Investigation Report

Investigation of a complaint against Independent HSC Provider

NIPSO Reference: 201917438

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Appendix 1 – The Principles of Good Administration
Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201917438

Listed Authority: Independent HSC Provider - Private Nursing Home

SUMMARY

I received a complaint about the actions of Clandeboye Care Home (the Home). The complainant raised concerns about the care and treatment the Home provided to her mother, (the resident). Four Seasons Health Care Group managed the Home during the time her mother was resident there.

The complainant is concerned with particular aspects of the resident's care and treatment, which the complainant believed were inadequate. In particular the complainant said that the Home failed to consult with the family to determine her mother's '*normal presentation*', failed to assess the resident using the Abbey Pain Scale at the appropriate times, and failed to create and follow a care plan in consultation with the family. The complainant believed the Home did not monitor the resident's condition and effectiveness of her medication, and failed to appropriately manage the resident's medication. The complainant believed the Home excluded the family from tending to her mother during her final days, and did not accurately record the circumstances of the resident's death. The complainant also queried whether the Home's staffing level was appropriate during the time her mother was a resident with the Home, and if the staff were appropriately qualified to provide care and treatment to her mother.

In order to assist with the consideration of the issues the complainant raised, I obtained independent professional advice from a Consultant Nurse for older people with over 20 years of relevant experience.

The investigation established that the Home provided appropriate medication management to the resident during the period 27 October to 4 November 2020. The investigation also established that the Home's staffing levels and qualifications were appropriate throughout the duration of the resident's time at the Home.

However my investigation found failures in care and treatment in relation to the following matters:

- Failure to consult with the family during the formulation of the resident's care plans;
- Failure to adequately interpret the resident's behaviour and consult with the family to determine the resident's '*normal presentation*';
- Failure to appropriately assess the resident using the Abbey Pain Scale upon intervention and movement and return from hospital discharge;
- Failure to appropriately manage the resident's medication during the period 11 November to 16 November 2020;
- Failure to keep accurate records in respect of medication administration and rationale for excluding medications;
- Failure to monitor the resident on 17 November 2020;
- Failure to allow the resident's family to tend to the resident in her final days; and
- Failure to accurately record the circumstances of the resident's death.

I concluded that these failures in care and treatment caused the resident to experience the injustice of a loss of opportunity to receive the appropriate care and treatment she required. I concluded that these failures in care and treatment caused the complainant and her family to experience the injustice of uncertainty, upset and distress. The complainant advised this Office she is deeply saddened by the way her mother passed. The complainant said my report identifies that the Home had the appropriate resources to make her mother's final hours more bearable, and this is difficult for the complainant to come to terms with.

I recommended the Home provide the complainant with a written apology for the injustice caused as a result of the maladministration and failure in care and treatment. Regarding failures in record keeping and in care and treatment provided to the resident, I made further recommendations for the Home to address under an evidence-supported action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

Following the receipt of the draft Investigation Report the Home stated it seeks to provide the assurance that as an organisation it improves their resident and family experience by taking cognisance of the lessons learned.

THE COMPLAINT

1. I received a complaint about the care and treatment Clandeboye Care Home (the Home), (managed by Four Seasons Health Care Group) provided to the complainant's mother (the resident) from 27 October 2020 to 4 November 2020, and from 11 November 2020 to 17 November 2020.

Background

2. On 27 October 2020 following a hospital discharge, the resident was admitted to the Home. During her time at the Home, the staff raised concerns about the resident's eating and drinking. On 4 November 2020, the resident was admitted to hospital for treatment. On 11 November 2020, the hospital discharged the resident from hospital back to the Home. On 17 November 2020 the resident began to deteriorate and sadly passed away.

3. The complainant raised a number of issues of concerns about the care and treatment the Home provided to the resident during her residency. The complainant believed that the Home's care and treatment of the resident contributed to the resident's distress and discomfort in the days prior to her passing away. The complainant also believed her mother deserved a much kinder, more peaceful, pain free, and dignified end of life. The complainant said she is still coming to terms with her mother's passing.

Issue of complaint

4. The issue of complaint accepted for investigation was:

   Whether the care and treatment provided to the resident by the Four Seasons Health Care from 27 October 2020 to 4 November 2020 and from 11 November 2020 to 17 November 2020 was appropriate and in accordance with relevant procedures and standards.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Home all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Home's handling of the complaint.

Independent Professional Advice Sought

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

   - The IPA is a consultant nurse RGN, BA (Hons), MSC, PGCert (HE) for older people with over twenty years' experience across hospitals, care homes and community care.

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

7. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

8. 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[1]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- Department of Health, Social Service and Public Safety Care Standards for Nursing Homes 2015 (the Nursing Home Standards);
- Four Seasons Health Care Planned Admission, Emergency Admission and Re-Admission from Hospital Policy 18 April 2019 (FSHC Admission Policy);
- National Institute of Care and Excellence Guidance NG31 Care of Dying Adults in the Last Days of Life 16 December 2015 (NICE Guidance);
- Four Seasons Health Care Guidance on the Use of the Abbey Pain Scale 7 March 2018 (FSHC Abbey Pain Scale Guidance);
- Professional Guidance on the Administration of Medicines in Healthcare Settings Published by the Royal Pharmaceutical Society and Royal College of Nursing January 2019 (RPS and PCN Guidance);
- Regional Palliative Management Group NI, Public Health Agency October 2014, Guidance for the Management of Symptoms in Adults in the Last Days of Life (NI Palliative Guidance);

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

- Four Seasons Health Care Visitor Protocol – Home Manager Guidance September 2020 (FSHC Visitor Guidance);
- Public Health Authority Covid 19: Guidance for Nursing and Residential Care Homes in Northern Ireland July 2020;
- Royal College of Nursing (RCN) Guidance on Safe Staffing Levels in the UK 2010 (RCN Guidance);
- The Regulation and Quality Improvement Authority Provider Guidance 2019 – 20 Nursing Homes (RQIA Provider Guidance);
- Department of Health, Social Services and Public Safety Complaints in Health and Social Care Standards & Guidelines for Resolution & Learning April 2009 (HSC Complaints Guidance); and
- Nursing and Midwifery Council, The Code (the NMC Code), January 2015.

I enclose relevant sections of the guidance considered within the body of this report, and at Appendix four to this report.

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

Response to the draft Investigation Report

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

12. Both the complainant and the Home were given the opportunity to provide comments on the draft Investigation Report. These comments were carefully considered and have been reflected in changes throughout this final report. The complainant wished to highlight her view that the use of the word 'vomiting' within her mother's clinical records should be changed to hematemesis[2] or haemorrhage of blood from the stomach to ensure the full context of her

[2] Hematemesis is a serious condition that causes you to throw up blood which could be a sign that a resident is bleeding within their digestive system and should obtain medical attention right away.

mother's death and the seriousness of her condition which remained untreated up to her passing is understood.

THE INVESTIGATION

Issue 1: *Whether the care and treatment provided to the resident by the Four Seasons Health Care from 27 October 2020 to 4 November 2020 and from 11 November 2020 to 17 November 2020 was appropriate and in accordance with relevant procedures and standards.*

In particular this will include:

- Creation and following of Care Plan.
- Initial Assessment of the resident.
- Use of Abbey Pain Scale.
- Behaviour of the resident.
- Monitoring of the Resident's Condition and Effectiveness of the Medication.
- Medication Management.
- Monitoring of the resident on 17 November 2020.
- Exclusion of family.
- Staff Resources and Qualifications.
- Recording of Death.

Detail of Complaint

Creation and following of Care Plan.

