



Northern Ireland

Public Services

Ombudsman

Investigation of a complaint against Ann's Care Homes

Report Reference: 202004332

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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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Case Reference: 202004332

Listed Authority: Ann's Care Homes

SUMMARY

I received a complaint about the care and treatment Ann's Care Homes provided to the complainant's mother (the Resident) between 8 September 2021 and 28 September 2021. Sadly, the Resident passed away in the Home on 28 September 2021.

The complainant was concerned about how Ann's Care Homes prepared for her mother's transfer from one Home (Home A) and admission to another Home (Home B which is owned by Ann's care Homes). The complainant's mother suffered a choking episode whilst in Home B. She raised concerns about how Home B cared for the Resident in the days after that episode.

The complainant was also concerned about how Ann's Care Home dealt with her complaint regarding clinical observations carried out after the choking episode.

I upheld elements of the complaint. The investigation established a failure in both Home B's preparation for the Resident's admission. However, the investigation found that the care Home B provided to the Resident after the choking episode was adequate, appropriate and in accordance with appropriate standards.

The investigation identified a failure in the Ann's Care Home's handling of the complaint.

I recommended that Ann's Care Homes provide the complainant and her family with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (July 2019) for the injustice caused as result of the failures identified. I also recommended that for service improvement and to prevent future recurrence Ann's Care Homes discuss the contents of this report with relevant staff so they can reflect on the findings identified and to remind relevant staff of the importance of establishing the pre-admission needs of residents.

THE COMPLAINT

1. This complaint is about the care and treatment Ann's Care Homes provided to the complainant's mother (the Resident) from 8 September 2021 to 28 September 2021. The complainant also raised concerns about how Ann's Care Homes handled her complaint. The Resident sadly passed away on 28 September 2021.

Background

2. The Resident was suffering from dementia. Due to a deterioration in her health, the Resident was moved from her residence in Home A to Home B, which was owned by Ann's Care Homes Group. .
3. On 4 September 2021 the two care homes carried out a pre-admission assessment by telephone call. The pre-admission assessment recorded the Resident's mobility as quite mobile with supervision.
4. Home A transferred the Resident to Home B on 8 September 2021. Upon her admission it was evident that the pre – admission assessment did not describe her mobility accurately and that Home B was ill prepared for her arrival.
5. At lunch time on 24 September 2021 the Resident experienced a choking episode with orange juice, she cleared her airway independently with encouragement from nursing staff. First aid was not employed. Nursing Staff took clinical observations¹ and recorded blood pressure 146/56, temperature 36.1%, pulse 61 and oxygen saturations 96%.
6. On 27 September the Resident became unwell. Nursing staff made clinical observations which showed a deterioration in her health. Nursing staff administered oxygen. Home B contacted a GP who examined her and called the Acute Care at Home Team (ACHT)² from the Trust's Hospital.

¹ Clinical observations systematically record vital signs such as temperature, pulse, blood pressure , respiratory rate, and oxygen saturation levels. They are critical in detecting early signs of patient deterioration.

² Acute Care at Home Team - Acute Care at Home Team - A Care of the Elderly service aimed at providing hospital level care in the place of residence of patients aged 65 years and over, to prevent admission to hospital.

7. The ACHT carried out clinical tests and diagnosed aspiration pneumonia. It prescribed antibiotics and fluids via an intravenous drip³.
8. Early on 28 September 2021 a healthcare assistant in Home B became aware that the Resident had difficulty breathing and was cold and clammy. The healthcare assistant informed the Nurse on duty. The Nurse made clinical observations and called the Out of Hours Doctor. The Home contacted the Next of Kin who arrived within 15 minutes. The Resident sadly passed away shortly afterwards.
9. The complainant subsequently made a complaint to Ann's Care Homes. As part of the complaint, she asked were regular clinical observations carried out on her mother after the choking episode and before her death on 28 September 2021.

Issues of complaint

10. I accepted the following issues of complaint for investigation:-

Issue 1: Whether the care provided by the Home to the Resident from 8 September 2021 to 28 September 2021 was adequate, appropriate and in accordance with appropriate standards. In particular this will consider:-

- i) The Resident's admission to the Home**
- ii) Care and treatment provided after the Resident's choking incident.**

Issue 2: Whether the Home's complaint handling response was adequate.

