Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Conway Group Healthcare

NIPSO Reference: 201915712

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

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

I received a complaint about the care and treatment the complainant's mother received while she was resident in The Cottage Care Home ('the Nursing Home'), which is managed by Conway Group Healthcare. The complainant's mother, who sadly, passed away on 12 March 2019, is referred to in this report as 'the Resident'.

The complaint is about particular aspects of the Resident's care and treatment, which the complainant considered to be '*seriously inadequate and totally unsatisfactory*.' In particular, the complainant said the Nursing Home did not manage the Resident appropriately during and after a moving and handling incident that occurred on 15 February 2019. She described how, while the Resident was being assisted to transfer from her bed to a chair that day, her foot became caught in her bedrail and she sustained a fracture to her right femur.

The complainant also said the Nursing Home failed to provide the Resident with adequate oral health care and that, as a result of this, there was a delay in it being discovered, on 3 March 2019, that the Resident's dentures had become lodged in her throat. The complainant considered this incident caused the Resident to sustain a prolonged period without sufficient oxygen and, consequently, to develop pneumonia.

I obtained from the Nursing Home all relevant documentation together with its comments on the issues the complainant had raised. I also obtained independent professional advice from a Registered Nurse.

My investigation found a number of significant failings in the care the Nursing Home provided to the Resident. I concluded that the traumatic events the Resident experienced on 15 February 2019 and 3 March 2019, and their ultimate impact on the Resident's health, mobility and independence, may well have led to the shortening of her life.

In relation to the moving and handling incident on 15 February 2019, I found that the Nursing Home:

- failed to appropriately manage the Resident's transfer from bed to her chair, which I consider, on the balance of probability, caused the Resident to sustain a fracture to her right femur;

- failed to complete an appropriate clinical assessment of the Resident following the incident;

- failed to reassess the Resident for potential injury in the hours that followed the incident; and

- failed to contact the out-of-hours GP service on 16 February 2019, at the earliest opportunity, after swelling to the Resident's right thigh had been noted.

With regard to the incident involving the Resident's dentures on 3 March 2019, I found that the Nursing Home:

- failed to have in place an oral health policy and a detailed oral health care plan for the Resident;

- failed to provide appropriate oral hygiene care for the Resident on 2 and 3 March 2019; and

- failed to recognise the Resident's presenting symptoms at that time could indicate that she had swallowed her dentures.

In addition, I concluded that the manner in which the Nursing Home managed the Resident's oral hygiene care indicated it did not have proper regard to the Resident's human rights in terms of her dignity. The absence of appropriate oral hygiene care was of also of concern because of the well-documented association between poor oral hygiene and aspiration pneumonia, which accounts for 48% of all chest infections in nursing home residents.[1]

I considered it was highly likely that both the moving and handling incident on 15 February 2019 and the incident involving the Resident's dentures on 3 March

[1] GAIN Guidelines for the Oral Healthcare of Older People Living in Nursing and Residential Homes in Northern Ireland, October 2012

2019 caused the Resident to experience a significant degree of pain and discomfort. It is concerning that not only were both incidents, and the Resident's subsequent suffering, preventable but in both cases, appropriate action was initiated only after the intervention of family members.

I was satisfied therefore that the failures in care identified by my investigation caused the Resident to sustain the injustice of upset and distress, and a loss of opportunity to have the fracture to her femur and her displaced denture plate diagnosed and treated sooner than was the case.

I was also satisfied that the Resident's family members – in particular, her daughter (the complainant) and her two sons – experienced the injustice of uncertainty, upset and distress over the appropriateness of the care the Resident had received. They also experienced the further injustice of upset and distress at having to pursue, through my Office, their concerns about that matter.

I recommended that the Chief Executive of Conway Group Healthcare provide a written apology to the complainant for the injustice caused by the Nursing Home's actions, and that the Nursing Home implement a number of service improvements.

THE COMPLAINT

1. I received a complaint about the actions of The Cottage Care Home ('the Nursing Home'), which is managed by Conway Group Healthcare. The complaint concerned certain aspects of the care the complainant's late mother (referred to in this report as 'the Resident') received during the period February to March 2019, when she was 82 years old. Sadly, the Resident passed away at the Nursing Home on 12 March 2019.

2. The complainant raised concerns about two particular incidents. The first incident occurred while the Resident was being assisted by Nursing Home care staff to transfer from her bed to a chair on Friday, 15 February 2019. During the transfer, the Resident's foot became caught in the bedrail. The following day, an x-ray at Altnagelvin Hospital confirmed that the Resident had sustained a fractured distal femur.[2] The complainant said she believed this injury was caused as a result of the Nursing Home staff mismanaging the Resident's transfer from bed to her chair. The complainant also maintained that the Resident was not assessed appropriately after the incident occurred.

3. The second incident occurred on Sunday, 3 March 2019. The complainant said that she found the Resident's dentures at the back of the Resident's throat, partially obstructing her airway. The complainant expressed concern that the Nursing Home had not realised at an earlier stage that the Resident's dentures had become displaced. She said this meant that the Resident suffered a prolonged period of reduced oxygen.

4. The complainant said she believed the care the Resident received at the time of the two incidents was '*seriously inadequate and totally unsatisfactory, and non-compliant with the expected standards and regulations.'* She described the impact of the Nursing Home's actions. She said, *'My two brothers and I are deeply saddened, disappointed and hurt by these two incidents which had a detrimental effect on our mum's health causing huge level of unnecessary suffering and pain, and shortening of her life. We know that neither of these*

[2] A distal femur fracture is a break of the thigh bone just above the knee. It can result in cracks that extend into the knee joint itself. They can also happen around total joint replacements.

incidents should have happened. We regret how we had to observe our mum in her final days.' The complainant said too, *'Mum had to endure long and difficult journeys to and from various hospitals sharing ambulances and showing such fear as she really did not understand what was happening to her.'*

5. To emphasise the impact of the two incidents on the Resident, the complainant provided details of her previous typical daily routine in the Nursing Home. The complainant explained that the Resident, who had a history of Parkinson's Disease, dementia associated with Parkinson's Disease and osteoporosis, needed the assistance of two members of staff to transfer between her bed and chair, and that she required full assistance at mealtimes and with fluids. The complainant described how the Resident '*loved to be up every morning and sat in the foyer of the Nursing Home so she could see the activities going on around her.'* She said too that the Resident *'always enjoyed a wee chat with anyone who was coming in and out of [the Nursing Home].'* The complainant also explained that the Resident rested in bed every afternoon, was assisted out of bed in the late afternoon for tea, and was assisted back into bed afterwards for further rest. The complainant described how the Resident's family visited her '*at least twice every day'* and that they were *'very involved in her care'.*

Issues of complaint

6. I accepted the following two issues of complaint for investigation:

Issue One: Whether the care and treatment that was provided to the Resident on 15 February 2019 was in accordance with good medical practice. In particular:

(i) Whether the Resident was appropriately assessed in relation to her moving and handling risk assessment; and

(ii) Whether the resident was managed appropriately following the moving and handling incident on 15 February 2019.

Issue Two: Whether the care and treatment provided to the Resident on 3 March 2019 was adequate and in accordance with good

medical practice.

INVESTIGATION METHODOLOGY

7. In order to investigate the complaint, the Investigating Officer obtained from the Nursing Home all relevant documentation, together with its comments on the issues the complainant raised. This documentation included the Resident's Nursing Home records and information relating to the Nursing Home's handling of the complaint the complainant made to it on 21 July 2019 about the moving and handling incident on 15 February 2019 and the incident involving the Resident's dentures on 3 March 2019.

8. This complaint concerns care that was provided to the Resident by a number of specific Nursing Home staff – the two care assistants who assisted the Resident to transfer from her bed to her chair on 15 February 2019, the registered nurse on duty on 15 February 2019 and the senior registered nurse on duty on 16 February 2019. These staff members are referred to in this report as 'Care Assistant 1', 'Care Assistant 2', 'the Registered Nurse' and 'the Senior Registered Nurse'.

9. I should highlight that my investigation examined the actions of the Nursing Home only; it did not concern the actions of the (now former) Health and Social Care Board (HSCB) or the Northern Health and Social Care Trust (NHSCT), whose actions and/or procedures are also referred to in this report.

Independent Professional Advice Sought

10. I obtained independent professional advice from a Registered Nurse with 17 years' clinical experience of nursing within the National Health Service and the private sector in England, as well as overseas; in hospitals; GP surgeries; and nursing homes.

11. I should point out that independent professional adviser ('the IPA') provided me with 'advice'; how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

12. 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. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles:[3]

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

13. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions and professional judgement of the Nursing Home staff whose actions are the subject of this complaint.

14. The specific standards relevant to this complaint are:

- The Department of Health, Social Services and Public Safety Northern Ireland's[4] Care Standards for Nursing Homes (2015) ('the Department of Health's Nursing Home Care Standards');

- The Department for Health, Social Services and Public Safety Northern Ireland's Care Standards for Nursing Homes Resident's Guide (2015) ('the Department of Health's Nursing Home Resident's Guide');

- National Institute for Health and Care Excellence (NICE) Guideline - Oral Health for Adults in Care Homes (2016) ('the NICE Oral Health for Adults in Care Homes Guideline');

- Guidelines for Audit and Implementation Network (GAIN) Guidelines for the Oral Healthcare of Older People Living in Nursing and Residential Homes in Northern Ireland (2012) ('the GAIN Guidelines for Oral Healthcare');

[3] These principles were established through the collective experience of the public services ombudsman affiliated to the Ombudsman Association
[4] Now the Department of Health

- Conway Group Healthcare's Manual Handling Policy (2018) ('the Nursing Home's Manual Handling Policy');

- Conway Group Healthcare's Accidents Involving Residents Policy (2018) ('the Nursing Home's Accidents Policy');

- Conway Group Healthcare's Adult Safeguarding Policy (2018) ('the Nursing Home's Adult Safeguarding Policy');

- HSCB Northern Ireland Adult Safeguarding Partnership[5] Adult Safeguarding Operational Procedures[6], (2016) ('the HSCB's NIASP Adult Safeguarding Procedures'); and

- Northern Ireland Social Care Council's Standards of Conduct and Practice for Social Care Workers ('the NISCC Standards for Social Care Workers').

15. I did not include in this report all of the information obtained in the course of the investigation but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

16. I shared a draft of this report with the complainant, the Chief Executive of Conway Group Healthcare, Care Assistant 1, Care Assistant 2, the Registered Nurse and the Senior Registered Nurse to give them the opportunity to comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant submitted comments in response, and I gave careful consideration to those comments in finalising this report. I did not receive any comments from the Chief Executive of Conway Group Healthcare. Care Assistant 1, Care Assistant 2, the Registered Nurse and the Senior Registered Nurse all indicated they did not wish to make any comment on the draft report.