13. The complainant said the Home did not form a care plan for the resident in consultation with the family, and the Home did not follow a care plan during its care of the resident.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- Nursing Home Standards.

The Home's response to investigation enquiries

27 October 2020 – 4 November 2020.

14. The Home explained, *'in normal circumstances, the family would be encouraged to participate in the writing of care plans. We have acknowledged that during this unprecedented time that communication was not at the level we would aspire to be at'*. The Home further explained, regular visiting was not taking place and the Home staff formulated care plans from the information provided by the admission documentation supplied. The Home explained the resident *'was not in the home long and therefore a full life history was not available'*.

15. The Home stated that the resident had a suite of care plans in place, and listed fourteen care plans that were in place for the resident during her residency within the Home.

Relevant Home records

16. The Home provided the relevant records and a summary of these records is enclosed in Appendix six to this report.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

17. The IPA advised despite visiting restrictions, the Home should have made an effort to contact the family to obtain additional information about the resident. The IPA advised, *'it was not appropriate for the home to create care plans based only on the resident's admission forms'*.

11 November 2020 – 17 November 2020

18. The IPA advised the care plans in place for the resident upon return to the Home following hospital discharge were appropriate and developed within an appropriate timescale. The IPA also advised the Home reviewed these care plans at the appropriate times.

19. The IPA advised the resident's care plans during this period were appropriate; however there was no plan for the resident's personal preferences/lifestyle, or

management of distressed behaviour. The IPA advised also it is good practice to discuss the resident's needs on discharge from hospital, and there is evidence that the Home contacted the resident's husband to discuss DNACPR[3].

Analysis and Findings

27 October 2020 – 4 November 2020

11 November 2020 – 17 November 2020

20. The complainant said the Home did not form a care plan for the resident in consultation with the resident's family.

21. The Nursing Home Standards states, *'a detailed plan of care for each resident is generated from a comprehensive, holistic assessment and drawn up with each resident'*, and all residents' care needs should be written in partnership with the nursing staff, the resident and their relatives.

22. The Nursing Home Standards states, *'prior to admission and in line with timeframes agreed by the commissioning Trust, an identified nurse employed by the home visits the prospective resident and carries out and records an assessment of nursing care needs. This assessment includes information received from other care providers including family members as appropriate.'* The Nursing Home Standards also states, *'the care plan records evidence of the involvement of the resident and their relatives in the development and review of care plans, incorporating the decisions made, the agreements reached and the information which was shared'*.

23. The Home explained, *'in normal circumstances, the family would be encouraged to participate in the writing of care plans. We have acknowledged during this unprecedented time [Covid 19 pandemic] that communication was not at a level we would aspire to be at. Regular visiting was not taking place and care plans were being formulated from the information provided by the admission documentation supplied'*.

[3] Do not attempt cardiopulmonary resuscitation order is a legal document that formalizes decision-making about whether an individual should be treated with CPR, in the event of a cardiac arrest.

24. The IPA advised the care plans the Home put in place were appropriate and followed correctly. The Home’s records (the records) also contain a palliative and end of life needs assessment as part of the resident’s admission assessment, and was marked as low. However I note the records are blank in areas relating to any specific information on medical prognosis. The IPA also advised the records do not contain an end of life care plan formulated for the resident during this period. The IPA advised the Home did not consult the family during the formulation of the resident’s care plans.

25. I note the IPA advised the Home should have made an effort to contact the resident’s family in order to obtain additional information about the resident; for example lifestyle and personal choices. The IPA advised, it was not appropriate for the Home to create care plans based on the resident’s admission forms only.

26. On both admissions, the Home’s care plans for the resident were appropriate and appropriately monitored. However, I am critical that the Home did not act in accordance with the Nursing Home Standards. I also accept the IPA advice that it failed to consult with the resident’s family during the formulation of the resident’s care plans, and also to prepare an end of life care plan for the resident. I consider this a failure in care and treatment and partially uphold this element of the complaint.

27. I consider the failings identified caused the resident to experience the injustice of a loss of opportunity to have appropriate care and treatment. I also consider the failures identified caused the family to experience the injustice of uncertainty. This is because they will always question if the resident received the appropriate care from the Home in her final days and question what difference, if any, it would have made to the resident’s experience.

28. I acknowledge that the resident was with the Home during the Covid 19 pandemic, and there was a Covid 19 outbreak within the Home. I understand the Covid 19 pandemic was a difficult time for all health care sectors in Northern Ireland, but particularly for care homes. However, I consider the Home could have availed of other methods of communication to formulate care

plans with the resident's family. I note the Home have acknowledged this failing, and I will address this action in the conclusion of this report.

Detail of Complaint

Initial Assessment of the resident.

29. The complainant said the Home did not make enquiries with the family in order to identify the resident's *'normal presentation[4]'*.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- Nursing Home Standards.

The Home's response to investigation enquiries

27 October 2020 – 4 November 2020.

30. The Home explained, *'it was highlighted that staff did not contact family specifically to discuss the normal presentation with regards to the communication of pain'*. The Home stated, it took forward further training and supervision with staff on 10 March 2021. The Home communicated this action to the complainant during its internal complaints process.

11 November 2020 – 17 November 2020.

31. The Home stated that during the resident's time in the Home full Covid 19 restrictions were in place and normal visiting was not occurring. The Home explained, *'staff were very much guided in the information provided by the hospital to what [the resident's] normal presentation* was'.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

32. The IPA advised that the Home should have contacted a carer/family representative to discuss what the resident's *'normal presentation'* was. The IPA advised, *'the potential impact on the resident with dementia such as [the*

[4] Normal presentation means their pre-morbid level of function or baseline state of health and function. This includes both physically and mentally.

resident] could include misinterpretation of attempts to communication need or misinterpretation of non-verbal signs of need such as pain or discomfort'.

11 November 2020 – 17 November 2020

33. The IPA advised, *'I did not find any record of discussion with the family relating to [the resident]'s 'normal presentation' during this time. This could have impacted on assessment of her needs as an understanding of her 'normal presentation' might have supported interpretation of signs of agitation and communication'*.

Analysis and Findings

27 October 2020 – 4 November 2020

34. The Trust admitted the resident to the Home on 27 October 2020. The complainant said the Home did not speak with the family during the resident's admission to the Home, in order to identify her *'normal presentation'*.

35. The Nursing Home Standards states, *'It is imperative that for all planned admissions, a pre-admission assessment is carried out in the Person's current location and will involve the Person to be admitted and their representative (where possible)*'. I note the Nursing Home Standards also states, *'Life story work is considered fundamental to being informed about a resident's life experiences and so is integral to the assessment processes'*.

36. The Home stated that during the complaints process the complainant highlighted to the Home that its staff did not contact the resident's family specifically to discuss the resident's *'normal presentation'*.

37. The records do not contain an entry for social information/personal preferences. I note these records do not hold information on the resident's *'normal presentation'*, and '*My preferences – things that are important to me'* is not completed other than the resident's preferred name.

38. The IPA advised, *'there is no evidence in the pre-assessment information to indicate where the pre-admission assessment was carried out from or from*

whom the information was obtained.' I note the IPA also advised, *'I did not find any evidence that the home had discussed with the family how the resident communicated pain',* and advised the Home should have contacted a carer/family representative to discuss what the resident's *'normal presentation'* was.

11 November 2020 – 17 November 2020

39. The records indicate the staff monitored the resident for some signs of deterioration, however there are no records documenting that the Home discussed the resident's *'normal presentation'*, with the family during this period.