INVESTIGATION METHODOLOGY

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

³ Intravenous Drip – a means for medicine/fluids to be administered via a vein

Independent Professional Advice Sought

12. After further consideration of the issues, I obtained independent professional advice from the following Independent Professional Advisor (IPA):

- A Registered⁴ Nurse with 30 years' experience of nursing older people in hospital, community, and care homes. Consultant Nurse for Older People at NHS Trust for 21 years. Clinical Lecturer.

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

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

Relevant Standards and Guidance

14. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles⁵

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

15. 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:

⁴ Registered Nurse - Nursing is a safety critical profession founded on four pillars: clinical practice, education, research, and leadership. Registered nurses use evidence-based knowledge, professional and clinical judgement to assess, plan, implement and evaluate high-quality person-centred nursing care.

- Department for Health and Social Services ‘Care Standards for Nursing Homes’ 2015 (the Nursing Home Standards);
- Nursing and Midwifery Council : The Code updated October 2018 (the Code) ;
- Nursing and Midwifery Council. Future Nurse: Standards of Proficiency for Registered Nurses May 2019 (Standards of Proficiency)(Future Nurse);
- The Regulation & Quality Improvement Authority Care Standards For Nursing Homes 2015 (RQIA standards);and
- National Institute for Health and Care Excellence: Acutely ill adults in hospital: recognising and responding to deterioration; Clinical Guidance (CG50) July 2007 (the NICE Guidance)

16. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings. I enclose relevant sections of the guidance considered at Appendix three of this report.

17. A draft copy of this report was shared with the complainant and Ann’s Care Homes for comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered all of the comments I received.

THE INVESTIGATION

18. **Issue 1:** Whether the care provided by the Home to the Resident from 8 September 2021 and 28 September 2021 was adequate, appropriate and in accordance with appropriate standards. In particular this will consider :-

- The Resident’s admission to the Home
- Care and treatment after the Resident’s choking incident.

Detail of the complaint

19. Home A transferred the Resident to Home B because of a steep decline in her

advanced dementia. The complainant and her aunt were present with her when the Resident arrived at Home B. The complainant said Home B failed to communicate the Resident's mobility needs to its staff. She also believed the Resident did not receive appropriate care upon her admission to Home B.

20. The complainant said Home B did not ensure the Resident received regular clinical observations from the time of the choking incident on 24 September 2021 until she became 'visibly' unwell on the evening of 27 September 2021. The complainant also said Home B did not contact a GP after the choking incident. She believed a GP examination and preventative antibiotics may have prevented the Resident's death from aspiration pneumonia caused by fluid from the choking incident.
21. The complainant also believed that, in regard to the high risk of aspiration in elderly residents with advanced dementia, Home B did not follow guidance regarding the action it should take after a choking incident. She also raised a concern that the Home failed to consider guidance on the importance of clinical observations to identify deterioration in patients after a choking incident.

Evidence Considered

22. I considered the following Guidelines and clinical practice :
 - RQIA Guidance
 - The Nursing Home Standards;
 - The Code; and
 - Future Nurse.

Ann's Care Home Response to Investigation Enquiries

The Transfer of the Resident from Home A to Home B

23. Ann's Care Homes stated: Prior to any admission, a suitably qualified professional completes a pre-admission assessment. The assessment helps the home gain a baseline knowledge of a resident's current and past mental and physical health to assist in deciding if a residency can be supported. The Nursing home gathers information from medical records and Trust correspondence however, most of the information provided is by the outgoing

residential home.

24. As a minimum information provided as part of the pre-admission assessment includes current diagnosis and medication, assistance required for mobility/personal care, equipment, risks associated with care, medical history, spiritual needs, likes and dislikes, nutritional status, skin integrity, communication and current behaviours. The outgoing residential home usually completes face to face pre-admission assessments. However, during covid restrictions the assessments had to be completed via telephone or zoom to reduce the potential transmission of infection between facilities. In the complainant's case a Staff Nurse from Home B completed the pre - admission assessment with a Senior Care Assistant who provided information on behalf of Home A on 4 September 2021. The information Home A provided indicated:
- No concerns re mobility, no assistance with transfer;
 - No equipment requirements;
 - Mobility was fine with supervision, use a wheelchair for longer distances;
 - No issues with eating (but there had been 5kg weight loss in recent months);
and
 - Needs encouragement with fluids.
25. Home B recognised there is also a Trust Northern Ireland Single Assessment Tool and Guidance (NISAT)⁶ GP/Medical Practitioner Report dated 6 September 2021 which documented that the patient had experienced a rapid change in function with reduced mobility, weight loss and cognitive decline. Home B acknowledged there was inconsistent communication on the pre-assessment with its staff. On admission the Nursing Home adds to the information to create person centred care plans.
26. Home B disputes the comments that levels of care were unacceptable, as the Home explained it has recorded communication from the family thanking the management and staff for the care provided to their family member. However

⁶The Northern Ireland Single Assessment Tool (NISAT) is designed to capture information required for holistic, person-centred assessment of the older person.

