Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against South Eastern Health and Social Care Trust

NIPSO Reference: 18608

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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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Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

The complaint concerns the commissioning and oversight of social care provided by the South Eastern Health and Social Care Trust (the Trust) to the complainant's late mother (the resident). The resident was transferred from Lisburn Intermediate Care Centre to Dunmurry Manor Care Home on 13 October 2016. The placement was commissioned and funded (in part) by the Trust.

The complainant said the Trust failed to provide adequate information to her family about possible placement options when transfer was deemed necessary. She also complained that the Trust did not ensure that her mother's care needs were met during this placement and that it did not appropriately investigate two safeguarding concerns she raised. She further complained that the Trust ought to have informed her of issues arising from inspections carried out by the Regulation Quality Improvement Authority (RQIA) in relation to Dunmurry Manor. Finally, she complained that the Trust did not fulfil its obligation to ensure her late mother received good quality care.

In order to assist with the consideration of the issues the complainant raised independent professional advice was obtained from a social worker with experience in the provision of adult social care services.

The investigation considered the relevant policy and guidance in place at the time of the events giving rise to the complaint. In the course of the investigation, two members of Trust staff directly involved in the events, were interviewed. The investigation concluded that the Trust's actions regarding the extent of the information shared about Dunmurry Manor and its planning of the resident's care were appropriate. However, the investigation found failings in the timing of the information provided to the complainant, and in the recording of reasons not to investigate two safeguarding concerns.

The investigation also found failings in the Trust's governance arrangements and concluded that the Trust failed in its duty to monitor the quality of care provided to the resident on an ongoing basis. The investigation concluded that but for these failings, quality of care issues relating to Dunmurry Manor may have been brought to prominence sooner.

It was recognised that other reviews and investigations resulted in changes in process and structures having already been made.

I recommended that the Trust's Chief Executive apologises for the injustice resulting from the failures identified in the report and that it take a number of further steps to improve the service for other residents.

THE COMPLAINT

1. The complainant said the South Eastern Health and Social Care Trust (the Trust) failed to provide adequate information to her family about possible placement options when transfer of her late mother to a permanent placement in a nursing home was deemed necessary. She also complained that the Trust did not ensure that her mother's care needs were met during the placement and that it did not appropriately investigate two safeguarding concerns she raised. She further complained that the Trust ought to have informed her of issues arising from inspections carried out by the Regulation Quality Improvement Authority[1] (RQIA) in relation to Dunmurry Manor Care Home[2] ('Dunmurry Manor'). Finally, she complained that the Trust did not fulfill its obligation to ensure her late mother received good care. As a result, she said that her mother's health and in particular her weight, deteriorated significantly during her stay.

Background

2. The complainant's late mother (the resident) was transferred from Lisburn Intermediate Care Centre (LICC) to Dunmurry Manor on 13 October 2016. The placement was commissioned and funded (in part) by the Trust. On 7 December 2016, an initial care review meeting took place in relation to the resident. On 23 December 2016, following medical advice, the resident was admitted to Lagan Valley Hospital (LVH) for assessment. She sadly passed away on 25 January 2017 at a different care home.

Issues of complaint

3. The issues of complaint which I accepted for investigation were:

Issue 1: Were the Trust's action in relation to the placement of the complainants mother in a care home, appropriate, reasonable and in accordance with relevant standards?

[1] The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland (Source: www.rqia.org.uk)
[2] Dunmurry Manor was operated and run by Runwood Homes Limited, a company based in England. It was opened to residents in 2014.

Issue 2: Did the Trust have appropriate measures in place to discharge its obligations to residents in care homes under arrangements made by the Trust?

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint. The Investigating Officer interviewed two members of Trust staff in the course of the investigation: the Social Worker and the Care Manager (CM) directly involved in the case. The Investigating Officer and Director of Investigations also met with two Trust Assistant Directors.

5. This investigation report should also be read in the context of the Commissioner for Older People for Northern Ireland (COPNI)'s report entitled 'Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home' (hereafter 'Home Truths') published in June 2018. This investigation report made 61 findings across nine main themes and made 59 recommendations addressed to Dunmurry Manor, the RQIA, the Department of Health Social Services and Public Safety (the Department of Health) and the HSC Trusts. The complainant's experience was shared and formed part of the evidence base for the COPNI investigation. Following publication of the COPNI's investigation report, the Department of Health commissioned an Independent Review of the role played by the HSC system, undertaken by CPEA Ltd. The first evidence paper of the Independent Review was published in September 2020[3] (the CPEA Report). Any recommendations made by me should be considered in the context of recommendations already made by both COPNI and CPEA, and also such recommendations made in the future.

[3] CPEA's findings on regulation and complaints handling are due to be published in the near future (Source: www.health-ni.gov.uk)

Independent Professional Advice Sought

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

- Mr Joe Blake, Social Work Advisor with experience across a number of directorates including adult services (ISWA)

The social care advice I received is enclosed in Appendix two to this report.

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

Relevant Standards

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.

The general standards are the Ombudsman's Principles[4]:

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

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

The specific standards and guidance relevant to this complaint are:

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

- Department of Health (DoH) Circular HSC (ECCU) 1/2010 entitled 'Care Management, Provision of Services and Charging Guidance' issued on 11 March 2010 ('the DoH Circular');
- South Eastern Health and Social Care Trust, Information leaflet 'Older People's Social Work Service' December 2011 ('the Trust's Information leaflet');
- South Eastern Health and Social Care Trust 'Procedure for Admission into Permanent Care Home/Respite' June 2017[5] ('the Trust's admissions procedure');
- Department of Health 'Care Standards for Nursing Homes' April 2015 ('the Care Standards');
- Health and Social Care Board (HSCB) Northern Ireland, Northern Ireland Single Assessment Tool (NISAT) Procedural Guidance, January 2011 ('the NISAT Procedural Guidance');
- South Eastern Health and Social Care Trust ISO Procedure 'Monitoring and Reviewing Care Home Placements', June 2017[6], ('the Trust's ISO procedure');
- South Eastern Health and Social Care Trust 'Policy on Safeguarding Vulnerable Adults', December 2013 ('the Safeguarding Policy');
- South Eastern Health and Social Care Trust 'Safeguarding Vulnerable Adults – Good Practice Guide', January 2012 ('the safeguarding good practice guide');
- Northern Ireland Adult Safeguarding Partnership (NIASP) [7], 'Adult safeguarding operational procedures, September 2016 ('the NIASP Procedures');
- Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance, September 2006, ('the regional safeguarding guidance');
- Department of Health and Department of Justice (DoJ) 'Adult Safeguarding: Prevention and Protection in partnership', July 2015 ('the joint departmental safeguarding policy document'), and
- The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 ('the 2003 Order')

[5] Although this procedure post-dates the events giving rise to this complaint, the Trust has informed me that it was '*still applicable*'
[6] See footnote 4
[7] NIASP is made up of representatives from the main statutory, voluntary and community organisations involved in adult safeguarding work across Northern Ireland (source: www.hscboard.hscni.net)

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.

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

INVESTIGATION

Issue 1: Were the Trust's actions in relation to the placement of the complainant's late mother in a care home, appropriate, reasonable and in accordance with relevant standards?