40. I note the Nursing Home Standards do not hold any set specific criteria for an instance like this. The IPA advised that the time when the Home admitted the resident to hospital, and then discharged her back to the Home, was a short time period, and *'therefore any assessment of 'normal presentation' that had been made on admission to the care home would still be applicable'*. However, the resident's *'normal presentation'* was not assessed when initially admitted to the Home, and therefore those records could not be used when the resident was discharged back to the Home.

Overall

41. For both time periods, I am critical that the Home did not discuss the resident's *'normal presentation'* with the resident's family in line with the Nursing Home Standards. I consider this a failure in care and treatment, and I uphold this element of the complaint.

42. I consider the failings identified caused the resident to experience the injustice of a loss of opportunity to have her needs appropriately assessed. I accept the IPA's advice, *'the potential impact for the resident was that pain would not be appropriately identified or acted upon'*. I also consider the failures identified caused the family the injustice of uncertainty. Again, this is because they may always question if the resident's experience would have been different if she had received the appropriate assessments from the Home.

43. I welcome the Home's acknowledgement that it did not communicate with the resident's family to determine what the resident's *'normal presentation'* was, and I note that the Home have now taken this forward as learning to its staff. The Home informed this Office that it had delivered training to its staff on this area on 10 March 2021. I will comment further on this in the conclusion of this report.

Detail of Complaint

Use of Abbey Pain Scale.

44. The complainant said the Home did not initially assess the resident using the *'Abbey Pain Scale[5]'*.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- Nursing Home Standards; and
- FSHC Abbey Pain Scale Guidance.

The Home's response to investigation enquiries

27 October 2020 – 4 November 2020.

45. The Home stated, *'an Abbey Pain Scale was completed on admission on the 28 October 2020 with a score of 5 (mild pain)'*.

11 November 2020 – 17 November 2020.

46. The Home stated that the resident's Abbey Pain Scale score was *'not reviewed on readmission to the home on the 11th November [2020]'*. The Home advised that remedial action has taken place to address this identified as training needed.

[5] The Abbey Pain Scale is a standardized pain assessment tool developed for use in demented nonverbal patients.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

47. The IPA advised the Home did not follow the Abbey Pain Scale guidance when assessing the resident on 28 October 2020. The IPA also advised that during this period, the Home did not assess the resident using the Abbey Pain Scale at the appropriate times.

11 November 2020 – 17 November 2020

48. The IPA advised the resident was not assessed using the Abbey Pain Scale upon her return to the Home following her hospital discharge. The IPA advised, *'the implication is that the staff may not have specifically assessed or monitored for potential pain, possibly not identifying it in a timely manner.'*

49. The IPA advised the Home did not review the resident's Abbey Pain Scale score when she began to deteriorate. The IPA also advised there is only one entry to indicate that the resident was in pain, at 18.15 on 17 November 2020, however there is no record of the Home using the Abbey Pain Scale at this time. The IPA advised, *'the potential impact on the resident was that if significant pain was not identified, the appropriate pain relief might not have been given'*. The IPA advised that from the resident's medical records, the GP prescribed morphine as part of anticipatory medication[6], but the Home did not administer it, and, *'therefore if the resident was experiencing pain, it was not relieved by any analgesia'*.

Analysis and Findings

27 October 2020 – 04 November 2020

50. The complainant said the Home did not appropriately complete the Abbey Pain Scale assessment on the resident during her time at the Home. The complainant also said the Home had poor documentation about the resident's ongoing assessment of the Abbey Pain Scale.

[6] Anticipatory medication refers to medication which can be administered when the resident can no longer swallow.

51. The FSHC Abbey Pain Scale Guidance states, *'the staff recording the scale should, therefore observe the Person while they are being moved, e.g. during pressure area care, while showering, etc. Complete the Scale immediately following the procedure and record the results in the Person's notes'*. This guidance also states, *'a second evaluation should be conducted one hour after any intervention taken in response to the first assessment to determine the effectiveness of any pain-relieving intervention'*.

52. The Nursing Home Standards states that Home staff should recognise where a resident's behaviour may be caused by pain. This guidance states, *'staff are trained to use a validated pain assessment tool to ascertain if residents with dementia are in pain and respond effectively to the need for pain relief'*.

53. The Home explained the nursing staff assessed the resident upon her admission to the Home on 28 October 2020 using the Abbey Pain Scale assessment tool.

54. The records document the nursing staff assessed the resident using the Abbey Pain Scale on one occasion, which was on 28 October 2020. The records document that the resident scored five (mild pain), one for vocalisation (mild), one for facial expression (mild) and three for physical changes (severe).

55. The IPA advised the Home's use of the Abbey Pain Scale on 28 October 2020 was *'an appropriate use of this tool'*, however, the Home did not assess the resident in line with the Abbey Pain Scale Guidance. This guidance requires the Home to assess the resident whilst the nursing staff move the resident. The IPA also advised the resident was not assessed using the Abbey Pain Scale at the appropriate times.

11 November 2020 – 17 November 2020

56. The Home stated it did not review the resident's Abbey Pain Scale score upon the resident's readmission to the Home.

57. The Nursing Home Standards do not set out a detailed requirement for re-assessment of residents upon their return from hospital. However the Nursing

Home Standards set out, *'resident's health, personal and social care needs are set out in an individual care plan which provides the basis of the care to be delivered and is re-evaluated in response to the resident's changing need'*.

58. I note the records document the nursing staff assessed the resident using a readmission assessment on 11 November 2020, following her hospital discharge. However, these records do not include a nursing staff assessment of whether the resident was in pain.

59. The IPA advised the Home did not assess the resident using the Abbey Pain Scale at the appropriate times during the period 11 November 2020 to 17 November 2020.

Overall

60. I consider it was appropriate that the Home assessed the resident using the Abbey Pain Scale upon her admittance to the Home. However I accept the IPA's advice that the Home did not assess the resident using the Abbey Pain Scale at the appropriate times. I am critical that the Home only used the Abbey Pain Scale on one occasion, despite the resident being with the Home for approximately two weeks during the two periods. I consider this a failure in care and treatment and I uphold this element of the complaint.

61. I consider the failure identified caused the resident loss of the opportunity to receive a proper assessment of her pain, and to subsequently to receive appropriate pain relief. I accept the IPA's advice, *'the implication is that the staff may not have specifically assessed or monitored for potential pain, possibly not identifying it in a timely manner'* and *'the appropriate pain relief might not have been given'*. I consider the failing identified caused the family uncertainty and upset. This is because the family will always question if the resident was in pain but did not receive appropriate pain relief.

62. I cannot determine whether the resident was in pain during this time period from the records provided. I acknowledge the Home informed this Office it has taken remedial actions to address this failing as identified training needed, and

communicated this remedial action to the complainant. I will comment further on this action in the conclusion of this report.

Detail of Complaint

Behaviour of the resident.

63. The complainant said the Home had mistaken her mother's 'resistant' behaviour as normal behaviour or a symptom of her dementia rather than a symptom of her pain, confusion or fear.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- Nursing Home Standards.

64. The Nursing Home Standards states, *'staff recognise where behaviour may be caused by pain. Staff are trained to use a validated pain assessment tool to ascertain if residents with dementia are in pain and respond effectively to the need for pain relief'*.

The Home's response to investigation enquiries

27 October 2020 – 4 November 2020.

65. The Home stated the resident's records documented that she had a history of challenging behaviour with increased anxiety levels. The Home stated the staff, *'did not observe any non-verbal signs to indicate that [the resident] was in chronic pain'*. The Home said when it interviewed staff as part of the complaint process staff stated the resident did not display resistive behaviour at every intervention, but mostly displayed this behaviour during personal care.