Home B agreed there were some areas of learning, but there were also areas of good practice evident.

Care and treatment after the Resident's choking incident.

27. A care plan evaluation dated 24 September 2022 documented that the Resident choked on thin fluids. Ann's Care Homes stated that staff noted *'The fluids appeared to catch on her throat; however, she was able to clear her airway independently with encouragement. 'SLT'⁷ referral made. The Resident did not require urgent first aid, back slaps or abdominal thrusts. The Care Team recorded blood pressure 146/56, temperature 36.1% pulse 61 and oxygen saturations 96%. Home B noted the Resident 'was monitored with no change in condition and tolerating diet and fluids with no difficulty between the 24 and 26 September 2021.'*
28. Ann's Care Homes stated there is a difference between a choking episode and possible aspiration as follows:-
- a choking episode is characterised by someone who is unable to cough, where they present with actions such as clutching the throat, wheezing, and potentially going blue in the lips due to a blockage. A choking episode normally requires 3rd party intervention to facilitate to unblock i.e. back slaps/abdominal thrusts.
 - an episode of aspiration⁸ is when food/ fluid enters the windpipe and can often result in a short coughing episode where the person can clear the airway themselves or no symptoms. In the Resident's case she aspirated which staff were quick to note. She coughed and the choking episode resolved quickly after this.
29. Following a period of potential aspiration, the normal process is to complete a set of observations. If these observations are within normal limits staff would not normally repeat them, however, staff would observe the Resident for 24-48

⁷ SLT – Speech and Language Therapist

⁸ Aspiration- Aspiration is when something you swallow "goes down the wrong way" and enters your airway (trachea or windpipe) or lungs.

hours for the development of a wheeze, cough, or breathlessness. If any of these are noted in this period of time, then observations would be redone, and the Resident would be referred to a GP or if deemed necessary emergency services.

30. There is no specific guidance on how often observations staff should complete following a choking episode. The NICE Adult Choking Algorithm 2021 advises two pathways Mild and Severe.

- Mild airway obstruction with effective cough – encourage cough and continue to check for deterioration to ineffective cough or until obstruction relieved.
- Severe pathway includes where intervention i.e. back slaps/abdominal thrusts are required to relieve an obstruction. This would have been the pathway staff followed in this instance.

31. Ann's Care Homes stated that when Home B staff noted a change in the Resident's condition they reacted accordingly. *'For example, on 26 September 2021 records show that the Resident had bright blood from her back passage. Home B contacted the Out of Hours GP who advised staff to continue to monitor her and if the Resident complained of pain or discomfort to contact her GP the following morning.'* The Out of Hours GP also advised that if the Resident became dizzy/ill then staff should ensure the Home sent her to hospital. Staff recorded the following observations at 23.10 on 26 September 2021 ; blood pressure 106/75; pulse 77; temperature 36.4; and oxygen saturations 88%.

32. At 07.00 on 27 September 2021 staff in Home B recorded oxygen saturation levels of 98% and pulse 77. Staff also recorded that the Resident had her blood pressure checked. On 27 September 2021 staff recorded *'at check completed later that morning at 11.20 that the Resident appeared breathless and pale. There was no sign of a cough, and her oxygen saturation level was*

recorded at 92%, respirations 28, pulse 82, temperature was 36.6 and blood pressure 112/84.’ A GP was contacted as a precautionary measure owing to the breathlessness and presentation. Family was noted to have arrived at 11.30. Shortly after 11.30 staff checked oxygen which had dropped to 88%. Staff administered two Litres of Oxygen’.

