Investigation Report

Investigation of a complaint against

Belfast Health and Social Care Trust

NIPSO Reference: 16708

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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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EXECUTIVE SUMMARY

I received a complaint concerning the actions of the Belfast Health and Social Care Trust (the Trust). The complaint against the Trust relates to how the Trust dealt with a complaint regarding the care and treatment received by the late mother of one of the complainants from a Care Home. The patient was resident in Domnall Care Home (Domnall) during the period 10 September 2013 to 21 October 2013. She subsequently died in April 2014 aged 84 in the Ulster Hospital Dundonald.

Issues of Complaint

I accepted the following issue of complaint for investigation:

- Complaints Handling by the Trust.

The complainants also raised a complaint about the care and treatment the patient received while a patient with the South Eastern Health and Social Care Trust (Case reference (14634) and regarding the actions of the Domnall Care Home (Case reference 17241). I have investigated and reported on these complaints under the respective case numbers.

Findings and Conclusion

The investigation of this complaint has not identified maladministration in respect of the matter complained of. I consider that the Trust dealt with the complaint appropriately.

THE COMPLAINT

1. The issue of complaint which I accepted for investigation was:

(i) Whether the Belfast Health and Social Care Trust (the Trust) adequately investigated the complaint about Domnall Nursing Home?

2. The complainants provided a comprehensive and extensive narrative of the care and treatment which the patient received in Domnall Care Home (Domnall). This is a care home owned by Four Seasons Healthcare. They raised a number of concerns and queries which they considered should be answered during the course of this investigation. They also provided detailed responses and narratives in correspondence with the Trust. In particular, a detailed letter was sent to the Complaints Department of Musgrave Park Hospital on 22 September 2014. A total of 67 queries were raised in that letter of complaint. I refer to Article 30(6) of the above Order which states that 'the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the circumstances of the case'. It is for me to determine the significance of the various elements in a complaint to my office. This investigation has focused on the Trust's responses to the receipt of their complaint. The Trust is responsible for investigating the concerns raised by the complainants as it commissioned the patient's care.

INVESTIGATION METHODOLOGY

3. In order to investigate this complaint, the Investigating Officer obtained from the Trust its complaints file containing all relevant documentation. I have read the detailed correspondence in this file together with written responses to investigation queries. The Investigating Officer also obtained a copy of the contract between the Trust and the registered care provider, Domnall.

4. A copy of this report in draft form was shared with the Trust and the complainants for comments on factual accuracy and the reasonableness of the findings. The Trust had no further comments to make. I have considered the complainant's comment relating to a meeting held with the Trust and Four Seasons on 11 September 2015,

however I have not changed my findings and conclusion with regard to this complaint.

Standards

5. 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.

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

6. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional judgement functions of those organisations and individuals whose actions are the subject of this complaint.

The specific standard and reference relevant to the issue in this complaint is:

(i) Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning (April 2009, updated October 2013) (the HSC complaints procedure). This is the only complaints handling procedure in Northern Ireland that has a statutory basis.

Under the HSC complaints procedure a complaint can be raised by the complainant with the registered care provider or the Trust. The Trust has an overall responsibility to discharge its duty under Article 4 of the Health and Personal Social services (NI) Order 1972 to promote the social welfare of all residents in the home.

7. I have not included all of the detailed information obtained in the course of the investigation in this report. However, I am satisfied that all evidence that I consider

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

to be relevant has been carefully considered in my findings and conclusion.

Background to the complaint

8. The late mother of one of the complainants was resident at Domnall from 10 September 2013 until 21 October 2013.

9. The patient suffered from long standing poorly controlled type 2 diabetes and hypertension, and was in receipt of regular dialysis therapy. She underwent a below knee amputation of her left leg in August 2013 due to diabetic vascular disease, and was discharged from the Ulster Hospital, Dundonald (UHD) to Domnall on 10 September 2013. Previously she had lived in her own home. She was assessed at the UHD neurovascular clinic on 20 September 2013 following a presumed TIA (Transient Ischaemic Attack). She subsequently suffered a stroke on 18 October 2013. Following this stroke, she was readmitted to UHD on 21 October 2013 where she remained until she sadly passed away in April 2014 at the age of 84. During this period of time she received dialysis, normally 3 days per week, in the UHD Renal Unit.

10. On 21 April 2014, the complainants made a complaint to Domnall in relation to the care and treatment the patient had received while resident there. Following two detailed responses from Domnall on their issues of complaint (on 28 May 2014 and 1 September 2014), they complained to the Trust by letter dated 22 September 2014. The Trust responded to their complaint on 2 February 2015 and received further questions and comments from them on 27 May 2015. Following receipt of the complainants' further comments, the Trust arranged to meet them along with staff of Four Seasons Health Care. This meeting was followed with a further detailed response from the Trust to their issues of complaint on 27 October 2015. The complainants wrote to the Trust again on 17 December 2015. The Trust's response, dated 3 February 2016, included advice to the complainants that if they remained dissatisfied they should take their complaint to my office. By letter dated 30 March 2016, they complained to my office.