11 November 2020 - 17 November 2020.

66. The Home explained when the resident returned to the Home following her hospital discharge, it was documented the resident *'continued to be resistive to intervention'*. The Home stated, on 12 November 2020 her GP saw the resident, and stated in his report that the resident *'appears comfortable'*.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

67. The IPA advised, *'the care home recognised that [the resident] exhibited behavioural symptoms. The application of the Abbey Pain Scale did not assess [the resident]'s behaviour as being a significant contributory factor to pain at that time'*. The IPA also advised, *'there is no evidence that the home further interpreted the behaviour as being associated with pain. There is little evidence of interpretation of possible causes of distress until 03/11, at which point medical advice was sought, and this was appropriate'*.

11 November 2020 – 17 November 2020

68. The IPA advised, *'no formal assessments of pain were carried out. This was not appropriate'*. The IPA advised it is not possible to conclude whether pain was a significant factor in the resident's episodes of agitation.

Analysis and Findings

27 October 2020 – 4 November 2020

69. The complainant considered the Home thought the resident's resistant behaviour as normal or a symptom of her dementia, rather than a symptom of the resident's pain, confusion or fear.

70. The Home stated the resident did not display resistant behaviour at every intervention, and the resident mostly displayed this behaviour during personal care. The Home explained the nursing staff did not observe any non-verbal signs from the resident to indicate that she was in chronic pain, and her pre-admission documentation stated that the resident had a history of *'challenging behaviour'* with increased anxiety levels.

71. The Home explained that since the resident's admission on 27 October 2020 the resident had not been eating and drinking sufficiently and was admitted to hospital. I note the Home stated, *'it needs to be recognised [the resident] was only in the home for approx. 14 days and during this time full COVID restrictions were in place and normal visiting was not occurring. Staff were very*

much guided in the information provided by the hospital to what her normal presentation was'.

72. The records document on 28 October 2020, the nursing staff used the Abbey Pain scale to assess the resident's pain on 28 October 2020. As previously referenced, the IPA advised that *'this was an appropriate use of the tool'*. I note the records document on 28 October 2020 the nursing staff recorded the resident as having *'challenging behaviour. She could shout, scream and exhibit expressing speech'*.

73. I note the records contain a progress record which identifies appropriate strategies the Home deployed to address the resident's behaviour. These strategies included: leave and return *'plenty of encouragement to take medications, had to go back several times, nursed in bed and repositioned'*. Encouragement and assistance *'eating and drinking poorly, keeps refusing even when staff keep coming back to her'*, and referral for medical advice: *'GP called and talked to [GP] as refused for poor oral intake upon admission until now and behaviour, advised to check blood and urine'*.

74. I note the IPA advised, *'there is no evidence that the home further interpreted the behaviour as being associated with pain. There is little evidence of interpretation of possible causes of distress until 03/11, at which point medical advice was sought, and this was appropriate'*. I accept this advice.

75. I note the Home did seek medical advice on 3 November 2020; however I am critical that the Home did not investigate the possible causes of distress until that date. I consider this is inappropriate. I note the resident was subsequently admitted to hospital on 4 November 2020.

11 November 2020 – 17 November 2020

76. The records do not document that the nursing staff carried out any formal assessment of pain upon the resident's return to the Home. The records document that the resident's GP prescribed her medications for symptoms at end of life, which included Morphine for pain. The records document the resident's behaviour as *'resistive with interventions'* on 11 November 2020, and *'generally calm'* on 12 November 2020. The records also document that the

nursing staff continued with strategies of reassurance and settled the resident, and allowed her family to visit *‘by the window’*. On 17 November 2020 the Home’s records document that the nursing staff recorded the resident to be in *‘pain and moaning’*.

77. The IPA advised, *‘no formal assessments of pain were carried out’* upon the resident’s return to the Home on 11 November 2020, and *‘this was not appropriate’*. The IPA advised, *‘I would expect the Abbey Pain Scale to have been completed’* on 17 November 2020.

Overall

78. I am critical that the Home did not carry out formal pain assessments as referred to in paragraph 76 above. I am satisfied that this meant the Home did not appropriately investigate the reasons for the resident’s behaviour. This is a requirement set out by the Nursing Home Standards. I consider the Home’s lack of investigation into the resident’s behaviour a failure in care and treatment, and I uphold this element of the complaint.

79. I consider the failings identified caused the resident a loss of opportunity to receive an investigation into her distress and agitation, and to subsequently receive the necessary treatment, so her final hours may have been peaceful. I consider the failings identified caused the family the injustice of uncertainty and upset. I acknowledge the family will always question if the Home’s staff carried out investigations into her symptoms, the resident’s experience and final hours may have been different.

Detail of Complaint

Monitoring of the resident’s condition and effectiveness of medication

80. The complainant said that the Home did not monitor the residents condition, and the effectiveness of any medication and treatment given.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- Nursing Home Standards; and
- RPS and PCN Guidance.

81. The Nursing Home Standards states, *'re-assessment is an ongoing process that is carried out daily and at identified, agreed time intervals as recorded in care plans'*. The RPS and PCN Guidance states, *'registered health care professionals who administer medicines, or when appropriate delegate the administration of medicines, are accountable for their actions, non-actions and omissions, and exercise professionalism and professional judgement at all times'*. This Guidance also states *'any ambiguities or concerns regarding the direction for administration of the medicine are raised with the prescriber or a pharmacy professional without delay'*. The RPS and RCN Guidance states, *'where a medicine is not administered or refused, details of why (if known) are included in the record and, where appropriate the prescriber multidisciplinary team is notified in accordance with the organisation policies and procedures'*.

The Home's response to investigation enquiries

27 October 2020 - 4 November 2020.

82. The Home stated, since the resident's admission on 27 October 2020 the staff had great difficulty in getting the resident to eat or drink. The Home explained, on 2 November 2020 *'staff did contact the GP to highlight their concerns and the fact that [the resident] looked clinically dehydrated'*. The resident's GP requested the resident's bloods to be taken, and on 4 November 2020 her GP advised the Home that the resident had an electrolyte imbalance and required IV fluids. The resident was then admitted to hospital.

11 November 2020 – 16 November 2020.

83. The Home stated upon the resident's discharge back to the Home, the discharge letter stated that the nursing staff discussed the resident's care with her husband. The Home explained due to her poor oral intake and lack of improvement, it was felt that a palliative care approach would be in the

resident's best interest. The Home said the resident's GP would complete a referral to the palliative care team if needed, and the GP also prescribed anticipatory medication at this time for the Home to administer to the resident when necessary.

84. The Home stated that upon review of the resident's notes from 11 November 2020 to 16 November 2020, the Home did not raise any new concerns. The Home said when the resident vomited on the evening of 16 November 2020 the Home contacted the resident's husband. The Home stated the out of hours GP advised the Home's staff to keep the resident comfortable and prescribed anti-sickness medication which staff administered to the resident at 01.30 hours on 17 November 2020.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

85. The IPA advised, *'the resident's medication was reviewed and monitored appropriately during this period'*.

11 November 2020 – 16 November 2020

86. The IPA advised that the Home correctly monitored the resident's vital signs and consulted with the GP. The IPA advised, *'the home identified change of condition* [on 17 November 2020] *but that they only partially responded to change appropriately'*.

Analysis and findings

87. The complainant said the Home did not monitor the resident's condition, and the effectiveness of medication and treatment given.

88. The complainant said the Home were reactive and not proactive when it came to her mother's deteriorating condition. The complainant said she had to get the attention of the nursing staff on 17 November when her mother was beginning to deteriorate.