[5] The Northern Ireland Adult Safeguarding Partnership (NIASP) is a multi-agency, multi-disciplinary partnership, which brings together representatives from a range of statutory, community and voluntary organisations, who have a significant contribution to make to the safeguarding of vulnerable adults.
[6] The NIASP Adult Safeguarding Procedures provide that safeguarding concerns are investigated by the relevant Health and Social Care Trust, which appoints a Designated Adult Protection Officer (DAPO) to carry out the investigation

THE INVESTIGATION

Issue One: Whether the care and treatment that was provided to the Resident on 15 February 2019 was in accordance with good medical practice.

Detail of Complaint

17. The complainant raised concerns about a moving and handling incident that took place in the Nursing Home on 15 February 2019 ('the Moving and Handling Incident'). She complained that the care and treatment the Resident received in the Nursing Home at the time of the Moving and Handling Incident on 15 February 2019, and in the hours that followed it, was inadequate.

18. Specifically, she complained that the Resident's transfer from her bed to her chair was mismanaged, with the result that her foot became caught in the bedrail. The complainant also expressed concern that the Resident was not assessed appropriately following this incident, with the result that it was not discovered until the following day, following the Resident's transfer to Causeway Hospital, that she had sustained a fracture to her right femur.

Evidence Considered

Policies and Guidelines

19. I considered the following policies and guidelines:
    - the Nursing Home's Manual Handling Policy;
    - the Nursing Home's Accidents Policy;
    - the Nursing Home's Adult Safeguarding Policy;
    - the Department of Health's Nursing Home Care Standards; and
    - the HSCB's NIASP Adult Safeguarding Procedures.

20. Relevant extracts of the policies and guidelines I considered are at Appendix Two to this report.

Relevant Documentation

21. I completed a review of the documentation I obtained from the Nursing Home, which included the Resident's records; records relating to the Nursing Home's investigation of the Moving and Handling Incident; and the Nursing Home's file

relating to the complaint the complainant made to Conway Group Healthcare on 21 July about the care and treatment it had provided to the Resident.

22. I also reviewed records I obtained from the out-of-hours GP service the Nursing Home contacted on 16 February 2019, the day after the Moving and Handling Incident.

23. Relevant extracts of the documentation I examined are at Appendix Three to this report.

The Nursing Home's response to investigation enquiries

24. I asked the Nursing Home if the Resident had a moving and handling risk assessment in place at the time of the Moving and Handling Incident. The Nursing Home responded, '…[*The Resident] had a manual handling assessment completed on 01.02.2019 … by [named Registered Nurse]. The assessment identified [the Resident] requiring* [sic] *the assistance of two staff for transferring from bed to chair/toilet using a standing aid with a medium sized sling. It also documents that [the Resident] required the assistance of two staff and a slide sheet for moving up and down the bed. The manual handling technique carried out on the 15th February 2019 was as per this manual handling assessment.* The Nursing Home also stated, *'[The Resident's] manual handling assessment on 1 February 2019 was for two staff to assist with the aid of a stand hoist.*[7] *Between 1 February 2019 and 15 February 2019 there is no clinical indication to suggest that [the Resident] required a full hoist and full body sling.*[8]

25. In response to enquiries about its management of the Moving and Handling Incident, the Nursing Home stated, *'[Care Assistant 1] and [Care Assistant 2] reported the incident on the 15th February 2019 directly after the incident occurred to [the Registered Nurse], who was the registered nurse in charge. In her statement, [the Registered Nurse] states this was at approximately 16:30*

[7] Patient hoists were developed to assist carers in moving patients via a suitable manual handling method. A standing hoist is used by service users who have lost balance or strength to stand independently.

[8] Full-Body Slings are Hammock Slings. With this style sling the whole body is supported in the sling and the arms are inside the sling straps. However, the patient's legs (from knee-to-foot) will hang on the outside of the sling.

hours.' The Nursing Home also stated, *'[The Registered Nurse] has documented on 15th February 2019 that during her clinical assessment of [the Resident] she did not "grimace or express any discomfort". There were no further complaints of pain expressed from [the Resident] during the night.'*

26. In relation to the impact of the Moving and Handling Incident, the Nursing home stated, *'It is impossible to establish if the fracture occurred on 15th February 2019 due to [the Resident's] osteoporosis[9] and the fragility of her bones.'* The Nursing Home went on to point out that NHSCT's Adult Safeguarding investigation into the Moving and Handling Incident had concluded the matter was '*inconclusive/unsubstantiated as neglect.'*

27. In response to investigation enquiries regarding the documenting of the Moving and Handling Incident, the Nursing Home stated, *'I confirm from [the Registered Nurse's] entry in the electronic clinical records, that the incident was documented in [the Resident's] Epicare[10] records on 15.02.19 at 18:56. Due to the lack of evidence that an injury had been sustained at that time an incident report was not felt to be required and so was not completed, with further evidence and concerns escalated regarding the swelling to [the Resident's] leg on the 16th February 2019, an incident report was then completed on 16th February 2019'.*

Statements of Nursing Home Staff

28. I considered the written statements Care Assistant 1, Care Assistant 2, the Registered Nurse and the Senior Registered Nurse made regarding the Moving and Handling Incident, which the Nursing Home provided to me in response to my investigation enquiries.

29. The written statements are reproduced at Appendix Four to this report.

[9] Osteoporosis is a health condition that weakens bones, making them fragile and more likely to break. It develops slowly over several years and is often only diagnosed when a fall or sudden impact causes a bone to break (fracture). The most common injuries in people with osteoporosis are: broken wrist and broken hip.
[10] Epicare is the electronic clinical record system used by the Nursing Home.

Independent Professional Advice

30. I asked the IPA for advice on whether the Resident had a moving and handling risk assessment in place at the time of the Moving and Handling Incident. In response, the IPA advised, '*At the time of the incident on 15 February 2019 where [the Resident] was injured there was a manual handling assessment in place, dated 1st February 2019. The assessment reports that [the Resident's] balance varied, she was co-operative and had good weight-bearing. For the following tasks [the Resident] needed the assistance of two members of the nursing team:*

- *Chair to stand, medium sling, using a stand-aid*
- *Chair to toilet, medium sling, using a stand-aid*
- *Chair to bed, medium sling, using a stand-aid*
- *Bed to chair, medium sling, using a stand-aid*
- *Moving up the bed, slide sheet*
- *Moving down the bed, slide sheet'.*

31. The IPA further advised, *'[The Resident] was appropriately assessed in relation to her manual handling risk assessment. There was sufficient information, which was very clear and easy to understand, available in [the Resident's] moving and handling assessment for carers and nursing staff to select the correct equipment to carry out moving and handling tasks.*

32. In addition, the IPA advised, *'[The Resident's] manual handling assessment was completed in accordance with[the Nursing Home's] policy and procedures and in line with good medical practice. [The Nursing Home's] manual handling policy advises that [the Nursing Home] needs to comply with the Manual Handling Operations (1922), in that a suitable manual handling risk assessment is in place which sets out which hoists, slings and sliding aids should be used routinely to move patients without the need for manual lifting.'*

33. The IPA was asked for advice on whether Nursing Home staff continued to move the Resident after her foot had become lodged in the bedrail during the Moving and Handling Incident. The IPA advised, *'Yes, care staff continued to move [the Resident] when her foot became lodged in the bed. This was not*

appropriate and care should have been taken to ensure that limbs were not at risk of becoming trapped during the moving and handling process.'

34. I asked the IPA whether the available records demonstrated that the Resident had been assessed following the Moving and Handling Incident. The IPA advised*, 'After [the Resident's] foot was caught in the bedframe and she was transferred to her chair using a stand-aid … the carers asked [the Registered Nurse] to make an assessment of [the Resident's] right leg.'*

35. I asked the IPA for advice on whether the assessment of the Resident that had been carried out following the Moving and Handling Incident had been appropriate in the circumstances. The IPA advised, '*Hip fractures occur mostly in older people, many of whom have other health problems and some neurological impairment … Patients often present with pain in the outer thigh or groin, along with the inability to walk, but some movement may be possible. If the injury has caused the bones to come apart the affected limb may appear shortened and or rotated.'*

36. The IPA continued, *'While it was necessary for [the Resident] to be checked by a nurse following any potential injury caused during the transfer from bed to chair, it might have been more appropriate to call for the nurse to assess for injury while [the Resident] remained in bed. It is easier to compare the appearance and movement of limbs to assess for injury when a patient is lying down rather than sitting in a chair. It would have taken only a little time to lay [the Resident] down again and it might have been possible to observe if the right leg was shortened or rotated, which might have indicated a fracture and the need for hospital admission a day sooner.'*

37. The IPA provided further clarification of why he considered it may have been more appropriate for the Resident to have been assessed whilst lying in bed. Specifically, the IPA advised, '*It is possible that [the Resident] will have had a non-displaced fracture which would have no obvious deformity but in the majority of cases there will be some fracture displacement and, as a result, when a patient lies flat the affected leg will rotate externally and appear shortened. If a fracture is suspected it is best assessed when the patient is*

lying in a supine position[11] and had the nurse assessed [the Resident] when she was still in bed the injury might have been more evident, resulting in the need for hospital treatment sooner.' The IPA also advised, however, that he did not consider the fact that the Resident had not been assessed whilst lying down in bed meant there had been a failure in her care and treatment.

38. With regard to the specific assessment that was carried out while the Resident was in sitting in her chair, the IPA advised that he did not consider this to have been appropriate in the circumstances, and in accordance with relevant standards and guidelines. He advised, *'It was entirely appropriate for [the Resident] to be assessed by a nurse after [the Moving and Handling Incident] … [the Registered Nurse] came and carried out a clinical assessment to check for injury. The Resident was sat in a chair at the time. [The Registered Nurse] appropriately checked for evidence of redness, swelling and bruising to the right limb. [The Registered Nurse] also asked [the Resident]if she was experiencing any pain, to which she replied "No, only if I do something. If I do nothing I am ok". [The Registered Nurse] then carried out flexion[12] of the Resident's right foot , during which [the Registered Nurse] watched [the Resident's] facial expressions and [the Resident] didn't grimace or express any discomfort.'*

39. The IPA continued, *'It is possible to assess a patient for femur fracture if they are sitting in a chair, but this involves a different technique than flexing the foot. If a femur fracture is present, it will be painful and unstable at the thigh … and the patient would not be able to perform an active straight leg raise. An active straight leg raise has proven to be an effective way of diagnosing a femur fracture and involves asking the patient to straighten their leg at the knee and lift it into the air. It is likely that had [the Resident] been asked to perform a straight leg raise she would not have been unable to do so due to the instability of the femur and the pain involved. This might have resulted in the diagnosis of femur fracture on the day the injury happened, rather than [the Resident] experiencing possibly continuous pain from the injury until the following day,*

[11] Lying flat on the back.
[12] Where the foot is pushed upwards and downwards at the ankle.

when she was found in significant pain, and was unable to stand and was admitted to hospital.'