33. At 12.31 on the same day staff increased Oxygen to three litres and changed from nasal tubes to a face mask. At 13.15 a GP arrived, and notes indicate that he mentioned aspiration at this time. He discussed the option of hospital admission with the family. The family’s preference was that the ACHT treated the Resident in Home B. The ACHT attended the Resident at 17.10 and administered IV antibiotics.
34. Home B staff recorded clinical observations *‘at 19.27 as oxygen saturations 95%; respirations 26; and temperature 36.4. At 12.30 on 28 September 2021 clinical observations were blood pressure 138/105; pulse 121; temperature 35.7; and oxygen saturations were 70%. Staff increased oxygen to five litres/min. at 01.00 staff took clinical observations and recorded blood pressure 168/140; pulse 74 and oxygen saturation was 86%. Oxygen level was decreased to three litres/min and Out of Hours Dr contacted. Nurse advised to keep oxygen level at 3 litres/min. Appropriate action was taken in response to the Residents’ deterioration.’*
35. *‘While it is Ann’s Care Homes’ opinion that it took appropriate action in response to the initial incident – the appropriate terminology was not used to describe the incident, and this has potentially led to confusion. Ann’s Care Homes would like to apologise for this and highlight that in addition to previously cited actions our clinical trainer has completed a companywide supervision roll out in relation to the importance of correctly documenting Choking/aspiration.’*
36. Ann’s Care Homes stated there was no clinical intervention required in response to what staff considered to have been an aspiration incident and not a choking incident. There was no significant change in the Resident, her clinical

observations were within normal range and she was in good form with no coughing/wheezing. There did not appear to be a reason to contact the GP. Staff would always contact the GP if the Resident required 3rd party intervention such as back slaps/abdominal thrusts. Staff did not carry out either of these procedures on the Resident. Staff would also call a GP if there were any adverse effects observed as is evidenced in their response to the decline in the Resident's condition on 26 September 2021.

37. An RQIA Inspection report dated 3 March 2021 makes no reference to choking risks in the home/nor does it raise concern in this regard.
38. The IPA provided advice about the care and treatment Ann's Care Home provided to the resident. I enclose the IPA's full advice reports at Appendix two to this report.

Analysis and Findings

The Resident's admission to the Care Home

39. The IPA advised that the RQIA standards for nursing homes set out criteria for the development of assessments and care plans in nursing homes. Both standards state at:

Standard 2 – Individual Agreement

- Criteria 2 - 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. Any associated factors or risks are documented. A written record of the assessment and the decision as to whether or not the placement is appropriate is retained and made available on request to the Resident or their representative.

The Nursing Home Standards apply the same standard also at Standard 2 .

40. The IPA advised that Home A completed a pre-admission document on 4 September 2021. At section 10 'Mobility (level of assistance required indoors & Outdoors – please detail equipment for each) ' it recorded for indoors '*quite*

mobile; 'supervision; and for outdoors wheelchair for outdoors and longer distances.' The IPA advised that the two Care Homes carried out this pre admission assessment by telephone, and therefore Home B could not have verified the pre-admission assessment until the Resident arrived. The IPA advised this could have led to Home B being inadequately prepared for the Resident's needs on arrival including manual handling, equipment, and staff to assist the Resident.

41. The IPA advised that a progress sheet prepared on 8 September 2021 stated '*... arrived at [Home B] at 16.40...is requiring assistance of 2x staff for transfers as quite unsteady on feet*'. The IPA advised Home B prepared a mobility care plan on 12 September 2021 which documented the Resident requiring '*assistance from two staff members to meet her mobility needs at all times.*' She is '*able to bear weight with assistance but unable to walk independently*'. The IPA notes that the documentation on the mobility care plan '*represents a significant update on the pre-admission document*'. The IPA advised the GP report for the NISAT document dated 7 September 2021 specified the Resident had reduced mobility. The IPA noted the Home accepted there was a discrepancy between the level of mobility described in the pre-admission assessment and the Resident's actual level of mobility.
42. I reviewed the available records and care plans and I accept the IPA's advice that there was a discrepancy between the pre-admission assessment and the Resident's level of mobility on arrival at the Home. Clearly, this could have led to Home B being inadequately prepared for the Resident's needs upon arrival.
43. I note prior to admission to Home B a nurse it employed did not visit the prospective resident to carry out and record an assessment of nursing care needs. I note Ann's Care Homes' position regarding the impact of COVID-19 and that a telephone assessment was set up for the Resident's pre-admission assessment to ensure that COVID-19 did not spread from one home to another. I accept Ann's Care Homes had to make difficult decisions and take serious precautions to limit the spread of the virus. I am satisfied that it was reasonable and appropriate for Ann's Care Homes to have put precautions in

place to limit the spread of COVID-19.