27 October 2020 – 4 November 2020

89. The Home stated it contacted the resident's GP as it was concerned about the resident's difficultly to eat and drink. The GP requested the resident's bloods to be taken, and on 4 November 2020 her GP advised the Home the resident had an electrolyte imbalance and required IV fluids. The resident was admitted to hospital on 4 November 2020.

90. I attach records which demonstrate the Home monitored the resident in Appendix six to this report. These records contain progress notes relating to the resident's ability to take her medication, and communication between the resident's GP and the nursing staff about the resident's condition. The records document changes to the resident's condition during the period 27 October 2020 to 4 November 2020 - *'28/10 [the resident] took her medication slowly with encouragement, she will need referral for easy to swallow medication'* and *01/11 very sleepy and resistive to care, noticed dried skin on mouth and dark reddish discharge from mouth, cleaned with glycerine swabs as possible'*.

91. The IPA advised the Home appropriately reviewed and monitored the resident's medication during this period. The IPA also advised the Home monitored the resident *'for changes in her condition and responded appropriately'*.

92. I accept the IPA's advice that the Home appropriately responded to the resident's condition during this period. I am satisfied the Home monitored the resident's condition and effectiveness of medication in accordance with the RPS and PCN Guidelines.

11 November 2020 – 16 November 2020

93. The Home stated upon review of the resident's notes from 11 November to 16 November 2020, the Home's staff members raised no new concerns.

94. The IPA advised the Home maintained a set of medicines administered records and any exceptions to this which was appropriate.

95. I considered all of the evidence available to me, and I consider the Home appropriately monitored the resident during the period 11 November to 16

November 2020. I included how the Home monitored the resident's medication on 17 November under the heading below, *'Medication Management'*. I consider the Home appropriately maintained a set of medicines administration records. Overall I am satisfied that the Home appropriately monitored changes to the resident's condition and effectiveness of her medication during both periods and I do not uphold this element of the complaint.

Detail of Complaint

Medication Management.

96. The complainant said the Home did not follow the plan for the resident's medication management and did not administer it in accordance with her GP's prescription. The complainant said the Home did not provide the resident any medication in the nineteen hours prior to her death, which would have eased her pain and distress. The complainant also said the Home did not follow her mother's GP's instructions to use opioid analgesics[7] already prescribed to her to *'keep [the resident] comfortable'*.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- NI Palliative Guidance;
- RPS and PCN Guidance; and
- The NMC Code.

The Home's response to investigation enquiries

11 November 2020 – 17 November 2020.

97. The Home explained on the days prior to the resident's death, staff in their professional judgement did not feel that the resident was at end of life. Therefore anticipatory medication was not required. The Home stated its staff followed the correct procedure and contacted the out of hours GP on 16 November, when the vomiting commenced. The Home said, *'the medication prescribed was administered and effectiveness monitored'*.

[7] Medicines used to provide relief from moderate-to-severe acute or chronic pain.

98. The Home stated upon review of the progress notes, the Home did not give the resident any of her oral medication on the evening of 16 November 2020 due to her vomiting. Cyclizine[8] 50mg was given at 01.30 17 November, as per out of hours GP prescription. The Home stated the records document that the resident appeared comfortable and sleeping after receiving this medication, and anticipatory medication was not required at this time.

99. The Home stated, on 17 November 2020 the records document that she received her normal paracetamol medication, and there was no indication at this time that the resident required anything further. The Home explained the only record of pain and moaning was at 18.15 on 17 November 2020, when the nursing staff drew up Midazolam[9] but did not administer the medication.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

100. The IPA advised *'a complete medication administration record is available for this period, indicating that medication was given as prescribed. This was appropriate'*.

11 November 2020 – 17 November 2020

101. The IPA advised Midazolam was signed for on the medication chart as *'for general comfort – wasn't able to give due to vomiting and passed away'*. The IPA advised *'this was not an appropriate selection for end of life medication for relief of 'pain and moaning''*.

102. The IPA advised, *'I conclude that medication was not appropriately administered to the resident because there was not structured pain assessment, there is a transcription error on the medication chart and there is no prescription record for administration of paracetamol on 17 November'*.

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[8] Cyclizine is a medication that treats sickness caused by balance or movement problems such as vertigo, travel sickness, and problems affecting the inner ear.

[9] Midazolam is a benzodiazepine medication used for anesthesia, procedural sedation, trouble sleeping and severe agitation.

103. In relation to the administration of Midazolam the IPA advised, *'Northern Ireland Palliative Hub (Regional Palliative Medicine Group NI) care guidance states that Midazolam is given for agitation at end of life, not pain. The resident did not receive the injection because she passed away before it could be administered'*.

104. The IPA advised, *'there is no rational given for why Haloperidol*[10]*, which was already written up for nausea, was not considered first line, as it could have been administered earlier when nausea and vomiting were first identified'*.

105. The IPA advised *'paracetamol had been discontinued on 16 November, but according to the Progress record it was administered on 17 November. I could not find a record of its administration'*. The IPA advised this is not correct practice.

106. The IPA advised that the key failings were: *'inadequate assessment of pain; incorrect transcribing of indications for administration of Midazolam; inadequate record keeping relating to administration of paracetamol on 17 November; absence of rationale for omission of other anticipatory medications, including the correct use of Midazolam which would have been for agitation (a known symptom of [the resident]'s); absence of rationale for obtaining cyclizine prescription rather than administering haloperidol'*.

107. The IPA advised that the likely impact of these identified failings would be that the resident's nausea and vomiting might have been relieved sooner if the staff had considered administering Haloperidol on symptom onset. The IPA further advised if the Home used a structured pain assessment, the Home may have considered more appropriate analgesia for managing the resident's pain, and a more appropriate management of agitation might have been achieved.

Analysis and Findings

108. The complainant said the Home did not *'follow or evaluate'* the resident's medication plan as expected. The complainant said the Home did not provide the resident with any medication in the 19 hours prior to her death, which would

[10] A synthetic antidepressant drug used chiefly in the treatment of psychotic conditions.

have eased her pain and distress. The complainant also believed that the Home did not follow instructions from the resident's GP to use opioid analgesics already prescribed.

27 October 2020 – 4 November 2020

109. The Home's records document the medication prescribed and administered to the resident during this period. Full details on these medications are attached in Appendix six to this report. The Home administered 500mg of paracetamol to the resident four times a day.

110. The IPA advised the Home appropriately administered medication to the resident as prescribed. The IPA also advised the Home provided the resident with regular paracetamol for her pain.

111. After consideration of all evidence available to me, I accept the IPA's advice that the Home appropriately managed the resident's medication during this period. For this reason I do not uphold this element of the complaint.

11 November 2020 – 17 November 2020

112. The resident's GP prescribed her with Midazolam, Morphine, Haloperidol for nausea and agitation, and Paracetamol 500mg one tablet, four times a day upon her return from the Home following her hospital discharge. The out of hours GP added the prescription of Cyclizine on 17 November. I will consider the Home's management of the medication below.

Midazolam

113. The NI Palliative Guidance states that Midazolam is recommended for agitation at end of life.

114. The Home stated, staff in their professional judgement did not feel that the resident was at end of life and therefore anticipatory medication was not required.

115. The records document a complete record of medication the GP had prescribed, and medication the nursing staff administered to the resident. The prescription

sheet[11] documents on 11 November, Midazolam 'for pain', whereas the Progress note[12] on 11 November documents Midazolam for 'nausea/agitation'.