Detail of Complaint

12. The complainant said there was a failure in the social care provided to her late mother in relation to the following three issues, which will be addressed in turn:

i. Preparation and planning for admission to Dunmurry Manor
ii. Care Planning
iii. Response to safeguarding concerns

i. Preparation and planning for admission to Dunmurry Manor

13. The complainant said that she and her family did not receive any guidance or information in relation to their choices, when her late mother was required to move to a care home. She also complained that her mother was assessed by Dunmurry Manor without her knowledge or involvement, and that she ought to have been informed by the Trust regarding issues arising from inspections of Dunmurry Manor carried out by the RQIA.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the DoH circular and noted paragraph 78 is relevant to this issue of the complaint:

'78. HSC Trusts should provide a directory of residential care and nursing homes and information about other useful sources of information such as the latest inspection report from the RQIA. The directory of residential care and nursing homes should contain all homes in the area that are registered with the RQIA. Some individuals may choose to live outside the HSC Trust's area for a variety of reasons, for example, to be close to family or friends. HSC Trusts should seek to facilitate such placements subject to confirmation of the home's registration with the RQIA, and its agreement to the HSC Trust's terms and conditions of contract…'

15. I considered the minimum care standards and noted the following in relation to 'before admission' section:
'It is vital that at the pre-admission stage prospective residents, their relatives and representatives have all the information they need to make an informed choice about moving into the home. This is particularly important for those residents whose capacity to make informed choices might be limited due to learning disability, mental health issues or cognitive impairment such as dementia.
The manager or other appropriate staff of the home should visit the prospective resident in their current location (which may be their home or in hospital) and undertake a pre-admission assessment. This also helps to establish communication and relationships with the potential resident and their relatives as well as addressing the emotional impact of the move…'

16. I also considered the Trust's admissions procedure, a copy of which is contained at Appendix three to this report.

Trust's response to investigation enquiries

17. In response to enquiries made, the Trust stated there is no policy outlining the information which should be provided to family members in such scenarios, however '*there is engagement with and information provided to the service user and/or their family and support offered throughout…*' The Trust said *'in addition, the SEHSCT provide an information pack including relevant information to support an individual when considering moving into a care environment'*. The Trust provided a sample information pack containing documents such as a list of care homes and contact information, in the Trust area, an RQIA information leaflet and a '*care homes pack*

receipt'. The Trust also said that as a result of this complaint, it updated its 'Moving into Care' booklet and '*work is continuing in the formation of a citizen's hub to improve the communication between all parties during placement in long term care'*.

18. The Trust also said *'…a pre discharge meeting was held on 3 October 2016 to discuss [the resident's] future care needs. Her son and two daughters attended the meeting along with the Social Worker, Nurse and Physiotherapist. [The resident's] care needs were outlined and future care options discussed. The family advised they wanted their mother to return home…it was agreed that an EMI[8] placement was the way forward.* The Trust further stated *'…it was not possible for the Trust to provide overnight care at home and the family were unable to provide this. Given the level of need required, in preparation for discharge from LICC, the Social Worker advised of available homes suitable for [the resident]'.* The Trust also stated '*the finance pack, which includes the Care Home Information Booklet, was given to [the complainant] by the Social Worker on 4 October 2016'*.

19. In its response to the complaint, the Trust also referred to the Minimum Care Standards and stated '*…it is considered good practice for a representative from a Nursing Home to visit with the person to complete a pre admission assessment, to ensure they can meet the individuals assessed needs. A pre admission assessment is completed between nursing staff of discharging and staff from receiving environments. It would not be common practice for families to be involved in this part of the assessment. Professional assessments are available and shared with the nursing home staff during this visit to ensure that they are aware and are able to fully meet the individual's assessed needs…'.* In response to further enquiries made, the Trust stated that it is not involved in arranging this assessment but is informed of the outcome and *'at the meeting on 14 September 2017, it was accepted that it would have been beneficial to involve the family to gain their perspective as [the resident] was unable to express her needs fully…'*

20. The Trust also stated to the complainant that when she was informed that the pre admission assessment took place and Dunmurry Manor was offering a placement

[8] Elderly Mentally Infirm - generally refers to older people who have been diagnosed with mental health frailties such as dementia. The resident required a nursing EMI placement.

'*there were no issues raised in relation to the pre admission assessment by your family and it was agreed that your mothers move would take place later that week…'*

21. In relation to the inspections carried out by the RQIA, the Trust stated in its correspondence to the complainant *'…it would not be custom or practice to inform families of a safeguarding investigation unless the resident is directly involved…'*

22. In response to further enquiries made by this office, the Trust stated that the RQIA inspection post-dated the resident's placement and *'…following the RQIA inspection and findings, the Trust suspended admission to the home on 25 October 2016. The Trust agreed an action plan to support the home to make the necessary improvements to ensure compliance with the Minimum standards and legislation.'*

23. The Trust stated that thereafter, the then Assistant Director for Primary Care & Older People, '*sent a letter to all next of kin of residents in Dunmurry Manor on 28 November 2016, notifying them of concerns and if they had any questions regarding the home, to contact a named Senior Practitioner, Adult Safeguarding. In response, [the complainant] contacted the Senior Practitioner on 2 December 2016 when she raised a number of issues…'*

24. The Trust was asked to clarify if it was aware of any issues regarding Dunmurry Manor's RQIA inspections prior to the resident's placement. The Trust stated that it '*would have been aware that a number of inspections had taken place since the opening of the Nursing Home and prior to [the resident]'s admission on 13 October 2016. In June and September 2016, care and pharmacy inspections were held and whilst requirements and recommendations were made, no enforcement action was taken…at the time of [the resident's] transfer to Dunmurry Manor, the MDT coordinating and arranging her transfer, were not aware that there were any issues regarding Dunmurry Manor's RQIA inspections.'*

25. The Trust provided minutes of the contract review meeting[9] which took place between the Trust and Dunmurry Manor on 23 September 2016. There were no

[9] The purpose and context of contract review meetings will be discussed further under issue 2

previous contract review meetings between the Trust and Dunmurry Manor prior to this date.

RQIA's response to investigation enquiries

26. The RQIA was asked about communication with the Trust when an inspection takes place. The RQIA said it '*does not routinely alert trusts to the findings of inspections of services as these reports are published on RQIA's website eight weeks after an inspection…where RQIA identifies more serious concerns, these are managed in line with our enforcement processes…'*

27. The RQIA outlined *'where RQIA identifies serious concerns in relation to a service, resulting in enforcement action by RQIA, we advise a number of stakeholders of this action via email. This includes the Chief Executive of the five health and social care trusts.'*

RQIA Inspection Reports

28. The inspection reports published in relation to Dunmurry Manor in the period 2015-2016 were reviewed. An unannounced inspection was carried out by RQIA on 11 November 2015. This inspection outlined three requirements and eight recommendations. There was no enforcement action taken as a result of this inspection. It was also noted that between 22 and 24 June 2016, RQIA carried out a further unannounced inspection. The June 2016 inspection report resulted in two requirements and five recommendations, all of which were first time occurrences and required completion by 31 July 2016. There was no enforcement action taken as a result of this inspection.

29. On 7 September 2016, a medicines (pharmacy) inspection was carried out by RQIA. This resulted in seven requirements and six recommendations being made. The inspection report noted '*enforcement action did not result from the findings of this inspection. However, the outcomes of the inspection resulted in a discussion with the senior pharmacist inspector in RQIA. It was agreed that due to the turnover in managers the Northern Ireland Operational Director of Runwood Homes Ltd would be contacted and advised of the concerns raised. A further inspection will be undertaken to ensure compliance with legislative requirements and professional*

standards.'

30. It was noted that further unannounced inspection took place over three days on 17, 18 and 24 October 2016. This inspection resulted in three failure to comply notices[10] being issued to Dunmurry Manor and a Quality Improvement Plan was put in place in relation to 12 areas of care in which issues were identified.