40. In relation to the further review and/or monitoring of the Resident, in the hours that followed the Moving and Handling Incident, the IPA advised, *'It is documented that staff continued to monitor; however, no record is made of any further assessment for the rest of the day, when [the Resident] was moved and repositioned for the bathroom, or transferred back to bed.'* The IPA further advised, *'… I appreciate that [the Registered Nurse] was assured that there was no apparent injury following [the Moving and Handling Incident] and, in this instance, it would be sufficient to observe for any signs of possible injury during future patient care. However, as [the Resident] had not been asked to perform a straight leg raise to rule out a femur fracture, the correct method of clinical assessment had not been performed, and any such injury could not be ruled out.*

41. The IPA continued that the Registered Nurse *'…could have reassessed [the Resident's] lower right limb when [she] was being transferred into bed using the hoist on the night of the 15th February [2019], on the day the potential injury happened. This additional clinical assessment might have resulted in finding that [the Resident's] right lower leg appeared shortened and externally rotated, or caused [the Resident] pain on rolling the limb from left to right, which could have diagnosed a femur fracture a day sooner.'*

42. The IPA provided advice on the management of the Resident the following day, 16 February 2019. He advised, '*It wasn't until the following day, 16 February 2019, when [the Resident] was again being transferred from her bed to the 'stand-aid' hoist that she complained of pain in her lower back and right hip. [The Senior Registered Nurse] was asked to attend who noticed swelling to the right thigh, reporting that [the Resident] was in excruciating pain.'* The IPA further advised, *'Once [the Senior Registered Nurse] noted [the Resident's] level of pain and the thigh swelling, I believe [she] acted appropriately, first contacting the GP for advice and later arranging for an ambulance to transport [the Resident] to hospital. However, careful manual handling when moving [the Resident] in bed in the first instance could have avoided this injury.'*

43. I requested advice from the IPA on the extent to which the impact of the fracture the Resident sustained to her femur may have led to a shortening of her life. The IPA advised, *'When [the Resident] returned to the Nursing Home on 23rd February 2019 she had a cast on her right leg to help the broken bones to heal, by holding them in place for up to 12 weeks. Due to the presence of the cast, the plan of care agreed with the family on [the Resident's] return to [the Nursing Home] meant that [the Resident] would remain on bed rest, she would need regular pain relief and would be exposed to frequent checks and positioning changes by nursing and care staff … As well as being interrupted every two hours for these checks and repositioning, staff would also visit [the Resident] every half hour during the day and every hour at night to check to assess if she was in pain and [the Resident] would be given pain relieving medication regularly. Sleep disruption in care homes is known to increase the likelihood of early death in long-term residents and it is possible that the frequent checks and repositioning [the Resident] was exposed to could have shortened her life.'*

44. The IPA continued*, 'For older people who are already frail, remaining in bed for a number of weeks can also be detrimental.'* The IPA went on to advise that such individuals can suffer from constipation, loss of appetite, as well as anxiety, depression and confusion, as a result of prolonged bed rest. He advised too that patients can become dehydrated, their blood pressure and oxygen levels can drop, their breathing can become laboured, and they can be at increased risk of respiratory infections.

45. The IPA advised, *'People experiencing immobility due to a femur fracture are already at a higher risk of death than the general population … and it is likely that some the above factors contribute to this. With this in mind, it is entirely possible that [the Moving and Handling Incident] which resulted in a femur fracture, a leg cast, a need for frequent pain relief and a period of enforced bed rest and its accompanying negative side-effects could well have led to the shortening of [the Resident's] life.*

46. The IPA was asked for advice regarding the appropriateness of the nursing plan that was put in place for the Resident following the Moving and Handling

Incident. The IPA advised, '*After the moving and handling incident on 15 February 2019 a new nursing plan of care was put in place in advance of [the Resident] returning from the hospital on 23rd February with a cast on her right leg. The cast was in place to keep the fractured leg in position and possibly would be in place for 12 weeks … This nursing plan of care included the following:*

- *POP[13] checks would be documented*
- *Registered Nurse to be present for all turns*
- *[The Resident's] position would be changed every 2 hours*
- *POP leg would be supported by one person during repositioning, needing 3 staff*
- *Check for continence needs and skin damage during repositioning*
- *Using Abbey pain scale to monitor pain levels*
- *Analgesia (pain relief) to be given slowly using a syringe orally*
- *[The Resident] to be checked half-hourly during the day and hourly during the night*
- *Assistance with meals and a carer to be allocated to provide hourly fluids, or more often, if not drinking.'*

47. The IPA also advised, '… *this nursing plan of care was appropriate and reasonable and in accordance with good medical practice. Appropriate cast observations were carried out during manual handling to watch for complications which might be caused due to a leg cast being in place, including pressure sores and circulation problems. [The Nursing Home] also recorded levels of pain, repositioning, fluid intake, half hourly checks during the day and hourly checks at night.'*

48. The IPA was asked for advice regarding the adult safeguarding measures the Nursing Home undertook. In response, the IPA advised, '*As part of the Adult Safeguarding process, on the 21st February 2019 [the Nursing Home] completed an Adult Protection Referral in which they included a report concerning the resident's fracture following [the Moving and Handling Incident], under the category of physical neglect. [The Nursing Home] acknowledged in*

[13] Plaster of Paris

this report that [the Resident] will have experienced pain, she now needed a cast to be in place which might cause irritation and possible skin breakdown and complications might occur including the fracture not healing together, the risk of deep vein thrombosis, bone infection and a further decrease in mobility.'

49. The IPA continued, '*This Adult Protection referral was sent to [the NHSCT]. In doing so the Nursing Home acted in an open and transparent manner surrounding this event, in line with [the HSCB's NIASP Adult Safeguarding Procedures]. By appropriately reporting this incident in a timely manner [the Nursing Home] also met the requirements of [the Nursing Home's Adult Safeguarding Policy].'*

50. The IPA further advised, '*In response to the safeguarding incident the home made a number of changes. They altered [the Resident's] moving and handling plan to require three care staff for repositioning, for circulation checks to be carried out along with half hour checks during the day and hourly checks during the night. Pain levels were also recorded. [The Nursing Home] arranged for staff to have supervision meetings on moving and handling, stressing the importance of ensuring that limbs are free from the side of the bed, bedrails and protective covers when assisting patients to sit at the bedside.'*

51. The IPA's full advice report is at Appendix Five to this report.

Analysis and Findings

52. The complainant raised concerns about the Nursing Home's actions in relation to the Moving and Handling Incident, which occurred on 15 February 2019. She considers the incident itself was mismanaged, and that the Resident was not assessed appropriately following it. The complainant also maintains that the incident caused the Resident to sustain the fracture to her right femur that was identified in Causeway Hospital the following day, and that the impact of this fracture ultimately shortened the Resident's life.

53. My investigation of this first issue of complaint examined whether the care and treatment the Nursing Home provided at, and following, the time of the Moving and Handling Incident on 15 February 2019 was in accordance with good

medical practice. Specifically, I considered whether the Nursing Home had an appropriate moving and handling risk assessment in place for the Resident at the time the Moving and Handling Incident occurred, and whether the Resident received appropriate care and treatment, both during and following the Incident. I also examined whether the Nursing Home took appropriate action in relation to the investigation of the Moving and Handling Incident. My findings on each of these elements of this first issue of complaint are set out below.

The Resident's Moving and Handling Risk Assessment

54. The Moving and Handling Incident occurred on 15 February 2019. I note that in response to investigation enquires, the Nursing Home stated that a moving and handling risk assessment for the Resident had been completed two weeks previously, on 1 February 2019. The Nursing Home said this assessment identified that when transferring from bed to her chair or toilet, the Resident required the assistance of two staff, using a standing aid with a medium sized sling, and that for moving up and down her bed, the Resident needed the assistance of two staff and a slide sheet. The Nursing Home also informed me that the moving and handling technique being used to transfer the Resident from bed to her chair at the time of the Moving and Handling Incident was that set out in the Resident's moving and handling risk assessment.

55. I note the IPA advised that at the time of the Moving and Handling Incident, '*there was a manual handling assessment in place and [the Resident] was appropriately assessed in relation to her manual handling risk assessment'.* I note the IPA also advised, *'the Resident's manual handling assessment was completed in accordance with the Nursing Home's policy and procedures and in line with good medical practice'.* In this regard, I note the Nursing Home's Manual Handling Policy states, *'a proper risk assessment should identify the most appropriate handling method.'*

56. I accept the IPA's advice regarding the Resident 's moving and handling risk assessment. I am satisfied the Resident had a moving and handling risk assessment in place at the time the Moving and Handling Incident occurred on 15 February 2019, and that this assessment was appropriate and reasonable,

and in keeping with the relevant standards. Consequently, I do not uphold this element of the first issue of complaint.

Care provided to the Resident during the Moving and Handling Incident

57. The investigation established that on 15 February 2019, the Resident's foot became caught in the bedrail while Care Assistant 1 and Care Assistant 2 were assisting her to transfer from bed to her chair. The investigation found too that the next day, 16 February 2019, following an x-ray at Causeway Hospital, it was identified that the Resident had sustained a fracture to her right femur.

58. I note the written statements of Care Assistant 1 and Care Assistant 2 document their recollections of the Moving and Handling Incident. Specifically, Care Assistant 1 and Care Assistant 2 both recounted how they had been assisting the Resident out of bed – Care Assistant 1 at the bottom of the bed and Care Assistant 2 at the top. They both stated that after the Resident had expressed pain in her leg, Care Assistant 1 noticed that the Resident's slippered foot had become caught in the bedrail. The statements describe how Care Assistant 1 had then moved the Resident's foot off the bedrail and had checked the Resident's leg. Care Assistant 1 and Care Assistant 2 also describe in their statements that they continued to assist the Resident to her chair, using a stand-aid hoist, before informing the nurse on duty (the Registered Nurse) about the incident.

59. I note the adult safeguarding referral the Nursing Home made to the NHSCT on 21 February 2019 (a matter to which I will return later in this report) also provides an account of the Moving and Handling Incident. The referral form (APP1) states, *'On Friday, 15.02.19 [the Resident] was being assisted by [Care Assistant 1] and [Care Assistant 2] to sit at side of bed in preparation to transfer from bed using the stand aid hoist. One care* [sic] *was assisting top half of her body and another with legs. She was wearing bedroom slippers on her feet and as she was being assisted to sit her right foot caught on the protective covers of the bedrail.'*

60. The IPA advised that '*care staff continued to move the resident when her foot became lodged in the bed.'* I note the IPA also advised, *'This was not*

appropriate'. The IPA further advised, '… *care should have been taken to ensure that limbs were not at risk of becoming trapped during the moving and handling process'.* I accept the IPA's advice.

61. Having considered the available evidence, I am of the view that not enough care was taken while the Resident was being assisted to move to the edge of her bed in preparation for transferring to her chair, with the result that her foot became caught in the bedrail. In addition, I consider it was not appropriate to continue to move the Resident after she had expressed pain in her leg and it was realised that her foot had become caught.

62. Consequently, I conclude that the manner in which the Resident's transfer from bed to her chair was managed at the time of the Moving and Handling Incident on 15 February 2019 was a failing in care. I am satisfied the Resident experienced the injustice of distress and upset because of the pain she suffered as a result of this failure. I uphold this element of the first issue of complaint.

