response to investigation enquiries, this has been explained by Ard Mhacha as resulting from a fault in the weighing machine used. When it was recalibrated the resident's weight was recorded on subsequent occasions, both in the home and at Craigavon Area Hospital as being 64kg. I note the finding of both the IPA and the Trust's Adult Safeguarding Investigation which states that a weight loss of less than 5% does not warrant a referral to a dietitian. I also note the complex health problems experienced by the resident which were particularly acute during December 2016 and January 2017 which necessitated his treatment in hospital. I consider that this may have been a factor in any weight loss which he may have experienced at this time. I do not uphold this element of the complaint.

CONCLUSION

57. I received a complaint about the care and treatment of a resident of Ard Mhacha Care Home.

58. I have investigated the complaint and have found failures in relation to the following matters:

- Failure to carry out blood pressure monitoring
- Inconsistency between the falls risk assessment and the care plans and insufficient information about the resident's mental state
- Category of risk of fall
- Pain Management
- Bowel Management

59. I am satisfied that the identified failures caused the resident to experience the injustice of not having the known falls risk factors of blood pressure monitoring and mental state being comprehensively included in his falls risk assessment, being placed in a lesser category of risk of fall than necessary, suffering an unnecessary level of pain between 1 January 2017 and 4 January 2017, and of suffering an increased risk of constipation. I also consider it to have caused the complainant the injustice of distress and uncertainty regarding the consequences to his father of the care and treatment which he received at this time.

Recommendations

60. I recommend that the complainant receives an apology for the failures in care and treatment identified together with a payment of £500, in solatium, for the injustices sustained by him.

61. As part of my investigation, I shared a copy of a draft report with both the complainant and Runwood Homes. I am pleased to note that the Chief Operating Officer of Runwood Homes has stated that it accepts the recommendations made in

this report. It stated that it would like to assure the complainant that the lessons learned from this investigation have been applied across all Runwood Homes and measures have been taken and implemented in all services by way of proactive learning and development and as a means of avoiding incidents of a similar nature.

62. In relation to the falls management process, Runwood has developed a Falls Toolkit, designed by a qualified Occupational therapist, due to be implemented across all its homes. Further training in managing and grading a resident in terms of their risk score has also been rolled out across all services. Runwood stated that the Falls Toolkit includes areas whereby special consideration is given to any pre-existing medical conditions, medications, intrinsic and extrinsic factors associated with falls risk. Runwood has requested accreditation from the college of Occupational Therapy prior to the final rollout.

63. Runwood also stated that the use of the Abbey Pain scale, when completing pain assessment charts in dementia care, has been reemphasised. The Bristol Stool Chart used for the management of continence now includes a paragraph on the possibility of bowel extraction should a resident show any signs of pain along with loose type stools over a 24 hour period. This will serve as a reminder to all nurses and care staff that an obstruction may be the cause of both pain and discomfort and to seek further medical attention in the event that there could be underlying issues. Further continence training has also been sourced and will be delivered to all homes by the end of January 2019. In addition all Home managers have been reminded of the importance of a full admission assessment and to give special predisposition to any medical issues. Furthermore any resident presenting with low or high blood pressure must remain under close observation with blood pressure being taken in both a lying and standing position if applicable and prescribed by a medical practitioner.

64. As part of its monitoring processes Runwood has introduced a sampling of both pre-admission and admission assessments to identify any potential areas of concern. Monitoring visits also sample residents care files which include cross referencing any risk assessments with care plans to ensure correlation and that adequate care is

being provided. A monthly care file tool is also carried out by the Home manager and submitted to head office for senior management perusal. The Chief Operating Officer stated that he hoped that the steps taken to improve services might go some way to reassuring the complainant that Runwood Homes had fully taken on board the findings of my investigation report.

65. In response to receipt to a copy of my draft report the complainant accepted the findings of failings in the care and treatment that his father received. He was concerned that under the legislation which I operate, I cannot recommend that staff involved in his father's care be disciplined. However I am reassured by the significant systemic changes that have been made by Runwood and which evidence the learning which has come from this complaint.

MARIE ANDERSON
Ombudsman **February 2019**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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