Interviews

31. The Investigating Officer carried out an interview with the Social Worker responsible for the period of time when the resident was under the care of LICC until the time she was discharged to Dunmurry Manor.

32. The Social Worker stated that the 'finance pack' referred to in the social care records is the name she gave to the care homes information pack, which she stated was provided to the complainant. The Social Worker also said she provided the complainant with a green pack containing information about homes and types of homes and added '*I would have printed off the list of homes available in the area and gave it to her. If I said to her I was going to get her the list then I would have. She did have the list as she was contacting me and coming back to me about homes on that list and suggesting homes to me.'*

33. The Social Worker was unable to explain why a receipt was not in the file however she outlined that she had '*no doubt in [her] mind that [the complainant] had the care home pack and the information'*.

34. Following the interview, the complainant was asked further about this. She said that she was provided with a *'few pages of information'* on the day her mother was moved to Dunmurry Manor. The complainant's memory of being provided with this was that she had to sign a form to say that the family were willing to pay the top up of fees owed to Dunmurry Manor for her mother's placement. The complainant still

[10] A 'failure to comply notice' or 'Notice of Failure to comply with Regulations' is issued where RQIA has identified a serious or repeated breach in regulations. A formal notice is issued and compliance required within a stated timeframe, determined by the urgency of the matter (this can be no longer than 90 days). The provider can make written representation to RQIA within 28 days of issue on any point of law or fact regarding the notice. Where compliance is not achieved, further enforcement action may take place. (source: www.rqia.org.uk)

retained what she was provided with. The complainant said that the documents retained do not include the RQIA information leaflet.

Social Care Records

35. The Social Care records were examined and a chronology of the events was prepared and is contained in Appendix four to this report. In addition, extracts from the social care records pertaining to this issue are contained in Appendix five.

Independent Social Care Advice

36. In relation to the information provided when a resident is identified for transfer to a care home, the ISWA advised '*when a decision is made that an individual is best supported by admission to residential care, Social Services will provide support to the family to guide them through the process…there is no specific information given to families other than that which is focused on need and the potential homes which can address these needs…'* The ISWA also referred to the Trust's Information leaflet.

37. In relation to this case, the ISWA advised '*the social care records indicate that the resident's family, including the complainant, were informed about processes, and given information with respect to their mother's care…The Social Worker can direct families to information regarding homes but not try to influence decisions beyond supporting them to ensure that any facility they choose can best meet need of the person entering care'*. The ISWA further advised *'the agreement to send this information to the family is noted in the social work file entry of 04.10.2016. "SW to print list of homes and leave financial pack". It is assumed that this occurred as there is no further request raised by the family'*

38. The ISWA provided the following advice in relation to the level of family involvement in the process:
'There was a high level of engagement with the family throughout this process. Social work notes show the family being kept informed about their mother's health after various assessments had been commissioned and carried out to assess her physical and mental health.'

39. The ISWA was also asked to advise on the Pre Admission Assessment which took place on 11 October 2016. The ISWA advised '*The pre-admission process is largely a practical exercise to ensure that the prospective residents' needs are identified and that the home can provide services and supports to meet those needs'.* The ISWA also advised that the basis of the transfer is the Single Assessment Tool (NISAT)[11]. This is considered under sub-issue 2 below. The ISWA finally advised that it is not necessary for the family to attend the Pre Admission Assessment and it '*would not be normal practice'* for a family to attend.

40. The ISWA was asked to consider the records provided in relation to this resident and advise if there is evidence that the Trust was aware of there being issues pertaining to RQIA inspections in relation to Dunmurry Manor. The ISWA advised '*the records and documentation pertaining to the resident do not indicate that the SEHSCT was aware of or had issues pertaining to Dunmurry Manor following RQIA inspections…. this information would not necessarily be contained in an individual's file but would have been available to Trust personnel through communication channels with RQIA.'*

CPEA Report

41. I note in the conclusion of Evidence Paper 1 the following extract:
'Although residents' relatives knew a great deal about inattention to people's care and support, this did not impact on adult safeguarding practice or RQIA inspections…'

Response to draft investigation report

42. In response to the draft investigation report, the complainant said '*I concur with the comment regarding establishing communications and relationships with the potential resident and relatives as well as addressing the emotional impact…this is the ideal situation, but was never exercised in neither my mother's case, nor with me…'.* The complainant also said *'I attended a meeting on 26th October 2016 with the finance officer, SEHSCT in Newtownards who explained in depth all the financial implications of the placement into care. Most of which was the first time it had been*

[11] Northern Ireland Single Assessment Tool – a means of recording information for the assessment of a patient's needs

explained to me. Neither my family nor I were aware of the procedures to be followed regarding pre-admission assessment as this had not been explained to us, nor the expectation of what we should expect from a Nursing Home or the SEHSCT.' The complainant also said she disagreed with the ISWA that there was a high level of engagement with the resident's family.

43. In its response, the Trust said that it refuted the finding in relation to this issue, '*as clear evidence has been submitted that the Social Worker provided all relevant information in a timely manner, and furthermore, the Social Worker's contact records state that [the complainant] was advised to take her time to visit care homes and consider her choice'.* The Trust also said '*met with [the complainant] face to face on a number of occasions in order to offer support and information and responded to text messages [the complainant] sent.*

44. In relation to the Trust's actions in relation to the RQIA inspections, and referring to the contract review meeting, the complainant said *'Surely, these should have been warning signs / Red Flags to the SEHSCT that something was wrong if another Trust was receiving reports of complaints and incidents and recording the same?'. The complainant also said that she was aware that 'other HSC staff from other Trust areas informed their families prior to family members becoming residents in early 2016'.*

45. In respect of the overall actions of the Trust in relation to the resident, the complainant said *'The fact that the Trust relied on the RQIA as the regulator to alert them to failures in Care Homes is a lack in their duty of care to the residents and society in general and an absolute failure on their part. Dunmurry Manor was in the SEHSCT area, the CM appointed to ensure my mothers care was in the SEHSCT employ, therefore it was the SEHSCT responsibility to regulate and ensure the best of care was afforded to my mother, which it fell far short of not to mention the use of public money to fund part of my Mothers care?'*

46. In relation to the pre-admission assessment, the Trust said that it had no responsibility for the organising of same and this fell upon the care home to arrange and manage.

Analysis and Findings

Provision of guidance

47. I note the complainant firstly said that her mother and her family did not receive any guidance from the Trust regarding the options available in terms of homes available. In the course of this investigation, the complainant clarified that she received some documentation from the Social Worker on 13 October 2016 (the date of transfer) she reviewed this and it did not include RQIA information. She said that she gathered her own information about care homes in the area. The records reflect the social worker's intention to provide a 'finance pack' to the family on 3 October 2016 and that this was recorded as being actioned on 4 October 2016. The Social Worker clarified that this was the name she gave to the care homes information pack containing not only financial information but also information regarding types of residential care available for the resident. The social worker restated to the investigation that this was provided. I note the Social Worker was unable to account for the lack of receipt in respect of this documentation.

48. I note and accept the advice of the ISWA that it is the responsibility of the allocated Social Worker to provide support and information to the resident and their family, as outlined in the DoH circular and the Trust's admissions procedure. On balance of all the evidence, I conclude it likely that some documentation was provided to the complainant. I cannot conclude if the RQIA information was contained in what was shared with the complainant. However, the evidence points to the fact that even if this was provided it was at a very late stage, the day the resident was transferred. I consider that the terminology used by the social worker and other staff within the Trust (i.e. 'finance pack') gives a clear indication of what was considered the fundamental purpose of the sharing of this information. The Trust did not provide any records or a signed receipt to counter this evidence.