63. I am mindful that when it responded to my investigation enquiries, the Nursing Home stated, '*It is impossible to establish if the fracture occurred on 15 February 2019 due to [the Resident's] osteoporosis and the fragility of her bones.'* Notwithstanding the Nursing Home's position, my investigation found no evidence of another reasonable explanation of why the Resident sustained a fracture to her right femur on or around 15 February 2019. I have given careful consideration to the available evidence, including records relating to the pain relief administered to the Resident in the hours following the Moving and Handling Incident; witness accounts; the IPA's advice that *'careful manual handling when moving [the Resident] in bed in the first instance could have avoided this injury*', and the Resident's history of osteoporosis. Having done so, I conclude, on the balance of probability, that the fracture to the Resident's femur occurred while she was being assisted to transfer from bed to her chair on afternoon of 15 February 2019.

64. This is a particularly significant finding, given the IPA's advice that it was *'entirely possible that [the Moving and Handling Incident] which resulted in a*

femur fracture, a leg cast, a need for frequent pain relief and a period of enforced bed rest and its accompanying negative side-effects could well have led to the shortening of [the Resident's] life.' In this regard, I note that, sadly, the Resident passed away less than three weeks after her discharge from Causeway Hospital.

65. I cannot be certain that the femur fracture I consider the Resident sustained as a result of the Moving and Handling Incident did ultimately shorten her life. Nevertheless, I am satisfied that the detailed explanation the IPA provided in his advice of why such an injury has a particularly detrimental effect on older people, supports my conclusion that it is highly likely that the femur fracture the Resident sustained, and resulting impact on her mobility and independence, did contribute to the shortening of her life.

66. I should also record that I note the IPA highlighted in his advice the action the Nursing Home took in follow-up to the Moving and Handling Incident. Specifically, the IPA advised, '*[The Nursing Home] arranged for staff to have supervision meetings on moving and handling, stressing the importance of ensuring that limbs are free from the side of the bed, bedrails and protective covers when assisting patients to sit at the bedside.'* I welcome this action on the part of the Nursing Home. However, given the seriousness of the impact of the Moving and Handling Incident, I consider there are further steps the Nursing Home should take to minimise the risk of a similar incident occurring in the future and again causing injury to one of its residents. I will return to this matter later in this report.

Care provided to the Resident following the Moving and Handling Incident

67. The investigation established that shortly after the Moving and Handling Incident, Care Assistant 1 and Care Assistant 2 made the nurse on duty, the Registered Nurse, aware of what had happened. As recorded above, I note that Care Assistant 1 and Care Assistant 2 both referred in their written statements to having continued to assist the Resident out of bed and into her chair before informing the Registered Nurse about the Moving and Handling Incident.

68. I note that the Registered Nurse's written statement indicates that *'care staff'* reported to her *'at around 4.30pm'* that *'whilst assisting [the Resident] out of bed she caught her right foot on the way out'.* The Registered Nurse's statement provides an account of the action she took in response to this reporting of the Moving and Handling Incident. I note this states, *'I assessed [the Resident] there was no evidence of redness, swelling or bruising, I flexed [the Resident's] foot and watched her facial expressions, there was no change in same. I asked [the Resident] if she was experiencing any pain to which she replied "no only if I do something, if I do nothing I am OK". Paracetamol was administered as prescribed and appeared to have a good effect.'*

69. I note too that the Nursing Home incident report the Registered Nurse completed on 16 February 2019 regarding the Moving and Handling Incident also provides an account of the action she took when she was made aware of the incident by care staff. The Registered Nurse recorded in the incident report, *'I checked a short time later, asked [the Resident] if she was experiencing any pain, was unable to localise any pain, paracetamol given with good effect. During flexion of foot [the Resident] didn't grimace or express any discomfort, continue to monitor.'* I note the incident report did not include any reference to the Resident having told the Registered Nurse that she [the Resident] felt pain *'only if I do something, if I do nothing I am OK.'*

70. The investigation established therefore that the Registered Nurse, having been made aware of the Moving and Handling Incident, assessed the Resident for injury, whilst she was sitting in her chair, by checking for signs of injury (bruising, swelling and/or redness) and flexing her foot while observing her facial expression. The evidence available to me suggests the Resident did not express any pain during this flexion of her foot. That said, I consider the fact that the Registered Nurse recorded in her witness statement that the Resident had said she was not in pain so long as she did not move, implies that the Resident was experiencing pain when she moved some other part of her body. I am unable to reconcile these two accounts of the Resident's expression of pain when she was first assessed following the Moving and Handling Incident.

71. I examined two aspects of the assessment of the Resident that the Registered Nurse completed shortly after the Moving and Handling Incident. These were: where the assessment was carried out and the technique that was used.

72. Firstly, in relation to where the Resident was assessed, I note the IPA advised that although it was necessary for the Resident to be checked by a nurse for potential injury following the Moving and Handling Incident, *'it might have been more appropriate to call the nurse to assess injury while the Resident remained in bed.*' The IPA explained that it is easier to compare the appearance and movement of limbs to assess for injury when a patient is lying down, rather than sitting in a chair. I note the IPA advised that assessing the Resident whist lying down, even if that had required her to be assisted to return to bed, which, he highlighted, would only have taken a short time to do, may have indicated a fracture, and the need for her transfer to hospital, a day sooner than was the case.

73. I am mindful that the IPA did not consider the lack of assessment while the Resident was still in bed to be a failing in her care and treatment. Nevertheless, it is my expectation that the Nursing Home ensure that nursing staff are reminded of the need to consider assessing residents for potential lower limb injury while they are lying down, as described by the IPA.

74. In relation to how the Resident was assessed, I note the IPA's advice was that while it is possible to assess a patient for a potential femur fracture whilst they are sitting in a chair, such an assessment *'involves a different technique than flexing the foot.'* The IPA explained that if a femur fracture is present, it will be painful and unstable at the thigh, with the result that the patient will not be able to perform 'an active straight leg raise' (which involves asking a patient to straighten their leg at the knee and lift it into the air).

75. The IPA advised that if the Resident had been asked to perform a straight leg raise she would have been unable to do so if her femur had been fractured, due to instability of the femur and the pain involved. He advised too that assessing the Resident in this way may have enabled diagnosis of her fracture on the day of the Moving and Handling incident.

76. I accept the IPA's advice. I consider the failure to use the appropriate technique to assess the Resident for injury following the Moving and Handling Incident on 15 February 2019 to be a failing in care and treatment. I am satisfied this failing caused the Resident to experience the injustice of loss of opportunity to have her injury diagnosed and treated sooner than was the case.

77. I also examined the Nursing Home's further assessment and/or review of the Resident in the hours following the Moving and Handling Incident, prior to her transfer to Causeway Hospital on 16 February 2019. It is evident from documentation I examined – the Nursing Home's referral of the Moving and Handling Incident to the NHSCT on 21 February 2019; the Nursing Home's letter of 11 March 2019 to the NHSCT regarding the Moving and Handling Incident; and the Nursing Home's response of 30 August 2019 to the complaint the complainant made to it on 21 July 2019 - that after the Registered Nurse assessed the Resident for injury, Nursing Home staff *'continued to monitor'* her.

78. In this regard, I note the IPA highlighted in his advice that *'no record [was] made of any further assessment of [the Resident] for the rest of the day, when [the Resident] was moved and repositioned for the bathroom, or transferred back to bed.'* I note the IPA advised too that although no apparent injury had been identified during the Registered Nurse's assessment following the Moving and Handling incident, given that the Resident '*had not been asked to perform a straight leg raise to rule out a femur fracture … any such injury could not be ruled out'.* The IPA further advised that the Resident's right leg could have been reassessed when she was transferred into bed that evening, and that this may have *'resulted in finding that [the Resident's] right lower leg appeared shortened and externally rotated, or caused [the Resident] pain on rolling the limb from left to right.'* I note the IPA advised that reassessing the Resident in this way may have resulted in her femur fracture being diagnosed sooner. I accept the IPA's advice.

79. I consider the Nursing Home's failure to reassess the Resident for injury after she was transferred from her chair back to bed on the evening of 15 February 2019 was a failing in care and treatment. I am satisfied this failing caused the

Resident to again experience the injustice of loss of opportunity to have her injury diagnosed and treated sooner than was the case.

80. I then considered the care the Nursing Home provided to the Resident on 16 February 2019, the day following the Moving and Handling Incident, prior to her transfer to Causeway Hospital. I noted that the Resident expressed pain while she was being assisted to transfer out of bed that morning. Specifically, it was documented in the Resident's Progress Notes, *'When [the Resident] was being assisted to get out of bed [the Resident] was complaining of pain in her right hip and lower back'.* I found too the Senior Registered Nurse, who was on duty that day, recorded in her witness statement that the Resident *'was complaining of pain in her right hip and lower back'* and that paracetamol was administered to the Resident at 11:30am, *'with little effect'.* The Senior Registered Nurse also recounted in her statement that she telephoned the out-of-hours GP service and spoke to the on-call GP, who advised that a GP would visit the Resident that afternoon.

81. I note the Senior Registered Nurse further recorded in her witness statement that at 3:45pm, when swelling to the Resident's right leg was noted, she again contacted the out-of-hours GP service. The Senior Registered Nurse stated that when the on-call GP, who telephoned the Nursing Home at 4:30pm, heard that the Resident had swelling to her thigh and was in pain, an ambulance was arranged to transfer the Resident to hospital.

82. I note the IPA's advice on this aspect of the Resident's care and treatment was that he considered the Senior Registered Nurse, on noting the Resident's level of pain and the swelling to her thigh, *'acted appropriately, first contacting the GP for advice and later arranging for an ambulance to transport [the Resident] to hospital.'* I accept the IPA's advice that it was appropriate to again contact the out-of-hours GP service once swelling to the Resident's leg had been noted.

83. However, I note that the timeline of events the complainant submitted to my Office in support of her complaint ('the complainant's timeline of events'), relevant extracts of which are reproduced at Appendix Eight to this report,

refers to Resident's son, who had arrived at the Nursing Home at 10:30am, having noted *'what [he] thought was a lump on the upper part of [the Resident's] right leg'* and to him having *'informed the staff nurse about this.'*

84. Enquiries made to the Resident's son disclosed that *'the staff nurse'* he spoke to about the swelling was the nurse who was working that day in the Nursing Home's Benone Suite. In this regard, I note the Senior Registered Nurse recorded in her witness statement, *'On the 16-2-19 I was in charge in the Benone Suite.'* The Resident's son also advised that the nurse to whom he reported the swelling, that is, the Senior Registered Nurse, looked at the Resident's leg in response to his concern.

85. I cannot be certain, on the basis of the available evidence, whether this reporting of the swelling to the Senior Registered Nurse and her subsequent examination of the Resident's leg took place before or after the Senior Registered Nurse first telephoned the out-of-hours GP service on the morning of 16 February 2019. However, given that the transcript of the Senior Registered Nurse's conversation with the out-of-hours GP service call handler makes no reference to swelling of the Resident's thigh, I consider the evidence indicates that the first call to the out-of-hours GP service took place before the swelling was reported to the Senior Registered Nurse.