116. I note that Midazolam was recorded within the Home's records *'for pain'*, however I accept the advice of the IPA who advised that Midazolam is for agitation at end of life and not for pain. I also accept the IPA's advice that the Home incorrectly transcribed Midazolam *'for pain'*. I consider the Home failed to keep accurate records about the use of Midazolam. Therefore, there was a potential for the resident to receive Midazolam for the wrong reasons. I refer to the NMC Code which requires nursing staff to *'keep clear and accurate records'*. In my view, records should accurately record details in order to ensure clarity for those staff who will later rely on the information recorded in these records. I am satisfied that these actions in relation to record keeping fall below the required standard and constitute a failure in care and treatment. The IPA advised that *'anticipatory medications including morphine were available but not selected'*. I accept the IPA's advice, *'a more appropriate management of agitation might have been achieved if this too had been assessed in context of Abbey Pain Scale and midazolam considered as a possible treatment for this at end of life rather than as a treatment solely for pain'*.

Cyclizine

117. The Home stated it did not give the resident any of her oral medication on the evening of 16 November 2020 due to her vomiting, and administered her Cyclizine at 01.30 following the advice of the out of hours GP. Following the resident's receipt of Cyclizine, the Home stated the records document within the resident's nursing records that she appeared sleeping and comfortable, and anticipatory medication was not required at this time.

118. The IPA advised there was an *'absence of rationale for obtaining cyclizine prescription rather than the administering haloperidol'*. The IPA advised *'the*

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[11] Prescription sheet records details on medication administered to a patient/resident, and include details such as time and date administered, dosage, and reasons for administration.
[12] Progress notes are the part of a medical record where healthcare professionals record details to document a patient's/resident's clinical status over the course of their care.

likely impact is that nausea and vomiting might have been relieved sooner if haloperidol had been considered on symptom onset'.

119. The Nursing Home Standards require a nursing home to complete accurate records that includes the decision rationale for omitting dosages. I also refer to the NMC Code which requires nursing staff to *'complete full and accurate records relevant to your practice'*.

120. I am critical that the Home staff did not follow guidance and national standards and record the reasons for using Cyclizine rather than Haloperidol. I consider this a failure in care and treatment. I accept the IPA's advice that the resident's *'nausea and vomiting might have been relieved sooner if the nursing staff considered administering Haloperidol on symptom onset'*.

Paracetamol

121. The Home's record documents the resident was prescribed and administered paracetamol for pain relief up until 16 November 2020, at which point the medication chart indicates that it was discontinued. I note the Progress note documents that the resident was administered paracetamol on 17 November.

122. The IPA advised *'medication was not appropriately administered to the resident because there was not structured pain assessment […] there is no prescription record for administration of paracetamol on 17 November'*. The IPA advised *'paracetamol is an effective pain killer and would be an appropriate choice for mild to moderate pain. There is no record of structured pain assessment therefore it cannot be confirmed whether it was the most appropriate choice of analgesia at this stage'*.

123. I refer again to the NMC code and I consider the inadequate records relating to the administration of which requires nursing staff to complete all records at the time or as soon as possible after an event, and to complete all records accurately. I consider the Home's inadequate record keeping a service failure.

124. I accept the IPA's advice, *'a more appropriate analgesia eg morphine might have been considered if pain was correctly identified'*.

Overall

125. In considering this element of the complaint, I identified failings in the Home's management of the resident's medication. I previously found failings within this report in the Home's use of a structured pain assessment tool. I consider that in the absence of a structured pain assessment, unfortunately I am unable to conclude whether the resident was in pain, and whether the Home administered the correct pain relieving medication. I uphold this element of the complaint.

126. I consider the Home's failings caused the resident the injustice of a loss of opportunity to have her symptoms relieved sooner, and to receive appropriate medication. I consider the Home's failure to record the correct reasoning for the use of the medication Midazolam caused the family to suffer the injustice of uncertainty and upset. This is because the family will always be concerned that the resident did not receive the correct medication in her final hours. I acknowledge this must be very distressing for the family.

Detail of Complaint

Monitoring of the resident on 17 November 2020.

127. The complainant said the Home did not monitor the resident on the day of her death (17 November 2020) between 11.30 and 15.30. The complainant said the Home staff *'stayed away'* from the resident after 15.30 to give the family *'precious time together'*.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- Nursing Home Standards.

The Home's response to investigation enquiries

128. The Home said the resident had bedrails on her bed, and *'there is evidence to state that these were checked at 12:02, 13:08, 14:10 and 15:12 hrs on the 17th November 2020. There is also evidence to state that mouth care was given at*

11am and 15:00hrs. The repositioning charts evidence that repositioning took place 12:02, 14:10 & 16:38hrs.' The Home also stated, *'it was acknowledged that staff did observe from a distance to give family that valuable time on the 17th November 2020. Assurance was given that if further treatment had been required during that time staff would have attended'*.

Relevant Independent Professional Advice

129. The IPA advised that there are no specific records of monitoring of the resident between the hours of 11.30 and 15.30, and advised *'the implication is that there was no specific monitoring or it was not recorded'*.

Analysis and Findings

130. The Nursing Home Standards states, *'re-assessment is an ongoing process that is carried out daily and identified, agreed time intervals as recorded in care plans'*.

131. In relation to monitoring the resident on 17 November, the Home stated on the morning of 17 November, the resident was slightly resistive to medication, and at 15.30 when the resident had laboured and shallow breathing, it commenced oxygen therapy and informed the family. The Home stated there was no evidence that the resident was experiencing any pain until 18.15 when it was recorded the resident was in pain and moaning.

132. The records document that the resident appeared frail and resistive during interventions at 10.00 on 17 November 2020. The records document the resident had laboured and shallow breathing and the Home provided oxygen support. The records document the Home contacted the GP out of hours, who advised to keep the resident comfortable, and the resident's family were informed. However these entries are not time specific. The records document the Home staff checked the resident's bedrails at 12.02, 13.08, 14.10 and 15.12 on 17 November 2020. The Home's repositioning charts document that repositioning of the resident took place at 12.02, 14.10 and 16.38 on 17 November 2020.

133. At 18.15 the records document the resident was in *'pain and moaning'*, and the nursing staff were about to administer Midazolam as prescribed when the resident slowly deteriorated and was unresponsive.

134. The IPA advised, *'the only specifically recorded monitoring was at 15.30, the remaining notes being non-specific as to timing. The implication is that there was no monitoring or it was not recorded between 11.30 and 15.30'*.

135. I accept the IPA's advice, *'the implication is that there was no specific monitoring or it was not recorded between 11.30 and 15.30'*. Although the records document that the nursing staff checked the resident's bedrails and repositioned the resident during the period 11.30 to 15.30, I do not consider the Home staff specifically monitored the resident's condition during this period. In the absence of records directly relating to monitoring of the resident's condition, I conclude that the Home did not appropriately monitor the resident on 17 November 2020. I consider this a failure in care and treatment, and for this reason I uphold this element of the complaint.

136. I consider the failings identified caused the resident the injustice of loss opportunity to receive additional care and treatment that she may have needed. I accept the advice of the IPA, *'if significant pain was not identified, the appropriate pain relief might not have been given'*. I consider this caused the family the injustice of uncertainty and upset as they watched and cared for their mother in her final hours.

Detail of Complaint

Exclusion of family.

137. The complainant said the Home excluded the family from tending to the resident in her final days.

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- FSHC Visitor Guidance; and
- NICE Guidance;

- PHA Guidance.

The Home's response to investigation enquiries

138. The Home explained there was a Covid 19 outbreak within the Home which prevented any visiting except in exceptional circumstances. The Home stated, *'until the 17th November 2020 [the resident] was not perceived to be at end of life however whenever her condition deteriorated an exceptional visit was permitted'*.