49. I accept that the DoH circular is silent as to when this information is to be provided but it would appear reasonable that this ought to be provided when the decision is being considered. I cannot be satisfied on the basis of the evidence available, that adequate information was provided verbally to the complainant in advance of the transfer date. The second Principle of Good Administration requires

public bodies to be 'customer focused' by 'dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances'. I consider it a failing in this case that the Trust failed to provide the complainant with the required information at an appropriate time. I therefore **partly uphold** this element of the complaint. I conclude that as a result of this failing, the complainant suffered a loss of opportunity to be fully informed about her choices in relation to her mother's placement. This is further evidenced by the comments made by the complainant in response to the draft investigation report.

Pre-admission assessment

50. I also note the complainant said that the pre-admission assessment was carried out by Dunmurry Manor staff without her knowledge or involvement. I note the Trust's comments that the purpose of this assessment is to determine if the proposed placement meets the resident's needs, those needs having already been determined by the Trust in conjunction with the family. I note the Trust's account that it is not normal practice for family members to be involved in pre-admission assessments. I accept the advice of the ISWA that this account is correct. However, I note the Trust also accept that in this case, it would have been beneficial to involve the family due to the resident's diagnosis. I consider that while it may not have been normal practice, in this case it would have been helpful in communicating the resident's views. However, I accept that responsibility for arranging and undertaking the pre-admission assessment falls on the prospective care home and not on the Trust. I therefore make no finding regarding the Trust's actions in relation to this aspect of the complaint. I consider that given this is likely to be a stressful time for most families, it would be helpful to offer them the opportunity to attend pre-admission meetings. I make an observation to the Trust to consider making this suggestion to care home providers.

RQIA Inspections

51. I note the complainant said that the Trust should have informed her of concerns arising following RQIA's inspections of Dunmurry Manor prior to her mother's admission. I note that the resident moved to Dunmurry Manor on 13 October 2016 and 12 days later on 25 October 2016, the Trust suspended new admissions following enforcement action by RQIA. The Trust followed this with a letter to

residents' families on 28 November 2016. I make a comment that early communication with service users is essential in situations such as this. I note that the Trust said that inspections took place in May and September 2016 but that no enforcement action arose from these inspections and therefore its staff were only aware following the publication of the inspection report. This account is corroborated by the RQIA and the published reports. However, the investigation uncovered that during the same period, the Trust was carrying out its contract review process, which gave rise to concerns. The Trust provided contract review meeting minutes with the investigation, which indicated that the Trust were aware, at least at a senior level that Dunmurry Manor had not reported any complaints but the Belfast Health and Social Care Trust had received '*large numbers'* (paragraph 121 refers). This revealed that Dunmurry Manor was not sharing appropriate information about incidents and complaints with the Trust, as it should have been.

52. The investigation found no evidence that this information was shared with relevant staff dealing with residents and families, facing a choice of care home. I consider therefore that it is reasonable to conclude that at the time of the resident's planned transfer to Dunmurry Manor, Trust staff within the MDT team may not have been aware of the governance issues pertaining to Dunmurry Manor, over and above that which was in the public domain via RQIA. I note one of the conclusions of the CPEA's Evidence Paper 1 points to a failure in the process, resulting in known concerns not impacting on the approach of those tasked with overseeing care. The extent and appropriateness of the governance role played by Trust staff in the period between June and September 2016, is considered under issue 2.

53. The complainant is of the clear view that it was widely known amongst Trust staff that there were ongoing issues with Dunmurry Manor. However, in relation to this element of the complaint, the investigation found no evidence that the Trust were aware of ongoing issues affecting Dunmurry Manor's *capability* to accept new residents, to the extent that concerns should have been shared with the complainant prior to her late mother's admission[12]. I therefore **do not uphold** this element of the complaint. I note in the complainants account that other HSC Trusts were sharing

[12] The Trust now has its own escalation policy for concerns raised about care homes. See issue 2

information about concerns regarding Dunmurry Manor. I made further enquiries regarding this issue and I am satisfied there is no evidence that other HSC Trusts were proactively and formally sharing concerns about Dunmurry Manor with prospective or current residents.

(ii) Care Planning

Detail of Complaint

54. The complainant said that when her late mother was discharged from LICC to Dunmurry Manor, her specific needs were not recorded and the appropriate forms were not completed by Trust staff. As a result of this, she said that Dunmurry Manor staff were not aware of her mother's needs and her care plan. She believed when her care was reviewed, there was no documentation available in relation to her mother.

Evidence Considered

Legislation/Policies/Guidance

55. I considered the NISAT Procedural guidance, in particular page 34 where the role of the key worker is outlined as follows:

'A vital component of an effective assessment process is the ability to share and co-ordinate information by all those involved…

All health and social care staff involved in the older person's care have a responsibility to:

- Collaborate to ensure an up-to-date, single shared record is available for the older person and colleagues.

- Be aware of their roles and responsibilities, and those of others, in the assessment process.

- Be aware of the contents of the most up-to-date NISAT prior to any further assessment of the older person.'

56. The NISAT procedural guidance also contains a manual to assist Trust staff in the completion of NISAT documentation, outlining the process from initial assessment to core assessment and specialist assessment.

57. I also considered the Trust's ISO procedure and noted the following relevant extracts:
'Monitoring
1. For Residential/Nursing placements there should be a minimum of ***at least 1 face to face*** *contact with the client every* ***6 months****…*

Reviewing
1. The Key Worker will carry out an initial review of each case within ***8 weeks*** *of placement…*
7. The Providers Care Plan should be reviewed and adjusted to meet the client's needs accordingly…
9. A brief record of the review should be recorded on the R3 in the client's case file…..'

Trust's response to investigation enquiries
58. The Trust stated that '*professional assessments, treatment and care plans are shared with Care Homes prior to an individual's admission to assist the Nursing Home, who are responsible to care plan for the person and meet their needs. These assessments outline the care and support required by an individual…[the resident]'s functional ability, care needs, behaviours and risks were recorded by Occupational Therapy, Physiotherapy and Social Work using the core and specialist NISAT documentation. Her nursing needs were recorded on the Nursing Care and Treatment Plan…these were shared with Dunmurry Manor at the pre-assessment and they confirmed with LICC on 11 October 2016 that they were happy to accept [the resident]*'.

59. The Trust also stated that following receipt of these assessments Dunmurry Manor '*put a Care Plan in place'.*

60. In relation to the transfer of the resident's key worker, the Trust stated *'following discharge to Dunmurry Manor from LICC on 13 October 2016, [the resident]'s Key Worker transferred to the Community Care Manager. Initial phone contact was made on 18 October 2016 to arrange an initial care review in Dunmurry Manor for 6*

December 2016…the purpose of this meeting was to review the Nursing Home care plan and the suitability of [the resident's] placement'.