86. It is not clear from the complainant's timeline of events exactly when the Resident's son reported the swelling on the Resident's leg to the Senior Registered Nurse. However, given the timeline indicates that the Resident's son noted the swelling on the Resident's leg *'during the course of the morning'*, while he was *'rubbing [his] hand up and down the Resident's leg to comfort her while [he] chatted to her'*, and also that he left the Nursing Home *'after lunch'*, having tried (unsuccessfully) to encourage the Resident to eat, I consider it more likely than not that it was during some time mid- to late-morning that the Resident's son brought swelling to the attention of the Senior Registered Nurse.

87. It is of concern then that even though it appears the Senior Registered Nurse was made aware of the swelling before lunchtime, a further call to the out-of-hours GP service was not made until 3:45pm. It is of concern too, given the

Resident's son's recollection of events on 16 February 2019, that the transcript of that telephone call to the out-of-hours GP service documents that the Senior Registered Nurse informed the call handler that she *'didn't notice the swelling this morning and just noticed it there this afternoon.'*

88. I consider that on 16 February 2019, the Nursing Home ought to have contacted the out-of-hours GP service again, as soon as reasonably possible after the Resident's son reported the swelling on the Resident's right thigh. Such action would have allowed all relevant information about the Resident's condition to be brought to the attention of the out-of-hours GP service a number of hours sooner than was the case, and may have expedited the Resident's transfer to hospital for diagnosis of, and treatment for, the fracture she had sustained.

89. I consider that the Nursing Home's failure to again contact the out-of-hours GP service on 16 February 2019, as soon as the Resident's thigh swelling was reported to it, was a failing in care and treatment. I am satisfied this failing caused the Resident to experience the injustice of further distress and upset, and a loss of opportunity to receive appropriate treatment for her injury at the earliest possible opportunity.

90. I should also highlight that that evidence I examined in considering this element of the complaint suggests that when the Moving and Handling Incident occurred on 15 February 2019, the Nursing Home did not regard it to be serious enough to either warrant the completion of an incident report on the day or to take steps to ensure that the Resident's family was informed about what had happened.

91. Specifically, I note that in response to my investigation enquiries, the Nursing Home stated that it had been considered unnecessary to complete an incident report on the day of the Moving and Handling Incident because of '*the lack of evidence that an injury had been sustained at that time.'* In addition, I note that the complainant's timeline of events refers to the Resident's son being informed of the Moving and Handling Incident only as a result of him seeking out a staff member when he arrived at the Nursing Home on the evening of 15 February 2019 and found his mother upset and agitated. The timeline also indicates that

at that stage, the Resident's son managed to speak to a care assistant who recounted what had happened earlier that day. It further records that when the Resident's son visited the Nursing Home the following morning, the Senior Registered Nurse informed him that the Resident had had *'a rough night'* and was still in pain, but did not mention the Moving and Handling Incident until the Resident's son indicated that a care assistant had made him aware of it the previous evening.

92. It is my expectation that the Nursing Home reflect carefully on my observations regarding these matters and that in future, it gives careful consideration to the need to make a formal record of all incidents involving potential injury to residents and that it ensures that residents' family members are fully informed about such incidents in a timely manner.

93. In summary, my consideration of this element of the first issue of complaint found failings in care provided to the Resident following the Moving and Handling Incident on 15 February 2019, not only in relation to how she was assessed shortly after the incident but also with regard to the lack of reassessment in the hours that followed. I also found a failing in care provided during the earlier part of the following day, 16 February 2019, in that the GP out-of-hours service was not contacted, at the earliest opportunity, once the Resident's son brought swelling to the Resident's thigh to the Nursing Home's attention. I am satisfied these failings caused the Resident to experience the injustice of further upset and distress and a loss of opportunity to have her injury diagnosed and treated sooner than was the case. I uphold this element of the first issue of complaint.

Adult Safeguarding Procedures

94. I note the Nursing Home's Adult Safeguarding Policy refers to the role of a health and social care trust in relation to the handling of adult safeguarding concerns. Specifically, the Policy states, *'Each [Health and Social Care (HSC)] Trust will have an Adult Protection Gateway Service which will receive adult protection referrals … A Designated Adult Protection Officer (DAPO) will be appointed by the HSC Trust. They will be responsible for the management of each referral received from the Trust.'*

95. The Nursing Home's Adult Safeguarding Policy also states, *'The Home Manager/Adult Safeguarding Champion (ASC) is responsible for ensuring this policy is implemented within their Home and ensuring the regional protocols and regional procedures are followed when suspected, alleged or actual abuse has been reported … Where the Adult Gateway Service considers the concern to be a safeguarding issue, a [DAPO] will be appointed.'* I note the Nursing Home's Adult Safeguarding Policy further states, '*It is important that each adult protection intervention is conducted without undue delay, remains outcome focused'.*

96. The investigation established that following the Moving and Handling incident, the Nursing Home made an adult protection referral to the NHSCT on 21 February 2019, under the category of 'physical neglect'. The NHSCT appointed a DAPO to manage the referral. I note the DAPO documented the outcome of the NHSCT adult safeguarding investigation as, '*Matter is inconclusive/unsubstantiated as neglect. Home have taken appropriate actions to address the incident and minimise the likelihood of this occurring again… Home have addressed training matters and supports for staff*'.

97. I note the IPA advised that by reporting the Moving and Handling Incident to the NHSCT, the Nursing Home *'acted in an open and transparent manner [and] in line with [the HSCB's NIASP Adult Safeguarding Procedures].* I note the IPA advised too, '*By appropriately reporting this incident in a timely manner [the Nursing Home] also met the requirements of [the Nursing Home's Adult Safeguarding Policy].'*

98. I accept the IPA's advice. I consider the Nursing Home acted appropriately, in accordance with the Nursing Home's Adult Safeguarding Policy and the HSCB's NIASP Adult Safeguarding Procedures, by reporting the Moving and Handling incident to the NHSCT, who in turn appointed a DAPO to manage the referral and arrange an investigation. Consequently, I do not uphold this element of the first issue of complaint.

Summary of findings on Issue One

99. My investigation of this first issue of complaint examined whether the care and treatment provided to the Resident at the time of the Moving and Handling Incident on 15 February 2019, and in the hours that followed, was in accordance with good medical practice.

100. I found that an appropriate moving and handling risk assessment was in place for the Resident at the time of the Moving and Handling Incident and that the Nursing Home took appropriate action, following the incident, in making an Adult Safeguarding referral to the NHSCT.

101. However, I also found evidence of a number of failings in care and treatment. Specifically, I found that:

- there was a failure to appropriately manage the Resident's transfer from bed to her chair at the time of the Moving and Handling Incident on 15 February 2019;
- there was a failure to complete an appropriate clinical assessment of the Resident following the Moving and Handling Incident on 15 February 2019;
- there was a failure to reassess the Resident for potential injury in the hours that followed the Moving and Handling Incident on 15 February 2019; and
- there was a failure to contact the out-of-hours GP service on 16 February 2019, at the earliest opportunity, after swelling to the Resident's right thigh had been noted.

102. I partially uphold the first issue of complaint.

Issue Two: Whether the care and treatment provided to the resident on 3 March 2019 was adequate and in accordance with good medical practice.

Detail of Complaint

103. The complainant raised concerns about an incident involving the Resident's dentures, which occurred on 3 March 2019 ('the Dentures Incident'). The

complainant also believes the oral hygiene care the Resident received in the Nursing Home during the period leading up to the Dentures Incident was inadequate.

104. The complainant informed me that she is aware that on the morning of 2 March 2019, the Resident was *'notably chesty with a watery noise coming from her throat.'* She said that later that afternoon, the Resident *'became even more chesty with an audible wheeze.'* The complainant also described how the Resident was assessed in the afternoon of 2 March 2019 by an on-call GP, who prescribed an oral antibiotic and nebuliser, and how, by early evening that day, the Resident's respiratory rate had increased and her oxygen levels had decreased. The complainant said the Resident was by then struggling to swallow her oral medication and was not eating, and that although stable overnight, she remained unwell.

105. The complainant described how on 3 March 2019, the Resident remained sleepy and looked *'very unwell'*, and how she was refusing to eat or take her oral medication. The complainant said that at around 3.00pm, she requested *'gentle oral suction'* to the Resident's mouth after hearing *'a very audible watery noise'* coming from the back of her throat. The complainant said that it was when the suction catheter was being placed into the Resident's mouth that she (the complainant) saw that the dentures were not in place but had become lodged in the Resident's throat, partially obstructing her airway.

106. The complainant said that when she complained to the Nursing Home about this incident, it informed her that on the morning of 3 March 2019, the Resident had *'complained of a sore throat and she sounded as if she had a fullness in her throat.'* The complainant expressed concern that despite these observations, no action was taken by the Nursing Home until she requested the oral suctioning for the Resident.

107. The complainant also expressed concern that because the Resident's dentures had become lodged in her throat, she suffered a prolonged period of reduced oxygen. She questions whether the Resident would have *'just deteriorated and passed away'* if she (the complainant) had not requested the oral suctioning.

Evidence Considered

Policies and Guidelines

108. I considered the following policies and guidelines:
    - the NICE Oral Health for Adults in Care Homes Guideline;
    - the GAIN Guidelines for Oral Healthcare;
    - the NISCC Standards for Social Care Workers;
    - the Department of Health's Nursing Home Care Standards;
    - the Department of Health's Nursing Home Resident's Guide;
    - the Nursing Home's Adult Safeguarding Policy; and
    - the HSCB's NIASP Adult Safeguarding Procedures.

109. Relevant extracts of the policies and guidelines I considered are at Appendix Two to this report.

Relevant Documentation

110. I completed a review of the documentation I obtained from the Nursing Home, which included the Resident's records; records relating to the Nursing Home's investigation of the Dentures Incident; and the Nursing Home's file relating to the complaint the complainant made to Conway Group Healthcare on 21 July 2019 about the care and treatment the Nursing Home had provided to the Resident.

111. I also reviewed records I obtained from the out-of-hours GP service the Nursing Home contacted on 2 March 2019, the day before the Dentures Incident.

112. Relevant extracts of the documentation I examined are at Appendix Three to this report.

The Nursing Home's response to investigation enquiries

113. In response to enquiries regarding the resident's oral hygiene care plan, the Nursing Home stated, '*Prior to the incident on 3 March 2019, the oral hygiene goal was incorporated within the general hygiene care plan.'* The Nursing Home also stated, '*[The Resident's] personal hygiene care is documented within the Epicare records. As per her personal hygiene care plan "To assist*

[the Resident] to have a high standard of oral hygiene. [The Resident] has top and bottom dentures which are maintained by nursing staff". In practice [the Resident's] denture care was carried out by the care staff as a part of her personal hygiene care. Denture care was repeated in the evening where [the Resident's] dentures would be removed unless she had requested otherwise.'