THE INVESTIGATION

11. I have considered the standards for complaints handling outlined in the HSC complaints procedure which are relevant to this complaint. I have also considered detailed documentation from the Trust's complaints file and related correspondence with the complainants. I refer to the following extracts from the HSC complaints procedure which is relevant to this case:

12. **'*Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning (****the standard****)***

Paragraph 3.38 – 'A response must be sent to the complainant within 20 working days of the complaint, or where that is not possible, the complainant must be advised of the delay'.'
Paragraph 3.42 – 'The response should be clear accurate balanced simple and easy to understand…..'

13. I refer to Trust correspondence sent to the complainants dated 30 September 2014, 3 November 2014, 18 December 2014 from the Trust. This correspondence advised them that the Trust's investigation was ongoing and that they would be contacted when its investigation was complete.

14. As part of this investigation, I have also considered letters dated 12 June 2015, 26 June 2015, 4 August 2015, 14 August 2015 and 26 August 2015 to the complainants from the Trust. These advised of the progress made in its investigation of their complaint. They document attempts being made to arrange a meeting with the Trust, staff of Four Seasons Health Care and the complainants.

Analysis and findings

15. The complainants made a complaint to Domnall on 21 April 2014 in relation to its care and treatment of the patient. They remained dissatisfied with Domnall's subsequent responses to their complaint. They complained to the Trust in a detailed letter dated 22 September 2015. In response to the complaint, the Trust appointed

an Assistant Service Manager to carry out an investigation into the comprehensive and detailed concerns raised by the complainants in relation to the care of the late patient. The Trust determined that the complainants' letters of complaint consisted of 78 separate areas of concern. As part of the Trust's investigation, the Assistant Service Manager interviewed Domnall staff and reviewed its records. The Trust then provided three comprehensive responses to the complainants, on 2 February 2015, 27 October 2015 and 3 February 2016. I note that the Trust facilitated a meeting between them and Four Seasons Health Care, the owners of Domnall on 11 September 2015 in an attempt to resolve their concerns.

16. The relevant HSC standard of complaint handling states that a response must be sent to the complainant within 20 days of receipt of the complaint and where this is not possible the complainant must be advised of the delay. The complainants were advised of a delay in finalising the Trust's investigation of their complaint on eight occasions as evidenced in the attached chronology. I am satisfied that in this case the Trust met the standards outlined in the HSC procedure. I fully accept that there may be circumstance when complaints handling timescales may need to be exceeded. In this case, given the complex nature of this investigation and the voluminous number of issues raised, I consider it reasonable that the 20 day time limit for responding to a complaint was exceeded. The Trust dedicated a senior member of staff to investigate this complex complaint which demonstrates that it took the complaint seriously. This enabled comprehensive responses to be provided to the complainants. I do not find maladministration in relation to the time taken by the Trust to respond to their complaint. Although the responses were outside the timeframe outlined in the HSC complaints procedure, this was a complex and serious complaint which required detailed investigation by the Trust, given the nature of the concerns raised.

17. I note that the investigation relating to this complaint was conducted by two members of the Trust's staff. The Trust's Assistant Services Manager led the investigation assisted by its quality coordinator. The investigation consisted of reviewing Domnall's medical and nursing notes and assessments, obtaining and reviewing documentation relating to referrals from UHD, wound care, medication and dietitian advice. During the course of the Trust's investigation, the Home's Regional

manager and Domnall's manager and staff were interviewed. The Trust also facilitated a meeting between the complainants, Four Seasons Health Care and the Trust. A meeting was arranged with the Home manager and best practice was reviewed. I have also considered the responses from the Trust to the complainants dated 2 February 2015, 27 October 2015 and 3 February 2016. Having carefully examined these responses, I am satisfied that the Trust responded adequately and with the necessary level of detail and that responses to the clinical questions raised by them were responded to.

18. The Trust's letter of 3 February 2016 concluded by stating that if the complainants had any further concerns, they ought to raise their complaint with my office. I am satisfied that they were properly signposted to this office at the conclusion of the Trust's complaints process.

19. Overall, I have considered the progress of this complaint through the Trust's complaints process. I have also considered the detail of the Trust's correspondence with the complainants and the actions it took. I am satisfied that their complaint was properly addressed by the Trust. This was a serious complaint and given the multiple issues raised by them concerning the patient's care, it required a proportionate and comprehensive response from the Trust. Genuine efforts were made by the Trust to resolve the complainants' concerns as required by the HSC complaints procedure, which is aimed at providing 'an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint'. I am satisfied having regard to the second Principle of Good Complaints Handling (appendix three) that the Trust's response to this complaint demonstrated a customer focus with a genuine attempt to resolve the issues. Resolution of complaints of this nature where there is a bereavement can be difficult to achieve. The nature and detailed responses to their complaint and the meeting facilitated by the Trust, reflects in my view a concerted attempt to resolve their concerns. The Trust adequately investigated the complaint about the care and treatment provided to the patient by Domnall. The Trust's response to this complaint was comprehensive. There is no maladministration by the Trust in its dealing with this complaint. I commend the Trust for the comprehensive nature of its investigation.

CONCLUSION

20. I have investigated the concerns raised by the complainants about how the Trust handled their complaint regarding the care and treatment received by the patient at Domnall. Following my investigation I have not found evidence of maladministration. I am satisfied that that the Trust conducted the investigation into this complaint appropriately and thoroughly and I note and commend its actions in attempting to identify and resolve the multiple concerns met the standards of the HSC complaints procedure.

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.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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