61. Finally, the Trust stated that the resident's needs '*were recorded on the NISAT documentation and the Trust care plan and review reports. A handwritten addendum to the review was completed and signed by the Care Manager dated 12 December 2016. This also outlined some new specific issues to be addressed by the Nursing Home care staff…'*

62. Following additional enquiries being made, the Trust stated '*the social worker coordinates the multidisciplinary assessments and shares this information with care home managers and community teams where relevant'.*

63. The Trust outlined the responsibilities of the relevant individuals as follows :

- *'It is the responsibility of the multidisciplinary team to assess and recommend the care needs of the service user*
- *It is then the responsibility of the service user and/or their family to select an appropriate home to meet the assessed needs*
- *It is the responsibility of the Trust to share the assessment documentation with the home considering offering a placement to the service user*
- *It is the responsibility of the home to assess an individual to ensure they can meet the assessed needs and to inform the service user and their family and the Trust.'*

64. Finally, the Trust outlined that during the placement in LICC, the resident's progress '*was discussed at the weekly Multi-Disciplinary Team (MDT) meetings…the social worker coordinates the multidisciplinary assessments and shared this information with care home managers and community teams where relevant. The care needs of the individual are recorded on [NISAT] accompanied by other relevant multidisciplinary assessments, including medical allied health professional and nursing assessments.'*

Interviews with Trust staff

65. In the interview conducted as part of the investigation, the Social Worker responsible at the time of the resident's discharge from LICC to Dunmurry Manor outlined that an MDT meeting took place in LICC each Tuesday, following which a ward round took place, led by the consultant responsible for the care of the resident. The Social Worker outlined '*…the MDT takes assessments from a range of professionals. The aim was to place [the resident] in the best, least restrictive place…'*

66. In the interview conducted with the CM, he was asked about the review meeting which took place on 7 December 2016. The CM said he does not recall specifically but if the file was not there he would have asked for it. The CM referred to the Care management review pro forma which he said lists the considerations and at the end there is an evaluation and agreed actions. The CM said there would have been enough to read from.

Social Care Records

67. I examined the NISAT records in relation to the resident. These records include an Initial Assessment and a Core Assessment which were completed by the Social Worker. The Initial Assessment includes a table of risks which were identified. I note these risks include physical, lifestyle and medical categories of risk. The Core Assessment is organised by ten categories of assessment: physical health; mental health and emotional wellbeing; awareness and decision making; medicines management; communication and sensory functioning; personal care and daily tasks; living arrangements and accommodation; relationships, and work, finance and leisure.

68. Further, I note within the NISAT record a 'Community Rehabilitation Physiotherapy Report' and 'Community Rehab Occupational Therapy Discharge Report'. I also note a 'Nursing Care and Treatment Plan' which is a pro-forma, completed in handwriting and signed by a Nursing Sister in LICC and is dated 29 September 2016. Finally, the records contain a 'Transition Plan for Care and Support' which outlines details of the resident's requirements. On all of these

documents it is noted that the resident has difficulty with a number of tasks and that she requires the assistance of two people when mobilising.

69. The Investigating Officer was also provided with care records from Dunmurry Manor. The records contain pro-forma documents entitled 'Care Plan' which were completed by hand. There are 12 care plans contained within the records provided and it is noted that an evaluation of the planned care was completed in respect of each. The care plans are dated between 14 October 2016 and 17 November 2016, with the majority completed on 15 October 2016.

70. Finally, the records contain a 'Primary Care and Older People's Programme Review Pro Forma'. It is a 10 page document which documents the review which took place on 7 December 2016. The Proforma contains four listed action points following the meeting which include that the CM is to update psychiatry of old age team.

Independent Social Work Advice

71. The ISWA was asked if there was evidence within the records of Dunmurry Manor being informed of the resident's needs. The ISWA referred to the NISAT documentation and advised '*these documents were used to draw up a comprehensive care plan to address the resident's physical and emotional wellbeing. These are reflected in the specific care plan dated 14.10.2016. There are further entries in the file which note ongoing communication between the SEHSCT and the home…'* The ISWA further advised *'the care plan reflects an appropriate and reasonable communication of the resident's needs.'*

72. In relation to the review meeting which took place on 7 December 2016, the ISWA advised '*the 8 week review will have had access to ongoing communication between the SEHSCT largely through the Trust's Community Care Manager and the staff in the home. As the family were at this meeting, they will have been able to contribute further information. This meeting had enough information to fully assess the suitability of the placement. Nothing was presented that would have suggested any concerns about the suitability of the placement.'*

Response to draft investigation report

73. In response to the sharing of the draft Investigation report, the complainant said *'I am interested to read that a Care plan provided to the Ombudsman was in place and written up in my Mothers notes. I can't help but wonder when it was actually written up?'* Referring to the care review meeting, the complainant also said '*The family was very concerned and we expressed our concerns at the time'.* The complainant also said that there were inaccuracies within the 'Primary Care and Older People's Programme Review Pro Forma'.

Analysis and Findings

74. I note the complainant's concerns that her mother's specific needs were not recorded by the Trust and as a result, Dunmurry Manor staff were not aware of the care plan for her. I examined the social care records provided by the Trust and noted that these contain NISAT documentation completed by the social worker, the occupational therapist and the physiotherapist. The completion of this documentation is in line with the NISAT procedural guidance. There is also evidence of a care and treatment plan completed by staff treating the resident in LICC. I note and accept the advice of the ISWA who said that the communication of the resident's needs was appropriate and reasonable.

75. The complainant was also concerned about the review meeting which took place on 7 December 2016. A record of the meeting is contained within the social care records. I note the ISWA's advice that there was enough information before the review meeting to fully assess the suitability of the placement for the resident's needs. Notably, the purpose of this meeting was not to assess the quality of the care she was receiving. This will be considered further under issue 2. The complainant's presence and contribution to the meeting was noted. The complainant said there were inaccuracies in the review documentation. However this did not form part of the investigation and I remain satisfied that the Proforma serves as a record of the review meeting. On 12 December 2016, the CM made a handwritten record entitled 'care plan issues' which sets out concerns raised in relation to the management of resident's care by Dunmurry Manor. I therefore found no evidence to support the assertion that appropriate documentation was not completed in this case, or that care plans were not drawn up and communicated to Dunmurry Manor via the Trust.

The investigation found no evidence that the care plans were drafted retrospectively. While I understand the basis of the complainants concerns, particularly about the quality of care received, I am satisfied that in this case appropriate actions were taken by the Trust to assess and communicate the care needs of the resident, I therefore **do not uphold** this element of the complaint.

(iii) Trust response to safeguarding concerns

Detail of Complaint

76. The complainant raised a number of concerns with the Trust regarding incidents which occurred within Dunmurry Manor which she considered put her late mother at risk. The complainant reported that a male resident entered her mother's bedroom in a state of semi-undress. The second reported incident was that the resident displayed new bruising marks on her forearms, which the complainant considered to be 'grab' marks. The complainant stated that the Trust did not adequately investigate or act upon these reports.

77. In the context of this element of the complaint, it is important to note that the Home Truths investigation reported evidence of (amongst others) inconsistencies in the approach to adult safeguarding referrals, failures to report notifiable incidents and assaults by residents on each other. The CPEA report also found there was *'a critical need to reformulate the practice of adult safeguarding'*

Evidence Considered

Legislation/Policies/Guidance

78. The relevant Trust policy is the Safeguarding Policy. Section 7 refers to reporting and states:
'7.2 Use VA1 Reporting form (appendix 3) to report any safeguarding concerns to a Designated Officer.'

79. I also considered the safeguarding good practice guide and the regional safeguarding guidance. Relevant extracts are contained at Appendix six to this report.