114. In response to enquiries regarding the Dentures Incident, the Nursing Home stated, *'The last time [the Resident's] dentures were visibly seen was when a nurse was administering medication to the resident on 2 March 2019 at approximately 14.00 and the resident bit down on the syringe.'* The Nursing Home also stated, *'Two care assistants were attending to [the Resident's] incontinence needs on 3 March 2019 at 10.00. They washed her hands and face and swabbed her lips for dryness. Full mouth care was not carried out at this time.'*

115. In addition, the Nursing Home stated, '*[The Resident] was transferred to Antrim Area Hospital following an x-ray at Causeway Hospital on the 3rd March 2019. When transferred to Antrim Area Hospital the denture plate was removed and [the Resident] was diagnosed with C.A.A.P (community acquired aspiration pneumonia).*[14] *Treatment plan was to continue with antibiotic as prescribed on the 2nd March 2019. The family were keen for their mother to be nursed at the Nursing Home and not for hospital admission, as noted in the doctor's discharge letter.'*

Independent Professional Advice

116. I asked the IPA for advice regarding the Resident's oral hygiene assessment and care plan. The IPA advised, '*A care plan dated the 16th February 2018 records that [the Resident] requires assistance to have a high standard of oral hygiene and that she has top and bottom dentures which are maintained by nursing staff.'*

[14] The term aspiration pneumonitis refers to inhalational acute lung injury that occurs after aspiration of sterile gastric contents. In an observational study, it is found that the risk of patients hospitalized for community-acquired pneumonia in developing aspiration pneumonia is found to be about 13.8%.

117. The IPA also advised, *'From the documents provided to me in this case I cannot find any [Nursing Home] policy or procedures which include oral hygiene. While [the Resident's] oral hygiene care plan is very brief it is sufficient to meet [the Department of Health's Nursing Home Care Standards] (DHSSPS 2015) which briefly advises that a resident's personal care needs are regularly assessed and met, including oral care and dentures.'*

118. The IPA continued, '*However, [the NICE Oral Health for Adults in Care Homes Guideline] are more detailed. These guidelines were published in England in July 2016 and were adopted by the Department of Health Northern Ireland in October 2016. They recommend that care home managers have policies in place which promote and protect residents' oral health. These policies should include information about the local dental services, daily mouth care, the use of mouth and denture care products, the supply of oral hygiene equipment and what happens if a resident refuses oral health care. The guidelines also recommend that carers are supported to provide residents with their daily mouth care needs, including brushing natural teeth at least twice a day with fluoride toothpaste, providing daily oral care for full or partial dentures (such as brushing and removing food debris and removing dentures overnight) and using the residents choice of cleaning products. The guidelines also advise care managers of the training that staff should be provided with in order to assess dental health, monitor for infection, provide daily mouth and denture care and know how and when to report any oral health concerns. Without a comprehensive oral health policy or a detailed oral health care plan it is not possible to know if [the Resident] was appropriately assessed in relation to her oral hygiene. It is also possible that the lack of guidance from such a policy or care plan might have led to the incident where [the Resident] swallowed her dentures.'*

119. The IPA was asked for advice on the impact, if any, the Nursing Home's lack of oral health policy had on the Resident's oral hygiene assessment. The IPA advised, *'An oral health policy sets out what a care home needs to consider to maintain their residents' oral health, including instructions for daily mouth care needs, the use of denture care products, instructions to remove dentures*

overnight and oral hygiene training for care staff. Without an oral health policy to provide guidance it is possible that [the Resident's] oral hygiene assessment was insufficient, lacking clear instructions for oral health and denture care. In turn, this could have resulted in the incident where [the Resident] swallowed her dentures.'

120. I also requested advice from the IPA on whether the Nursing Home could have known the Resident had swallowed her dentures. The IPA advised, *'Yes, it was possible for the Nursing Home staff to have known [the Resident] had swallowed her dentures. When dentures are worn there is a risk that they can be swallowed. The risk of this potentially life-threatening event increases if the wearer has a neurological impairment, such as dementia. Symptoms of swallowed dentures can include throat pain, swallowing problems, breathing problems, a persistent harsh cough, a change in the voice and the sensation of something being stuck … If dentures are worn overnight then this also doubles the risk of pneumonia in the very elderly. So, if a resident is missing their dentures and these symptoms are reported then the suspicion that dentures may have been swallowed needs to be ruled out.'*

121. The IPA further advised, '*On 2nd March 2019 [the Resident's] breathing sounded chesty and the GP attended at 14:24 who reported her lungs had some crackles and wheeze. Her oxygen levels were considerably reduced. There were also concerns about her swallowing. She was diagnosed with aspiration which is when something is inhaled into the lungs, usually fluid. The nurse spoke to an on-call GP later in the afternoon as [the Resident] had difficulty swallowing her medication and drinks and at 19:10 another GP visited who discussed end of life care. These symptoms on the 2 March 2019 could have indicated that [the Resident] had swallowed her dentures. By the following day 3rd March 2019 at 15:00 [the Resident] reported a sore throat and it sounded like her throat was blocked. The nurse tried to suction her airway and it was then discovered that [the Resident's] upper denture was missing. An ambulance was called and [the Resident] was transported to hospital where an x-ray revealed the presence of her upper denture plate in the oropharynx,*[15] *the*

[15] The oropharynx is the middle part of the pharynx (throat), behind the mouth.

part of the throat that is at the back of the mouth. The denture was removed and [the Resident] was prescribed antibiotics for pneumonia which might have been caused by the presence of the swallowed denture.'

122. I asked the IPA for advice regarding the impact of the Dentures Incident on the Resident. The IPA advised that swallowing her dentures and being unable to eat would have impacted on the Resident's nutritional status, which could have affected her overall health. The IPA advised too that the Resident developing pneumonia resulted in an unnecessary hospital admission and potentially shortened her life.

123. In response to my request for advice regarding the Resident's oral hygiene care plan following the Dentures Incident, the IPA advised, '*I am unable to find a new oral hygiene care plan that was put in place after [the Resident] returned to [the Nursing Home] … In response to the safeguarding incident [the Nursing Home] state they have introduced a number of changes to reduce the risk of this event re-occurring. They say that care of dentures has been included in personal hygiene charts to prompt staff about dentures in the morning and the evening and staff have also been provided with knowledge of how dentures should fit and what to do if they don't. [The Nursing Home] has provided records of supervision meetings held between their staff and a senior nurse from 14th March 2019 where mouth care was discussed. The importance of good mouth care, fitting dentures and recording this, reporting dentures for poor fit or damage, the importance of removing dentures at night and recording this and, if needed, documenting if a resident wants to keep their dentures in overnight.'*

124. The IPA was asked for advice on whether he considered the care and treatment the Resident received in relation to her oral hygiene, both before and after the Dentures Incident, was adequate and in accordance with relevant guidelines. The IPA advised, *'I do not consider the overall care and treatment in relation to [the Resident's] oral hygiene both before and after [the Dentures Incident] was adequate and in accordance with relevant guidelines.* The IPA continued, '*There was a brief oral hygiene care plan in place before the incident but I cannot find a record of any new oral hygiene care plan introduced*

following the incident. After the incident the Nursing Home did put in place staff training to include oral hygiene and denture care and asked for denture care to be recorded on daily personal hygiene records, however this lack of detailed oral hygiene care planning was not adequate and it was not in accordance with [the NICE Oral Health for Adults in Care Homes Guideline].'

125. The IPA was also asked for advice regarding the adult safeguarding action the Nursing Home took in response to the Dentures Incident. The IPA advised, '*As part of the adult safeguarding process, on the 5th March 2019 [the Nursing Home] completed an Adult Protection Referral in which they included a report concerning [the Resident's] swallowed denture and her admission to hospital for its removal. The Adult Protection Referral was sent to [the NHSCT]. In doing so [the Nursing Home] acted in an open and transparent manner surrounding this event, in line with [the HSCB's NIASP Adult Safeguarding Procedures]. By appropriately reporting this incident in a timely manner [the Nursing Home] also met the requirements of [the Nursing Home's Adult Safeguarding Policy]. The outcome of [the NHSCT] Adult Safeguarding investigation found that there was a matter of neglect as more care could have been taken with mouth care and ensuring dentures do not get lodged in airways. [The NHSCT] concluded that [the Nursing Home] had since addressed and risk managed the matter.'*

126. In terms of learning from this complaint the IPA advised, *'[The Nursing Home] might want to take advice from the Health Education England Mouth Care Matters guide for hospital healthcare professionals (HEE 2019) who recommend simply placing a picture of a sunflower above a resident's bed. This picture symbolises to staff, without affecting a resident's dignity, that they have a denture and acts as a visual guide for care staff to check for dentures that might be wrapped in tissue, hidden in bed linen, or more importantly are missing and could have been swallowed.'*

127. The IPA's full advice report is at Appendix Five to this report

Analysis and Findings

128. The complainant raised concerns about the Nursing Home's actions in relation to the Dentures Incident, which occurred on 3 March 2019. She considers the oral hygiene care the Resident received in the Nursing Home leading up to the Dentures Incident was inadequate, and that this resulted in it not being realised for some time that the Resident's dentures had become lodged in the back of her throat, partially obstructing her airway.

129. My investigation of this second issue of complaint examined whether the care and treatment the Nursing Home provided to the Resident on 3 March 2019 was adequate and in accordance with good medical practice. Specifically, I considered whether the Nursing Home had an appropriate oral health care plan in place for the Resident at the time of the Dentures Incident and whether the Resident received appropriate oral hygiene care in the hours leading up to the discovery that her dentures had become dislodged in her throat. I also examined whether the Nursing Home took appropriate action in relation to the investigation of the Dentures Incident. My findings on each of these elements of this second issue of complaint are set out below.

The Resident's Oral Health Care Plan

130. I note that in response to investigation enquiries, the Nursing Home stated that prior to the Dentures Incident, *'the oral hygiene goal was incorporated within the general hygiene care plan'*. I established, from the records the Nursing Home provided to me, that 'Step 5' of the Resident's personal hygiene care plan dated 16 February 2018, stated, *'Assist [the Resident] to have a high standard of oral hygiene. [The Resident] has top and bottom dentures which are maintained by nursing staff.'*

131. I note the IPA's advice in relation to this element of the complaint was that the Resident's oral hygiene care plan was '*brief*' but did meet the requirements of the Department of Health's Nursing Home Care Standards, which are that a nursing home resident's personal care and grooming needs, including oral care and dentures care, '*are regularly assessed and met*'. That said, I note the IPA also highlighted that, contrary to the NICE Oral Health for Adults in Care Homes Guideline, the Nursing Home did not have an oral health policy in place.