44. However, I note there were two sources of information regarding the Resident's mobility needs recorded by Home A.; namely Page 12 of NISAT 3 September 2021 and Section 10 of the pre-admission assessment dated 4 September 2021. There is a discrepancy between the two documents regarding the level of mobility the patient experienced. It is clear from the NISAT document that the Resident's mobility had been deteriorating from July 2021 and was not as described. As a result, Home B may have received incorrect information about the Resident, and it was inadequately prepared for her admission.
45. I have reviewed Ann's Care Home's stage 2 complaint response to the complainant. Ann's Care Homes acknowledged that there *had been a change in the Resident's needs between the initial pre admission assessment and her arrival at Home B.* Ann's Care Homes also acknowledge that *'a deterioration in the Resident's wellbeing may have been expected over this time as a deterioration can be marked, when a move to nursing care is indicated.* The IPA noted the Home accepted there was a discrepancy between the level of mobility described in the pre-admission assessment and the Resident's actual level of mobility. She identified this as a failing in the care and treatment provided to the Resident.
46. Ann's Care Home acknowledged that a marked deterioration in the Resident's wellbeing may have been expected. I agree with the IPA that the discrepancy between the level of mobility described in the pre-admission assessment and the Resident's actual level of mobility resulted in Home B being unprepared for her arrival. I note that Ann's Care Home consider such marked deterioration to be something that may be expected. In such circumstances Ann's Care Homes failed to provide adequate care and treatment for the Resident on her arrival at Home A. I agree with the IPA that this was a failure in the care and treatment provided by Ann's Care Homes to the Resident. This failure resulted in distress to both her and her family. I uphold this element of the complaint.
47. The IPA further advised that RQIA requires at criteria one of Standard 4 – Individualised Care and Support.

- Paragraph 4; An initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. A detailed plan of care for each resident is generated from a comprehensive, holistic assessment and drawn up with each resident. The assessment is commenced on the day of admission and completed within five days of admission to the home.

The Nursing Home Standards apply the same standard also found at Standard 4.

48. I note the IPA's advice that on transfer to a Home an initial plan of care should be in place within 24 hours and a detailed care plan assessment completed within five days. The IPA advised that Home B completed a progress sheet on 8 September 2021 and drew up care plans between 11 September 2021 – 12 September 2021. She also advised that the Home carried this out within the timescales required by the RQIA. I reviewed the care plans and documentation and I accept the IPA advice that Home B drew up the care plans in accordance with both the RQIA guidance and Nursing Home Standards. I find that this part of the Resident's admission to Home B was in accordance with the relevant guidelines. I do not uphold this element of the complaint.

The choking incident

49. The Code states that to practice effectively, nurses '*should assess need and deliver or advise treatment or give help without too much delay and to the best of their abilities.*' Paragraph 6.2 of the Code states nurses must '*maintain the knowledge and skills you need for safe and effective practice*'.
50. Future Nurse states that '*Nurses are also required to be competent in identifying deterioration/ acute change in patients. They should use evidence-based, best practice approaches to take a history, observe, recognise and accurately assess people of all ages and demonstrate the knowledge and ability to respond proactively and promptly to signs of deterioration or distress in mental, physical, cognitive and behavioural health and use this knowledge to make sound clinical decisions.*'

51. RQIA guidance requires that *'risk assessment, analysis and decision making around the need for any restrictive intervention is recorded in detail – including the options considered and the outcome of any intervention.'*
52. The IPA advised that, as after the choking incident the Resident was able to clear her airway independently, she did not require first aid. She also advised that staff assessed her vital signs, contacted the next of kin, reassessed the choking risk referred her to SALT⁹ and completed a diet notification form. The IPA advised that *'these actions were appropriate'*.
53. The IPA also advised she did not find any reference to Home B contacting the GP immediately after the choking incident, either from the Home B's progress records or from the available GP records. However, from the records of the choking episode, she advised *'there was no acute change, the Resident spontaneously recovered and as the nurse took appropriate nursing actions there was no indication for an urgent GP review.'* The IPA advised this is in line with the Code standards. She advised that the Registered Nurse responded to the *'choking incident appropriately and made a clinical decision on that basis'*.
54. Based on my review of the available evidence and the IPA's advice I am satisfied staff involved in the choking incident acted in accordance the relevant standards. Therefore, I find no failing in the care and treatment Home B provided to the Resident in this regard. I do not uphold this element of the complaint.

Issue 2: Whether the Home's complaint handling response was adequate.