80. I also considered the joint departmental safeguarding policy document. This policy document moved away '*from the concept of vulnerability'* and towards the concept of adult safeguarding. The following extracts are relevant to this element of the complaint:

'10. ***Referral pathway for safeguarding concerns***
…in most circumstances there will be emerging safeguarding concerns which should normally be referred to the HSC Trust, for a professional assessment. It will be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate.
*…**10.3 A Determination that the Threshold for Referral to Adult Protection Gateway Service is Not Met – Alternative Safeguarding Responses***
Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult…and may include
a) Escalation to the service manager to address any issues about the quality of service provision;
…
c) Referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment…
…
Where an HSC Trust Adult Protection Gateway Service has agreed an alternative course of action, there must be mechanism in place to ensure that those given lead responsibility to take certain actions report back to the DAPO on the outcome of the actions taken. '

81. Finally, I considered the NIASP procedures. The following extract is relevant to this element of the complaint:

'6. Responding to an Adult Safeguarding Concern – the Role of the HSC Trust
6.1 Determining if an adult is at risk

On receipt of the adult at risk referral the HSC Trust keyworker will discuss the concern with their line manager to establish the facts of concern and determine if the threshold for an adult at risk is met. Where this is not met they will inform the referrer of the outcome of their decision and make any necessary recommendations for alternative responses. The line manager must ensure that the adult's immediate needs are met, eg they are in no immediate danger and that any medical assistance required has been sought…Where the decision is that the adult is potentially at risk of harm the line manager and the keyworker will discuss the appropriate response. This will include an assessment of the risk identified in the referral and review of the care and support needs which will minimise the risk of harm …

6.3 ***Alternative Safeguarding responses***

Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult…and may include:

a) *Escalation to the service manager to address any issues about the quality of service provision*

…c) referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment…

Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached.'

Trust's Response to investigation enquiries

82. The Trust stated that on two occasions, the complainant reported concerns in respect of the care of the resident. The Trust outlined the following information:

'21 November 2016

[The complaint] reported to the SET Care Manager that a male resident in the Dementia Nursing Unit in Dunmurry Manor had entered her mother's room in a state of semi undress and was aggressive in nature towards the family. An Adult Protection referral was made.

It was established that the gentleman was wearing a vest and became agitated when [the resident]'s son, who was present at the time, raised his voice to him. No serious harm was suffered and this was screened out of adult protection to risk management.

The Care Manager spoke to the Nursing Home manager to address any risk. She explained that a buzzer mat had been placed at the entry to [the resident]'s bedroom. This, when stood on, would alert staff to someone entering the bedroom. It was also agreed that staff in Dunmurry Manor would complete 15 minutes observations of the male resident. The manager of Dunmurry Manor advised she would speak to [the resident]'s family regarding the possibility of moving her to a room closer to the nurses station for observation.

7 December 2016

Post admission review was held as previously scheduled. At this review, the issues raised by [the complainant] in regards to the gentleman entering her mother's room and the risk assessment action plan were discussed. [The complainant] made further allegations of poor manual handling resulting in bruises on [the resident]'s wrists / lower arms.

An Adult Protection referral was made on 8 December 2016. Following information gathered, the case was screened out of Adult Protection investigation to risk assessment and management. A member of the Adult Protection Team contacted [the Complainant] by telephone on 10 January 2017 to discuss the rationale for screening this out of the adult safeguarding process and into risk management.

On 13 December 2016, the Care Manager spoke with the Nursing Home Manager to update the care plan and to agree the management of risks…'

83. The Trust also outlined that new regional policy in respect of adult safeguarding was issued in 2015 and new regional procedures (the NIASP procedures) were issued in 2016. The Trust explained that it was '*transitioning from implementation of the old to the new policy and procedures during this period and into 2017. Due to the phased roll out of training, some staff were implementing the old and some the new policy and procedures, which is reflected in practice'.* The Trust provided a copy of

the training plans in place in respect of the new procedures. The training plans indicate that awareness raising training commenced in November 2016 and specific training for Designated Officers took place in January and February 2017. The Trust also provided the agenda for 'Designated Officer forums' which took place from November 2015. The agenda on each occasion refers to the 'new' safeguarding procedures.

84. The Trust was asked about the steps taken by staff prior to the decision to 'screen out' the concerns. The Trust stated that the bruises were discussed with staff from Dunmurry Manor at the review on 7 December 2016 and were further discussed in a conversation with Dunmurry Manor's manager on 12 December 2016. The Trust further stated '*on the information provided and in consultation with the care manager, the Designated Officer decided it was appropriate that the Care Manager has spoken to the Home Staff Nurse and Senior Care Assistant.'*

Interview with Care Manager

85. As part of the investigation, the Investigating Officer interviewed the CM who was assigned as the resident's key worker during the relevant period. The CM stated that he commenced his position as the resident's key worker upon her admission to Dunmurry Manor on 13 October 2016. The CM outlined that the complainant contacted him quite quickly following her late mother's admission to Dunmurry Manor. As a result, the CM reported that the review meeting was arranged quite quickly and it took place on 7 December 2016.

86. The CM was asked about the safeguarding referrals and specifically about the review of measures put in place as a result of those referrals. In relation to the first referral, the CM said as monitoring was increased in relation to the other resident, that resident's care manager would have overseen that. In relation to the buzzer mat the CM said that his review of that would have been ongoing.

Social Care Records

87. The chronology of events contained at Appendix four is also relevant to this issue of complaint.

88. I note in respect of the incident regarding the male resident, it is recorded that following the referral to Adult Safeguarding on 21 November 2016, Trust staff spoke to the then Manager of Dunmurry Manor '*for clarity'*. It was noted that the Manager informed the Trust that the male resident '*is on 15 minute location checks'* and that '*it has to be discussed with [this resident's] family if they want to consider moving her to another room within the unit'*. I note it is recorded that a decision to 'screen' the matter out of adult safeguarding and into risk management and the rationale for such is noted as '*no actual abuse of [resident] identified. Risk management advised to manage behaviours'*.

89. I note from the care management file that the care manager recorded a discussion with the then Manager of Dunmurry Manor on 21 November 2016, wherein it was outlined that the Manager was aware of the situation and that a 'buzzer mat[13]' was in place and the male resident referred to was under 15 minute observations by staff.

90. In respect of the complainant's concerns regarding bruising, it is recorded that these concerns were raised to the Care Manager on 7 December 2016 and a referral was made to the Adult Safeguarding team on 8 December 2016. I note it is recorded that '*when the bruises were discussed with the agency staff nurse and senior carers in the review, [Staff Nurse (SN) and Senior Care Assistance (SCA)] it was denied that there was any inappropriate manual handling and the bruises were as a result of daily aspirin administration and [the resident] possibly hitting her arms on the table in her room.'*

91. Further, I note a 'Screening Referral' which was completed by the Designated Officer and is dated 9 December 2016. In this document, it is noted that these

[13] A sensor mat which alarms when pressure is placed upon it

concerns were also ‘screened out’ of the Safeguarding policy and the reason recorded for this is as follows:
‘*no actual abuse of [the resident] identified, as the (sic.) were no witnesses & staff refuted any poor practice in Moving & Handling.*
[The resident] is on daily aspirin. Aspirin is an anticoagulant medication and anti-platelet agents reduce your blood’s ability to clot, allows enough blood to leak out and cause a bruise.
Risk management advised & [the resident] to be placed on 15 min observations.’

92. I note the Designated Officer informed the CM of the decision by email dated 9 December 2016. The Designated Officer also outlined in this email a number of other concerns expressed by the complainant in the course of the previous safeguarding concern.