132. In this regard, I note the NICE Oral Health for Adults in Care Homes Guideline recommends that care home managers '*Ensure care home policies set out plans and actions to promote and protect residents' oral health'*, and that such policies include information about '*daily mouth care and use of mouth and denture care products'.* The NICE Oral Health for Adults in Care Homes Guideline also recommends that managers of care staff who support residents' daily care ensure that those carers *'provide residents with daily support to meet their mouth care needs and preferences'*. The Guideline further recommends that care home managers ensure that care staff who provide daily personal care to residents *'know how to deliver daily mouth care'.*

133. I note the IPA also advised, '*Without a comprehensive oral health policy or a detailed oral health care plan it is not possible to know if [the Resident] was appropriately assessed in relation to her oral hygiene.'* The IPA advised too that the Nursing Home's lack of oral health policy meant that the Resident's oral hygiene assessment may have been *'insufficient'* and lacking in *'clear instructions for oral health and denture care'* and that '*In turn, this could have resulted in the incident where [the Resident] swallowed her dentures'.*

134. I accept the IPA's advice. I am satisfied that the Nursing Home's failure to have an oral health policy in place meant the Resident did not have a detailed oral health care plan. Furthermore, in the absence of any evidence to indicate otherwise, I conclude that the lack of detailed oral health care plan led to the Resident's dentures not being routinely cared for by Nursing Home staff, resulting in a missed opportunity to identify that her dentures had become lodged in her throat. Consequently, I consider it wholly unacceptable that the Nursing Home did not have an oral health policy or a detailed oral health care plan for the Resident in place at the time the Dentures Incident occurred.

135. I consider the failure to have in place an oral health policy and a detailed oral health care plan for the Resident to be a failing in care. I am satisfied this failing caused the Resident to experience the injustice of loss of opportunity to have her oral health care needs properly assessed and met.

136. I should also record my view that the human rights principles of fairness, respect, equality, dignity and autonomy (the FREDA principles) can be infringed as a result of providing poor care. Central to applying a human rights approach to healthcare is the recognition of a patient as an individual and the delivery of care that is appropriate to their needs. I consider the FREDA principles when applying the Ombudsman's Principles of Good Administration, which are reproduced at Appendix One to this report.

137. The First Principle of Good Administration, 'Getting it right', which means acting in accordance with the law and with regard for the rights of those concerned, creates expectation that those delivering public services will have regard to published standards, such as the Department of Health's Nursing Home Care Standards and the NICE Oral Health for Adults in Care Homes Guideline, and that failure to do so will attract criticism. It is my view that the Nursing Home's failure to have in place an oral health policy and a detailed oral health care plan for the Resident, which led to her not receiving an appropriate standard of oral hygiene care, indicates the Nursing Home did not have proper regard to the Resident's human rights in terms of her dignity. I therefore conclude that the Nursing Home's failure to make appropriate provision for the Resident's oral health care does not meet this Principle of Good Administration..

138. I uphold this element of the second issue of complaint.

Care provided to the Resident on 2 and 3 March 2019

139. My investigation found that on the afternoon of 3 March 2019, the complainant, being concerned about the Resident's deteriorating condition, and about what she (the complainant) described as *'a watery noise'* at the back of the Resident's throat, asked the nurse on duty in the Nursing Home to apply suction to the Resident's mouth. The investigation established too that it was as a result of this action that it was discovered that the Resident's top denture plate was no longer in place. The Resident's Nursing Home records document that this was observed at approximately 3.10pm.

140. I note the Nursing Home stated in response to investigation enquiries, '*The last time [the Resident's] dentures were visibly seen was when a nurse was*

administering medication to [the Resident] on 2 March 2019 at approximately 14.00.' I note the Nursing Home provided this same information regarding the dentures when it wrote to the Regulation and Quality Improvement Authority (RQIA) on 14 March 2019. Specifically, the Nursing Home informed RQIA, '… *the last person to notice the dentures in place was [the Senior Registered Nurse] on 2 March 2019. She was administering medication using a syringe with caution and [the Resident] had bitten down on the syringe.'* I further note that the Resident's Nursing Home records for 2 March 2019 document on a number of occasions that evening that the Resident experienced problems with swallowing. The Resident's records also document that at 2.35pm on 3 March 2019 it was noted that '*due to poor swallow [the Resident] has not ate or drank anything today'.*

141. I cannot be certain of exactly when the Resident's dentures became lodged in her throat. However, having considered the available evidence, I consider it most likely that it occurred sometime between 2.00pm on 2 March 2019 and 3.00pm on 3 March 2019.

142. My investigation considered whether the Nursing Home provided appropriate oral hygiene care to the Resident during that period, and whether there was a missed opportunity to discover the displaced denture plate sooner than was the case.

143. I note that in response to investigation enquiries, the Nursing Home stated, '*In practice [the Resident's] denture care was carried out by the care staff as a part of her personal hygiene care. Denture care was repeated in the evening where [the Resident's] dentures would be removed unless she had requested otherwise'.* I was presented with no evidence that Nursing Home staff provided denture care to the Resident on the evening of 2 March 2019 and that they removed her dentures at that time or that the Resident, or a member of her family, requested that the dentures were not removed.

144. I note too that the Resident's Nursing Home personal hygiene records document that she received *'mouthcare'* at 10.00am on 3 March 2019, and that her food and fluids records for 3 March 2019 document that Nursing Home staff

again provided *'mouthcare'* at 1.00pm. I note neither record provided any specific detail of what this mouth care entailed.

145. I consider there are three further matters relating to the Resident's oral hygiene care on 2 and 3 March 2019 that are significant to my findings on this element of the complaint. These are: firstly, that the Nursing Home indicated to RQIA that during the period 2 and 3 March 2019 the Resident's family had '*refused intervention other than continence* care'; secondly, that the Resident's Nursing Home records document that her family were providing mouth care to her on 3 March 2019, prior to being realised that her dentures had become displaced; and thirdly, that some weeks prior to the Dentures Incident, Nursing Home staff asked the Resident's family to purchase 'Fixadent'[16] for the Resident because her dentures were loose.

146. With regard to the first matter - the Nursing Home's contention that the Resident's family had refused most forms of intervention for the Resident on 2 and 3 March 2019 - I note that when the Manager of the Nursing Home wrote to RQIA on 14 March 2019 about the Dentures Incident, she stated, *'Staff report to me that the family of [the Resident] had refused intervention other than incontinence care from staff during this period and records have verified this.'*

147. The complainant challenges the accuracy of this statement, informing me that the Resident's family *'refused nothing for [the Resident] that would help her.'* The complainant said too that *'after much discussion'*, the Resident's family *'decided that for [the Resident's] best interests [they] wished "conservative management" rather than "active treatment"'* because they knew at that stage that the Resident's condition was not going to improve and they did not want to put her through the trauma of another transfer to hospital.

148. The Nursing Home presented me with no evidence to support its position that the Resident's records *'verified'* that her family had '*refused intervention other than incontinence care'.* My examination of the records found that the Nursing Home documented at 2.28pm on 2 March 2019 that the Resident's family *'do not want hospital transfer';* that at 6.30pm on 2 March 2019, it recorded that the

[16] A brand of denture adhesive.

complainant *'doesn't want [the Resident] to have oxygen at this time';* and that at 2.55pm on 3 March 2019, it recorded that the Resident's family *'don't want [the Resident] to be disturbed too often.'*

149. In my view, these documented expressions of the Resident's family's wishes for the Resident's care do not amount to a refusal of '*intervention other than incontinence care'*. It is of concern then that the Nursing Home indicated otherwise to RQIA.

150. I should also highlight that in commenting on the draft of this report, the complainant said she was *'very disappointed and deeply hurt that nursing home staff felt [the Resident's family] had refused any sort of care for [their] dear mum.'* The complainant reiterated that the family *'would never have refused any care that was vital to [their] mum's wellbeing and comfort.'*

151. In relation to the second matter – the Nursing Home having documented that the Resident's family were providing mouth care on 3 March 2019 - I note that the Resident's food and fluid records for 3 March 2019 document the Resident had '*mouthcare given by family'* at 8.00am, 10.00am, 11.00am, 12.00pm, 1.00pm and 2.00pm.

152. Enquiries to the Resident's son established that he was present at the Nursing Home throughout the period from 8.00am to 2.00pm on 3 March 2019. The Resident's son disputed he had given mouth care to the Resident and he said he would not have known how to do this. He recounted that he had been wetting the Resident's lips with water to ease discomfort, and that he had not been opening the Resident's lips to see inside her mouth as she had not been fit for this. The Resident's son said too that he was not aware that the Nursing Home had recorded that he had been giving mouth care to the Resident.

153. I was presented with no evidence that the Nursing Home discussed the Resident's mouth care with her son or that it advised him of what was required whilst providing mouth care. As such, I consider it reasonable to conclude that the Resident's son did not consider his actions, aimed at alleviating any unnecessary discomfort for the Resident, to be providing mouth care. I was presented with no evidence either that Nursing Home staff informed the

Resident's son that it was being documented that he was providing mouth care to the Resident.

154. It is of concern to me then that the Nursing Home staff documented in the Resident's records that her family was giving mouth care on 3 March 2019. In this regard, I am mindful that the NICSS Standards for Social Care Workers require that social care workers '*maintain clear and accurate records as required by procedures established for your work*'.

155. In relation to the third matter - that the Nursing Home asked the Resident's family to purchase denture adhesive - I note that the complainant's timeline of events states that at the end of January/beginning of February 2019, the staff at the Nursing Home asked the Resident's son to purchase Fixadent for the Resident *'as he was told that [the Resident's] dentures were loose'.* The timeline indicates too that the denture adhesive was '*purchased by [the Resident's son'] immediately and given to staff.'*

156. I note that when he spoke to the Investigating Officer during the investigation, the Resident's son advised that after the Resident has passed away, and he had been collecting her belongings from the Nursing Home, he found the Fixadent he had purchased was still in the Resident's ensuite bathroom, unopened. I am aware that the Resident's son informed the Investigating Officer that it had been distressing to find that the Fixadent had never been used.

157. Given that my investigation did not specifically examine this particular event, I did not make enquiries to the Nursing Home about it. I am conscious therefore that only the Resident's son's perspective is presented here. That said, I have no reason to doubt the validity of his account of events.

158. In my view, the fact that the Nursing Home was aware that the Resident's dentures were loose but did not then make use of the denture adhesive the Resident's son had provided, as he had been requested, indicates that an appropriate standard of a denture care was not being provided to the Resident in the period leading up to the Dentures Incident.

159. I note the IPA advised he did not consider the oral hygiene care the Nursing Home provided to the Resident both before and after the Dentures Incident '*was adequate and in accordance with relevant guidelines'*. I note too that the IPA highlighted that '*the outcome of [the NHSCT] Adult Safeguarding Investigation found that more care could have been taken with mouth care and ensuring dentures do not get lodged in airways.'*

160. I have given careful consideration to all the available evidence relating to this element of the complaint, including the IPA's advice, which I accept. I conclude that the Resident did not receive appropriate oral hygiene care on 2 and 3 March 2019. This finding is of particular concern given that good oral hygiene care is recognised as a measure to reduce the incidence of respiratory disease in high risk elderly adults living in nursing homes, and that it is suggested that where regular oral hygiene care is not provided for residents, the likelihood of pneumonia associated death is tripled.[17]

161. Furthermore, I note the IPA advised that because symptoms of swallowed dentures can include throat pain, swallowing problems and breathing problems, and because the risk of such an event increases if the wearer has a neurological impairment, such as dementia, *'it was possible for [the Nursing Home] staff to have known [the Resident] had swallowed her dentures'*. Again, I accept the IPA's advice. I am, therefore, highly critical that the Nursing Home did not recognise sooner the possibility that the symptoms the Resident was experiencing could be related to her dentures having become displaced.