Relevant Independent Professional Advice

11 November 2020 – 17 November 2020

139. The IPA advised, when there is a Covid 19 outbreak within a care home, visitation by family members is not allowed. The IPA advised that the guidance Four Seasons issued allowed for room visiting in 'exceptional circumstances' but could not find a specific listing of a definition of 'exceptional circumstances'. The IPA advised that in most care settings, visiting at end of life was considered to be 'exceptional circumstances' but would be locally determined, and subject to appropriate risk assessment. The IPA also advised *'it would not usually be appropriate to exclude a family member from tending to the resident during that period, for humanitarian reasons, but I am not able to comment further on this as I do not have access to the regulations that were in place at that time'*.

Analysis and Findings

11 November 2020 – 17 November 2020

140. The complainant said the Home excluded the complainant and her family from tending to the resident during her final days.

141. The NICE Guidance states, *'it can often be difficult to be certain that a person is dying. The recommendations supplement the individual clinical judgement that is needed to make decisions about the level of certainty of prognosis and how to manage any uncertainty'*.

142. The FSHC Visitor Guidance state that during the Covid 19 pandemic visits are to be controlled and internal visits are limited. The guidance permits one visit from a family member once a week for 30 minutes. This guidance states, *‘resident room visiting should only happen in exceptional circumstances and under strict infection control measures’*. I note the PHA Guidance states, *‘in the event of an outbreak in a care home, the home should limit indoor visiting to essential visits including End of Life visiting’*.

143. The Home explained that during the period the resident stayed in the Home, the Home was experiencing a Covid 19 outbreak, which prevented any visiting except in exceptional circumstances. The Home stated that up until 17 November 2020, the Home did not perceive the resident to be at end of life, and therefore the Home could not permit the family to visit the resident.

144. However I note the records document on 11 November, *‘[the resident] is on end of life care since she was discharged from hospital today’*. The records document on 17 November 2020 the complainant was outside of the resident’s suite and *‘she was reassured but refused entry for infection control reasons, since her mother did not appear to be dying’*. The progress notes document that the nursing staff informed the family of the resident’s rapid deterioration, and they were able to be present at the resident’s side at the time of her death. The Home have not provided this Office of a record of what time on 17 November the family were permitted to enter the resident’s suite to be with the resident.

145. The IPA advised that Home correctly recognised that the complainant had entered an *‘end of life’* stage upon her return from hospital on 11 November, and subsequently correctly identified that her death was imminent on 17 November.

146. I note the IPA advised, the FSHC Visitor Guidance does not specifically list a definition on what circumstance is ‘exceptional’, but advised, *‘during the Covid pandemic, in most care settings, visiting at end of life was considered to be ‘exceptional circumstances’ but would be locally determined and subject to appropriate risk assessment’*.

147. The IPA advised, *'it would not usually be appropriate to exclude a family member from tending to the resident during that period, for humanitarian reasons, but I am not able to comment further on this as I do not have access to the regulations that were in place at that time'*. The PHA Guidance states during a Covid 19 outbreak in a care home, visiting by relatives was not permitted, unless it was *'exceptional circumstances'*.

148. I note the Home advised this Office that it excluded the family from tending to her during her final days, as she was not perceived as *'end of life'*, and therefore a visit was not permitted under the Covid 19 guidelines. However, from the records, I note the Home recognised the resident was at end of life upon her return from hospital on 11 November. Therefore, I consider the Home should have permitted the resident's family to visit the resident in accordance with the PHA Guidance. I consider *'end of life'* is exceptional circumstances, and under both the PHA Guidance and the FSHC Guidance the family were permitted to visit the resident. I do not consider it was appropriate for the Home to exclude the family from tending to the resident during her final days, and I uphold the element of the complaint.

149. I consider the failing identified caused the resident the injustice of a loss of opportunity to have her family surround her during her last days of life. It also meant the family were not of able to spend quality time with the resident in her last days. The impact of this failure deeply saddens me.

Detail of Complaint

Staff resources and qualifications.

150. The complainant said the Home did not answer her following query: *'were staff qualified or resourced enough to know what to do with a highly dependent patient?'*

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- RCN Guidance; and
- RQIA Provider Guidance.

The Home's response to investigation enquiries

151. The Home stated that during the resident's time in the Home, *'there were no major staffing issues identified'*. The Home said it *'would have no concerns that staff would not have been able to nurse a resident with [the resident]'s dependency needs'*.

Relevant Independent Professional Advice

27 October 2020 – 4 November 2020

152. The IPA advised, *'nursing homes are required to have a minimum of 1 [Registered Nurse] on duty per shift and this was met on all these dates'*. The IPA advised the Home's shift roster provides continuous cover by three care assistants, with an additional care assistant on duty between 09.30 to 14.00. The IPA advised, the Home's roster provides a registered nurse, patient ratio of 1:14, and a total staff: patient ratio of 1:3.5 rising to 1:2.8 between 09.30 to 14.00.

153. The IPA advised, *'there are no specific recommended staffing levels for care homes in Northern Ireland at the time of this case'*. The IPA referenced the RCN Guidance, which gives the ratio of Registered Nurses to patients as 1:18.3 and patient to all nursing staff as 1:4.2. The IPA advised, *'this does not mean that this is an ideal staffing ratio, but it represents the staff in a typical home, therefore I have benchmarked against this. When reviewing the staffing data provided by [the Home] in comparison to the RCN care homes survey, the [Home] planned staffing levels are reasonable.'*

11 November 2020 – 17 November 2020

154. The IPA advised that the planned staffing levels during this period was reasonable. The actual staffing ratio contained a reduction of staff but remained reasonably close to those the RCN Guidance quoted. The IPA advised, *'I conclude that the declared staffing levels were reasonable'*.

Analysis and Findings

27 October 2020 – 4 November 2020

155. The Home's records document a Registered Nurse: resident ratio of 1:14, and a total staff: resident ratio of 1:3.5 rising to 1:2.8 between the hours 9.30 – 14.00. The staff roster provides continuous cover by three care assistance within the Home, with an additional care assistant on duty between the hours of 09.30-14.00. On 27 and 31 October the care assistant cover was unfilled during the hours of 8.00 – 14.00. This reduced the nurse: resident ratio to 1:4.7 between the hours 08.00 – 09.30, and to 1:3.5 between the hours 09.30 – 14.30.On 3 November the care assistant cover was unfilled during the hours 18.00 – 20.00, reducing the nurse: resident ratio to 1:4.7. The IPA advised the Home's staffing levels were reasonable during this period.

156. I considered all of the evidence available to me, and I accept the advice of the IPA that the Home's staffing levels during this period were reasonable. Despite vacancy of a care assistant on 27, 31 October and 3 November, I consider the Home's staffing levels remained reasonably close to those the RCN quoted. I do not uphold this element of the complaint.

11 November 2020 – 17 November 2020

157. The Home provided staffing levels for the period 13 November to 17 November which was staff: resident ratio 1:4.3. The Home provided information on a reduction of staff as only fourteen residents were occupant within the Home during this period. The IPA advised the Home's staffing levels were reasonable during this period.

158. The RQIA conducted an inspection on 12 November 2020, and examined the staffing levels of the Home. The inspection concluded that the Home's staffing levels were satisfactory, and the levels and skill mix of the staff on duty met the Home's residents' needs.

159. After consideration of all of the evidence available to me I accept the IPA's advice that the Home's staffing levels during this period were reasonable and I do not uphold this element of the complaint.