93. I also note in a record made of a visit to Dunmurry Manor on 13 December 2016, the Care Manager spoke to the home manager and ‘*highlighted concerns as detailed in [Designated Officer]’s email 9/12/16 and concerns recorded in [the two safeguarding reports]…’*

94. Thereafter, I note that the Trust, in an email, requested confirmation of the following from Dunmurry Manor on 22 December 2016:

- *‘Moving and handling is provided by staff to [the resident]*
- *Bruising recorded details e.g. dates, copies of body charts*
- *Did staff inform family when bruising was noted?*
- *care plan in place to manage bruising risk as [the resident] is on aspirin’*

95. Dunmurry Manor provided a response to the Trust on 25 January 2017. In it, the Acting Manager of Dunmurry Manor indicated that bruising to the resident’s forearms was documented following a report from the family and referred to possible causes of the bruising being clasping her own arms or hitting the table. The response further stated ‘*there was not a care plan to manage bruising at that time as staff had not identified it as an issue’.* Finally, the response outlined action taken which entails the use of shower chairs and dementia training.

96. I also note an email from the CM dated 10 January 2017 to the Designated Officer said the CM '*spoke with [Dunmurry Manor Manager] re concerns…and concerns from family. Discussed the issues that needed addressed and highlighted changes to be made to the care plan'.* I also note that the CM listed in this email eight changes to be made to the resident's care plan, including the buzzer mat to be in place at all times and for 15 minute observations of the resident.

Independent Social Work Advice (ISWA)

97. Regarding the concern about male resident entering the resident's room, the ISWA was asked if it was appropriate that the concern was 'screened out' of the adult safeguarding process. The ISWA advised '*this was an appropriate decision as the issue could be best addressed by creating practical solutions regarding the behaviour of the other party'.* The ISWA further advised that potential solutions were identified in communication between the Trust and Dunmurry Manor which were placing a buzzer mat at the resident's door and placing more frequent observation on the male resident. The ISWA advised *'the decision to more closely monitor the situation to ensure that this situation did not reoccur or could be addressed promptly was a reasonable response.'*

98. The ISWA was asked if the Trust carried out a review of the measures put in place. The ISWA advised '*there is no evidence of a formal review process specifically linked to these issues as no further concerns were raised. However, it is noted that they were discussed at ongoing meetings the Trust and the Home as overall professional development. This would be an appropriate response in these circumstances. As this was reclassified as a risk management there was no need for the Trust to report this to RQIA as it was not deemed to be a Safeguarding concern.'*

99. Regarding the bruises on the resident's arms, the ISWA advised that the decision to 'screen out' was appropriate in this case and said '*while a serious incident, that this was a concern that could be addressed through links between the Trust and The Home.'* The ISWA provided advice on the steps taken by the Trust and said the '*home was contacted and two members of staff were interviewed and they indicated that nothing untoward had occurred. In the circumstances the issue*

was screened out of Safeguarding Adult procedures and progressed under risk management. Furthermore, possible explanations as to how the bruising might have occurred. This included the resident's tendency to hit her arms off the bedside furniture coupled with vulnerability to bruising as she was taking Aspirin.'

100. The ISWA was asked about the steps taken by the Trust and advised '*given the seriousness of the allegations it would have been helpful if the Investigation had sought confirmation from, for example the Family and/or the GP that this was typical of behaviour manifested by the resident.'* The ISWA concluded as the matter was closed, no further review would have been necessary.

CPEA report

101. I considered the CPEA report which stated in respect of safeguarding referrals made to the Trust concerning Dunmurry Manor:
'107. Once again, the greatest number of referrals concern residents harming other residents by hitting, grabbing or pushing. Claims such as, no serious harm…no harm…unsubstantiated, no serious harm appear unduly reassuring in the absence of corroboration. It was noted of one incident that the, Investigation could not establish if harm actually occurred.'

Responses to draft investigation report

102. In response to the sharing of the draft investigation report, the complainant said 't*he table manifested later in the reports in your draft by CM/staff DM to a trolley, the bed and the bedside furniture. None of which are compatible with the bruises [she had]. My Mother sat in front of a trolley for months before and months after DM and had no bruising…'* The complainant also said *'while "Aspirin" may have been mentioned at this stage there was no mention of the suggestion that she hit her arms off the trolley (table) in her room. This suggestion only appeared later in my dealing with them.'* The complainant provided photographs which she stated were of her the residents bruising to her arms and legs. The complainant also said that she believes the DM Manager was not on duty on 21 November 2016 and it was in fact the Regional Manager whom Trust staff spoke with. The complainant further said there were occasions when the 'buzzer mat' was not functioning properly, or not plugged in and she considers this amounted to neglect in the care of her mother.

103. In its response to the sharing of the draft Investigation Report, the Trust referred to information obtained, including body maps and said '*all information evidences that [the resident] had, and continued to have, bruises to her hands / arms that, on the balance of probabilities, were self-inflicted.* The Trust also said *'the ISWA advised the Ombudsman that in both cases the actions of the Trust was appropriate and reasonable and the Trust would hold that this is the case.'* The Trust also said *'[complainant] was contacted by the Designated Officer on 10 January 2017 to discuss the rationale for screening this out of the adult safeguarding process and into a generic risk management process. Furthermore from 21/11/2016 to 26/5/2017, the Designated Officer communicated on 22 separate occasions with [complainant] ensuring no uncertainty of process was suffered…'*

104. Referring to my observation regarding raising the issue of unexplained bruising with staff at the care review meeting, the Trust said *'as the concern was raised by the family of [the resident] in the care review, it was deemed right and proper to address it at that time as the people present in the room were the people who could provide answers and allow the family to hear first-hand any rationale for the injuries. The family would have had an opportunity to challenge their reasons for the bruises at that time. It was also discussed with the complainant outside the review process.'*

105. The Trust also said that in taking the screening-out decision regarding the bruises, '*corroboration of evidence was sought with a review of medical information gathered from ECR, from Psychiatry of Old Age Consultant and case notes of previous incidents of bruising when in other facilities. In addition, the role of the Adult Safeguarding Specialist Nurse is to advise and guide the Designated Officer in nursing and medication issues. The Adult Safeguarding Specialist Nurse was involved in [the resident]'s case and was included in emails informing the Care Manager of the decisions made.'*

106. Finally, the Trust said *'the Adult Protection Team was at that time compiling a record of all adult protection referrals, actions and outcomes for all adult protection cases in Dunmurry Manor and were therefore in regular contact with Dunmurry Manor.'*

Analysis and Findings

107. The purpose of my investigation of this complaint is to establish and consider the standards applicable at the relevant time, and assess whether the actions of Trust staff, were appropriate and reasonable. I note both Home Truths and the CPEA report made recommendations regarding failures in the adult safeguarding process itself. Both of these publications are relevant to the circumstances in Dunmurry Manor at the time of the resident's stay. My considerations and findings should therefore be read within this wider context.

108. I accept the Trust's account that adult safeguarding was undergoing a period of transition at the relevant time. I therefore considered the Trust's actions against both the old and the new policies and procedures. I note that there are some differences in procedure in the two sets of policies/procedures, however the principles underpinning them, remain the same.

109. I will firstly address the complainant's concerns about the Trust's handling of her report of a male resident entering her mother's room. I am satisfied that the concern was appropriately referred to the safeguarding team within the Trust by the CM. The records reflect that the concern was 'screened out' of adult safeguarding, as part of the process outlined in the safeguarding good practice guide. This would appear to have been a decision taken on the facts of the incident itself, without further information being gathered.