Detail of Complaint

55. The complainant said she repeatedly asked Ann's Care Homes if it had undertaken clinical observations from the time of the Resident's choking incident until she became 'visibly unwell' on 26th September 2021. The complainant said she did not receive a direct answer to that question.

⁹ SALT-Speech and Language Therapist

Ann's Care Home Response to investigation enquiries

56. Both first and second stage response letters stated that there was no 'significant' change noted in the Resident's overall health directly following the choking incident. This is evident from the progress notes. If there had been any change, the Ann's Care Homes expects that staff make clinical observations. It expects each Nurse to make their own clinical judgement on this. Until the deterioration in the Resident's condition on 26 September 2021 there is no indication from the notes that staff should take such action. After staff observed the Resident's deterioration, they took appropriate action.
57. Ann's Care Homes reviewed the NICE guidelines and Regional Trust guidelines. There is no specific guidance on how often care home staff should complete clinical observations following a choking episode.

Analysis and Findings

58. I reviewed Ann's Care Homes' complaint files. I note between 1 March 2022 and 25 October 2022 the complainant repeatedly asked the Home if the Resident's *'clinical observations were made regularly over the course of the weekend, due to aspirational pneumonia, or were these only checked on the Monday due to mum's breathing difficulties?'*
59. The Principles of Good Complaint Handling *'Being Customer Focused'* requires a public body to treat complainants sensitively and in a way that takes account of their needs.
60. I reviewed Ann's Care Homes' responses. I note that in the stage one response dated 11 May 2022 and the stage two response dated 12 September 2022 it did not give the complainant the definitive answer she sought. On 13 December 2022 Ann's Care Homes responded to an email from the complainant *'in relation to the query regarding observations being carried out from the date of your Mother's choking incident on 24 September to the date of her decline on 26 September 2021, I would reiterate that there was no evidence from the care records that indicated the necessity for observations to be further completed. Therefore , I can confirm that, no, there were no observations completed , or*

indicated in the record’.

61. I reviewed all the available documentation the complainant sent to me on this issue. I am clear that the complainant requested a ‘yes or no’ answer to her query about clinical observations during the time period she was concerned about.
62. Having reviewed all the available evidence I consider that Ann’s Care Homes did not respond to the complainant’s query within its two stage complaint responses. It was some three months after Ann’s Care Homes signposted the complainant to my office that it finally gave a clear response to her query which failed to adhere to the Principles of Good Complaint Handling. I consider the failure to appropriately handle the complaint constitutes maladministration. I uphold issue two of this complaint.

CONCLUSION

63. I received a complaint about care and treatment resident received from received from Ann’s Care Homes from 8 September 2021 to 28 September 2021.
64. In respect of Issue one the investigation found:
 - Home B failed to follow the relevant guidelines regarding the resident’s admission. As a result Home B was inadequately prepared for her admission. Because of this, the Resident and her family experienced the injustice of uncertainty and distress about the care Ann’s Care Homes provided to the Resident. I upheld this element of the complaint.
 - Home B’s actions in relation to the to the choking episode were appropriate. I did not uphold this element of the complaint.
65. In respect of Issue two the investigation found:

- Ann’s Care Homes failed to adhere to the Principles of Good Complaint Handling as it did not handle the complaint sensitively and in a way that took account of the complainant’s needs. This failure to appropriately handle the complaint constituted maladministration.
66. The transition of a close family member into permanent residential nursing care is one of life’s challenging milestones that sooner or later, many family members may have to face. There is no doubt that any form of poor care provision, when it occurs, greatly adds to the stress and anxiety associated with the transition.
67. I consider it an indication of the love and commitment shown by the family, to their mother and sister, that the complainant made the decision to pursue this matter and to seek a resolution to her concerns. I hope that my finding that the Home’s actions in relation to the choking incident were appropriate offers the family some reassurance.

Recommendations

68. I recommend that Ann’s Care Homes provide the complainant with a written apology in accordance with NIPSO ‘Guidance on issuing an apology’ (August 2019), for the injustice caused as a result of the failures identified within **one month** of the date of this report.
69. For service improvement and to prevent future recurrence, I further recommend that Ann’s care Homes:
- i. Discuss the findings of this report with all staff involved in the Resident’s care and treatment to allow them to reflect on the findings; and
 - ii. Remind relevant staff of the importance of establishing the pre-admission needs of residents.

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Taking responsibility for its actions.

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

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 relevant guidance, 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.