162. I consider the Nursing Home's failure to provide appropriate oral hygiene care to the Resident on 2 and 3 March 2019, and its failure to recognise that the symptoms the Resident was experiencing at that time could indicate that she had swallowed her dentures, to be failings in the Resident's care. I am satisfied that these failings caused the Resident to experience a loss of opportunity for it to be identified at a much earlier stage that her dentures had become displaced and were lodged in her throat, and also the injustice of distress and upset due to the resulting pain in her throat, swallowing and breathing difficulties, and

[17] The GAIN Guidelines for Oral Healthcare

being unable to eat or drink. I uphold this element of the second issue of complaint.

163. I welcome the steps the Nursing Home has taken to minimise the risk of a similar incident with dentures occurring in the future. In this regard, I note that when the Manager of the Nursing Home wrote to RQIA on 14 March 2019 about the Dentures Incident, she stated, *'We did not have a system in place to ensure patients dentures were removed when in bed but this has since been incorporated into personal hygiene charts.'* The Nursing Home Manager also informed RQIA, *' All staff have been informed of this regrettable incident and supervisions are and continue to be carried out with staff to highlight this to prevent it from happening to other patients.'*

Adult Safeguarding Procedures

164. I note the Department of Health's Nursing Home Care Standards states that '*following an allegation of abuse, neglect or exploitation'* the Registered Manager of the Nursing Home should arrange '*a de-brief with staff to discuss the conclusion of the investigation and the learning arising'*. The Department of Health's Nursing Home Care Standards indicates that evidence that a nursing home is achieving the required standard with regard to safeguarding[18] includes that '*Incidents are recorded and reported appropriately to the [relevant health and social care trust] and RQIA'.*

165. As already noted in this report, the Nursing Home wrote to RQIA on 14 March 2019, providing details of the Dentures Incident and the action taken to avoid a reoccurrence in the future. In addition, the records I obtained document that the Nursing Home informed the NHSCT of the incident. In this regard, I note the IPA highlighted in his advice that that *'on the 5th March 2019 [the Nursing Home] completed an Adult Protection Referral … [which] was sent to [the NHSCT]. In doing so [the Nursing Home] acted in an open and transparent manner surrounding this event, in line with [the HSCB's NIASP Adult Safeguarding Procedures]'* I note that the DAPO, who was appointed to manage referral, documented the outcome of the NHSCT adult safeguarding

[18] Standard 13

investigation as, '*Matter is substantiated as neglect as more care could be taken regarding mouth care and ensuring dentures do not get lodged in airways'.*

166. I further note that the IPA advised that '*By appropriately reporting [the Dentures Incident] in a timely manner [the Nursing home] also met the requirements of [the Nursing Home's Adult Safeguarding Policy].'*

167. Having considering the available evidence, including the IPA's advice, which I accept, I am satisfied the Nursing Home acted appropriately by initiating its Adult Safeguarding Procedures, in accordance with the Nursing Home's Adult Safeguarding Policy and other relevant standards, including the Department of Health's Nursing Home Care Standards and the HSCB's NIASP Adult Safeguarding Procedures. Consequently, I do not uphold this element of the second issue of complaint.

Summary of findings on Issue Two

168. My investigation of this second issue of complaint examined whether the care and treatment that the Nursing Home provided to the Resident on 3 March 2019 was adequate and in accordance with good medical practice.

169. I concluded that following the Dentures Incident, the Nursing Home took appropriate action, in making an Adult Safeguarding referral to the NHSCT. However, I found evidence of a number of failings in the Resident's care and treatment. Specifically, I found that:

- there was a failure by the Nursing Home to have in place an oral health policy and a detailed oral health care plan for the Resident;
- there was a failure by the Nursing Home to provide appropriate oral hygiene care for the Resident on 2 and 3 March 2019;
- there was a failure by the Nursing Home to recognise the Resident's presenting symptoms on 2 and 3 March 2019 could indicate that she had swallowed her dentures; and

- there was a failure by the Nursing Home to have proper regard to the Resident's human rights in terms of her dignity.

170. I partially uphold the second issue of complaint.

CONCLUSION

171. The complainant submitted a complaint to me about the care and treatment her mother (the Resident) received in the Nursing Home. Specifically, the complainant raised concerns about a moving an handling incident that occurred on 15 February 2019 (the Moving and Handling Incident) and an incident which resulting in it being discovered on 3 March 2021 that the Resident's dentures had become lodged in her throat (the Dentures Incident).

172. My investigation found that the Nursing Home acted correctly in having an appropriate moving and handling risk assessment in place for the Resident at the time of the Moving and Handling Incident. It found too that following both the Moving and Handling Incident and the Dentures Incident, the Nursing Home acted appropriately in relation to the implementation of adult safeguarding procedures.

173. However, my investigation also found several failings in the care and treatment the Nursing Home provided to the Resident.

174. In relation to the Moving and Handling Incident, I found that the Nursing Home:

- failed to appropriately manage the Resident's transfer from bed to her chair on 15 February 2019;

- failed to complete an appropriate clinical assessment of the Resident following the Moving and Handling Incident;

- failed to reassess the Resident for potential injury in the hours that followed the Moving and Handling Incident; and

- failed to contact the out-of-hours GP service on 16 February 2019, at the earliest opportunity, after swelling to the Resident's right thigh had been noted.

175. With regard to the Dentures Incident, I found that the Nursing Home:

- failed to have in place an oral health policy and a detailed oral health care plan for the Resident;
- failed to provide appropriate oral hygiene care for the Resident on 2 and 3 March 2019, in the hours leading to the discovery that the Resident's top denture plate was missing;
- failed to recognise that the Resident's presenting symptoms at that time could indicate that she had swallowed her dentures; and
- failed to have proper regard to the Resident's human rights in terms of her dignity.

176. I am satisfied that the failings in care and treatment disclosed by my investigation caused the Resident to experience the injustice of upset and distress, not only because of the pain she suffered as a result of not receiving appropriate care at the time of the Moving and Handling Incident and the Dentures Incident, but also because of the trauma she endured at having to be transferred to, from and between hospitals. The Resident also sustained the injustice of loss of opportunity to have her oral health care needs appropriately assessed and met, and loss of opportunity to have both the fracture she sustained to her right thigh and her displaced denture plate diagnosed and treated sooner than was the case.

177. In addition, having given careful consideration to the advice I obtained from the IPA, I am very conscious that, in particular, the injury I am satisfied the Resident sustained as a result of the Moving and Handling Incident, and the resulting impact on her mobility and independence, may well have led to the shortening of the Resident's life.

178. I am conscious too that the Moving and Handling Incident and the Dentures Incident must have been highly distressing for the Resident's daughter (the complainant) and the other members of the Resident's family, most notably, her two sons. I am satisfied therefore that the failings identified in this report

caused the complainant and her brothers to experience the injustice of upset, distress and uncertainty about the appropriateness of the care and treatment the Resident receive. In addition, I am mindful that the complainant and her brothers experienced the further injustice of upset and distress in having to pursue, through my Office, their concerns about the care the Nursing Home provided to their mother. I am in no doubt that their engagement in the investigation process brought back painful memories of a highly upsetting and anxious period.

179. With this in mind, I should also record that although throughout this report, I refer to 'the Resident', I am mindful that my investigation concerned the care and treatment the Nursing Home provided to a much-loved mother. It is clear, from the documentation I considered during the investigation, that the Resident's three children – the complainant and her two brothers – were devoted to her, and very much concerned with, and involved in, decisions regarding her care. The trauma and distress of losing their mother in the circumstances reflected in this report is very evident in their correspondence to the Nursing Home and to my Office. I hope this report goes some way to addressing the family's concerns about the care their mother received.

180. Overall, I partially uphold this complaint.

Recommendations

181. I recommend that within one month of the date of this report, the Chief Executive of Conway Group Healthcare, which manages the Nursing Home, provide the complainant, and her brothers, with a written apology, made in accordance with NIPSO's 'Guidance on issuing an apology'[19] for the injustice caused as a result of the failings in care and treatment disclosed by my investigation.

182. I also recommend the Nursing Home implement the following service improvements:

[19] https://nipso.org.uk/site/wp-content/uploads/2019/07/N14C-A4-NIPSO-Guidance-on-issuing-anapology-July-2019.pdf

(i) the Nursing Home should bring the failings identified in this report regarding the Moving and Handling Incident to the attention of the relevant staff;

(ii) the Nursing Home should review and update, as necessary, the moving and handling training it provides to care staff to ensure it emphasises the learning from this complaint and includes guidance on appropriate action should a limb become caught or a resident express pain during a moving and handling procedure;

(iii) the Nursing Home should bring the failings identified in this report regarding the Dentures Incident to the attention of the relevant staff, emphasising importance of providing appropriate mouth care and denture care;

(iv) the Nursing Home should develop an oral healthcare policy that is reflective of relevant standards and best practice, including the recommendations set out in the NICE Oral Health for Adults in Care Homes Guideline;

(v) the Nursing Home should reflect on the IPA's recommendation regarding the placing of a picture of a sunflower (or similar) above a resident's bed to indicate, without affecting a resident's dignity, that they have a denture and to prompt staff to check for dentures that might be wrapped in tissue, hidden in bed linen, or more importantly are missing and could have been swallowed; and

(vi) the Nursing Home should ensure that relevant staff evidence a reasonable level of reflection on the issues raised in this complaint, and that there is discussion of the matter at their next performance appraisal.

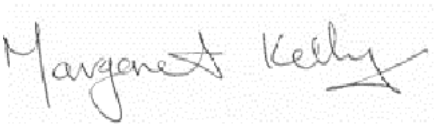
183. I recommend that the Nursing Home implement an action plan to incorporate these service improvement recommendations and that it provide me with an update within six months of the date of this report. The update should be supported by evidence to confirm that appropriate action has been taken in relation to each of the recommendations.

184. In addition, although not formal recommendations, it is my expectation that the Nursing Home reflect on the observations I made in this report regarding:

(i) the need to remind nursing staff that they should consider assessing residents for potential lower limb injury while they are lying down; and

(ii) the need to the need to make a formal record of all incidents involving potential injury to residents and the need to ensure that residents' family members are fully informed about such incidents in a timely manner.

185. I intend to provide a copy of this report to the RQIA and to the NHSCT in order that they may consider the serious issues arising out of this case.



MARGARET KELLY
Ombudsman **26 September 2022**

Appendix 1

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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

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

3. Being open and accountable

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

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.