Detail of Complaint

Record of circumstance of death

160. The complainant said the Home did not answer her query: *'Why was [the resident's] death described as peaceful when the complainant observed [the resident] in distress before she died?'*

Evidence Considered

Legislation/Policies/Guidance

I considered the following policies/guidance:

- HSC Complaint Guidance;
- The NMC Code.

The Home's response to investigation enquiries

161. The Home stated, *'staff have advised that [the resident] had been comfortable up until the last 3 hours before her passing'*. The Home said it *'can advise that when someone is nearing the end of their life there are regular signs such as restlessness and change in breathing'*, but it hopes to reassure the complainant that *'the nurses responded appropriately'* to the resident's rapid changing condition.

Relevant Independent Professional Advice

162. The IPA advised *'from the Progress Notes, 17/11, [the resident] was noted to be in 'pain and moaning' at 18:15 i.e. shortly before she vomited, deteriorated and passed away 10 minutes later. This was not a peaceful death.'*

163. The IPA advised that the staff only partially responded appropriately to the resident's rapidly changing condition. The IPA advised *'the steps taken did not provide a comfortable death as [the resident] exhibited symptoms of 'in pain and moaning' and 'vomiting coffee ground''*.

Analysis and Findings

164. The complainant said she was concerned the Home described the resident's death as peaceful despite her witnessing the resident dying in distress. The complainant said she witnessed her mother in pain and moaning from 17.00 on 17 November 2020, and struggled to get a nurse to attend with her mother until 18.15.

165. The complainant said the Home did not address this query, when raised as part of the complaints process.

166. I wish to remind the Home of the importance of addressing all issues of the complaint as set out in HSC Complaint guidance.

167. The records document the resident as having a peaceful death. The records also document that the nursing staff monitored the resident's vital signs, provided oxygen, updated her next of kin, and received advice from the resident's GP at 15.30 to *'keep [the resident] comfortable*'.

168. The records document that on 17 November 2020 at 18.15, the resident was '*in pain and moaning'*. The records also document the resident *'vomiting coffee ground'*, deteriorated and passed away at 18.25.

169. The IPA defined a peaceful death as *'being absent of symptoms of pain, agitation, nausea and vomiting'*.

170. The IPA advised the resident was not comfortable on 17 November 2020. The IPA advised, *'the staff only partially responded appropriate to her rapidly changing condition. They monitored her vital signs, providing oxygen, updated her next of kin and updated the GP'*. The IPA advised the nursing staff failed to make an adequate assessment of the resident's pain (as already identified under the heading *Medication Management above*).

171. The IPA advised, due to the failures identified under *Medication Management*, the nursing staff did not respond appropriately to the resident's changing condition on 17 November 2020, and the resident did not have a peaceful death. The IPA advised *'the steps taken did not provide a comfortable death as*

[the resident] exhibited symptoms of 'in pain and moaning' and 'vomiting coffee ground''.

172. I accept the IPA's advice *'this was not a peaceful death'* and therefore I consider the records are not accurate. I refer again to The NMC Code requires nurses to *'keep clear and accurate records'*. I am critical that Home staff did not meet national guidance and standards. I consider this a service failure I uphold this element of the complaint.

173. I consider this failure caused the family to suffer the injustice of distress. This is because the family witnessed the resident's passing, and the records did not accurately reflect what happened on 17 November 2020.

CONCLUSION

174. I received a complaint about the actions of the Home. The complainant raised a number of concerns about the care and treatment the Home staff provided to her mother, the resident.

175. The investigation of the complaint found that the Home appropriately monitored the resident's condition and medication during the periods 27 October to 4 November 2020, and 11 November to 16 November 2020. The investigation established the Home appropriately administered and managed the resident's medication during the period 27 October to 4 November 2020. The investigation the Home maintained the appropriate staffing levels, with the appropriate qualifications during the periods the resident stayed with the Home.

176. The investigation established the following failures:

i) The Home failed to appropriately interpret the resident's behaviour and delayed seeking medical advice. The Home failed to interpret the resident's behaviour as signs she was in distress and pain;

ii) The Home failed to assess the resident using a structured pain assessment, as it failed to use a pain assessment following intervention and movement. The Home failed to assess the resident using a structured pain assessment tool upon her return to the Home following hospital

discharge. The investigation established the Home failed to use a structured pain assessment tool at the appropriate times;

iii) The Home appropriately created and followed care plans, however upon creating care plans for the resident the Home failed to consult with the resident's family;

iv) The Home failed to administer and manage the resident's medication during the period 11 November to 17 November 2020;

v) The Home failed to maintain appropriate and proper records about the administration and rational to exclude medications;

vi) The Home failed to appropriately monitor the resident on 17 November 2020;

vii) The Home failed to permit the resident's family from tending to the resident during her final days; and

viii) The Home failed to appropriately record the circumstances of the resident's death.

177. The failures identified in this report are of concern to me, and I would expect the Home and its staff to learn from the failures identified in this report. I note the complainant's description of the impact of the Home's care and treatment to her mother.

178. As part of the investigation the Home informed my office that it has taken remedial action to prevent some of the failings identified from this report. I am concerned that the Home felt it was necessary to take remedial action given how fundamental it is to work in partnership with the family in order to create care plans, discuss the resident's *'normal presentation'* and behaviour. I would also have expected a Home caring for elderly relatives to know the importance of using a structured pain assessment tool such as the Abbey Pain Scale, which is fundamental for the care and treatment provided to its residents.

179. Following the receipt of the draft Investigation Report the Home stated it seeks to provide the assurance that as an organisation it improves their resident and family experience by taking cognisance of the lessons learned within the draft Investigation Report.

180. The complainant said it was not only her mother that suffered as a result of the failures identified, but these failures had an effect on herself and her family. Her family had to watch her mother endure a death that was not peaceful in any way and was not permitted to be with her mother until the very end. The complainant said this is very difficult to come to terms with and understand.

181. I consider that the experience of watching the resident's health deteriorate during her time in the Home, and the impact that Covid 19 had on visitation, must have been extremely distressing for the complainant and her family. I offer my condolences on their sad loss of a much loved mother.

Recommendations

182. I recommend that the Home provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified (within **one month** of the date of this report).

183. I further recommend for service improvement and to prevent future recurrence that:

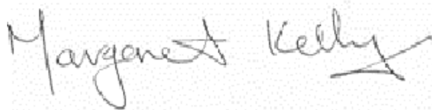
i) The Home brings the failures identified in this report to the attention of staff, highlighting the importance of the following: communication with the resident's family when formulating care plans, communication with the family to discuss a resident's normal presentation, use of a structured pain assessment such as the Abbey Pain Scale, recording the correct use for medication, and decision rationale for excluding dosages, regular monitoring of a resident at the appropriate times, and recording the accurate circumstances of a resident's death; Home staff involved in this case should evidence a reasonable level of reflection of findings in the complaint including discussion of the matter in their next appraisal

ii) The Home provides training to staff on the use of the Abbey Pain Scale:

iii) The Home provides staff with training on the correct use of the medication Midazolam; and

iv) The Home undertakes an audit using a random sampling of nursing records over the last six months. The audit should assess if the records contain the following: completed assessments with a resident's family to determine a resident's *'normal presentation'* and behaviours, completed pain assessments used at the appropriate times, regular monitoring of a resident at the appropriate times, and circumstances of a resident's death. Take action to address any identified trends or shortcomings. The Home should report its findings to this Office, and ought to include any recommendations identified in its update to this Office.

184. I recommend that the Home implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).



Margaret Kelly
Ombudsman **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.