110. The rationale outlined for this decision to screen out the first concern does not reflect the factors outlined in the regional safeguarding guidance paragraph 12.3. I consider the rationale cited within the records provided is insufficient and I cannot be satisfied that the factors within the regional safeguarding guidance were taken into account. The first Principle of Good Administration, 'getting it right' requires public bodies to act in accordance with its published guidance. The third Principle of Good Administration requires public bodies to be 'open and accountable' by 'stating its criteria for decision making and giving reasons for decisions'. I find the failure to provide an *appropriate* rationale constitutes maladministration. I am satisfied that as a result of this failure, the complainant sustained the injustice of uncertainty regarding the safeguarding process undertaken by the Trust. However, I accept the

ISWA's advice that the decision was reasonable on the basis of his review of the records available. I also accept The ISWA's view that appropriate steps were taken by Dunmurry Manor, overseen by the Trust in retrospect and that no other reasonable steps could have been taken as a response to the concerns being raised. I note and accept the advice of the ISWA that there was no specific review of the arrangements put in place but rather there was ongoing review. In this case, events precipitated due to the second safeguarding report. However, I make an observation to the Trust to reflect on the appropriateness of keeping measures put in place following a safeguarding concern, under specific review. It is important to note that the Trust responsibility to the resident persists, even if matters have not been deemed a safeguarding issue.

111. Regarding the concerns about the bruises on the resident's arms, I note that this concern was also 'screened out' of adult safeguarding and a rationale provided. As with the previous concern, the rationale cited within the records does not evidence that the Trust considered the factors for 'screening out' as outlined in the regional safeguarding guidance. I make an observation that the rationale cited in this instance is poorly scripted and the Trust should reflect on this and the impact on a resident/their family having sight of the reasons. Similarly therefore, I find that the failure to record an appropriate reason for the decision is contrary to the first and third Principles of Good Administration and constitutes maladministration. I considered the Trust's comments in response to the draft report and I am satisfied that as a result of the failure, the complainant sustained the injustice of uncertainty regarding the process.

112. Further, I considered the steps taken by the Trust prior to the exercising its judgment in 'screening out' the concern. On balance, I cannot be satisfied that all reasonable steps were taken to ascertain all available information before the decision was made. I note the complainant's comment regarding the accuracy of which member of staff in DM was spoken to, however this is not a matter relevant to the investigation. The Trust's safeguarding records reflect that Dunmurry Manor staff were spoken to regarding the report. The investigation uncovered that this discussion occurred at the care review meeting on 7 December 2016, between staff and the CM. I make an observation to the Trust to consider whether this was an

appropriate forum to discuss the concern, with other people present in the room. Notably, Trust staff did not seek to discuss the account provided by the Dunmurry Manor that the resident had a tendency to hit her arms off a tray table, with the resident's family or seek medical advice. I note the Trust's comments following the sharing of the draft report that it considered my observation. I remain of the view that in the interests of fairness and seeking good quality evidence, the care review meeting was not an appropriate forum in which to raise such issues with staff.

113. In response to the draft investigation report, the complainant said that her mother did not have such bruising in other placements (hospital and LICC). I accept that a family discussion may not have provided probative evidence, or changed the decision itself. The ISWA's advice also reflects this. The GP's opinion may have been helpful in considering the effects of asprin on the resident. A discussion with the family may have satisfied the complainant regarding the involvement of the family and also the extent of Trust consideration of the matter. I note the Trust's comments in response to the draft report. The investigation found no evidence that the Trust considered the resident's body maps or other medical evidence at the time of the decision. Therefore I am not satisfied that the evidence recorded as having been considered by the Trust, was sufficient to form a view that the bruises were 'self-inflicted' without other corroborating evidence. Lack of corroboration of evidence in the adult safeguarding process was also noted in the CPEA report. I note the Trust's comments in this regard. However, the records do not reflect this account and I find that the failure to take these further steps is a failure in the social care provided to the resident. As a result of this failure, the resident and the complainant lost the opportunity to have the concern fully considered by the Trust. I therefore **uphold** this element of the complaint.

114. I note that following a decision to 'screen out' this second concern, the Trust's safeguarding staff relayed to the CM concerns regarding the resident's care which were highlighted by the complainant, which included continued concerns about the two safeguarding reports. I also note that the CM raised these issues with Dunmurry Manor on 13 December 2016 during a visit. I further note that whilst the safeguarding report was closed, the safeguarding team remained involved in reviewing the actions taken and the CM emailed the Designated Officer and others on 10 January 2017,

reporting review steps taken. However in the intervening period, I note that the safeguarding team were also in communication with Dunmurry Manor seeking further information regarding steps taken. I make an observation to the Trust to reflect on delineating the roles of Trust staff in reviewing measures put in place to mitigate risks to residents[14]. I note the Trust's response to the draft investigation report informed me the steps taken in this case were unusual due to the circumstances within DM.

Issue 2: Did the Trust have appropriate measures in place to discharge its obligations to residents in care homes under arrangements made by the Trust?

Detail of Complaint

115. The complainant raised concerns that the Trust failed in its duty to protect her late mother and did not take steps to ensure that the care she was provided with in Dunmurry Manor, was of a sufficient standard. The investigation therefore considered this and the measures the Trust had in place to discharge its obligations to the resident and other residents who have been placed in permanent care home placements by the Trust[15].

116. I acknowledge the NIAO report[16] in recognising that responsibility for ensuring the quality of care in such scenarios '*lies with a variety of different bodies'*, namely the commissioners of the care (in this case the Trust), the providers of care (Runwood Homes Limited / Dunmurry Manor) and the regulators of care (RQIA). In consideration of this issue of complaint, focus is on the role played by the Trust.

Evidence Considered

Legislation/policy/guidance

[14] The 'Home Truths' Report made a recommendation for an Adult Safeguarding Bill which should *'clearly define the duties and powers on all statutory, community, voluntary and independent sector representatives working with older people'*

[15] It is recognised that the role of commissioning care is undertaken by the Regional Health and Social Care Board (HSCB) from the Health and Social Care Trusts through an area Local Commissioning Group

[16] Northern Ireland Audit Office 'Arrangements for Ensuring the Quality of Care in Homes for older people' (8 December 2010)

117. I considered the 2003 Order and in particular noted the following provision:

'Duty of quality

34.—*(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—*

(a)the health and personal social services which it provides to individuals; and

(b)the environment in which it provides them...'

118. I also considered the Minimum Care Standards[17] which outlines 48 standards which nursing home providers must adhere to, compliance for which is inspected and assessed by the RQIA. The standards are underpinned by nine values, which are produced as Appendix seven to this report.

Contract for Service

119. I was provided with the 'Regional Residential and Nursing Provider Specification and Contract' (the Trust's Care Home contract) which was in place between 1 November 2015 and 31 March 2017. In particular I noted the following relevant clauses:

'8.0 ***Unsatisfactory Performance***

8.1 Should the Provider[18], in the opinion of the Trust, fail to provide the Service or any part thereof to a standard which is fully in compliance with the Contract, this will be regarded as "Unsatisfactory Performance" and the Trust may do one or more of the following:-

8.1.1 Bring such Unsatisfactory Performance to the attention of the Provider in writing requiring the Unsatisfactory Performance to be dealt with in a manner prescribed by the Trust;

8.1.2 Where the Trust considers it appropriate, it may issue a Performance Notice in

[17] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/care-standards-nursing-homes.pdf
[18] In this case, the Provider was Runwood Homes in respect of Dunmurry Manor

the form set out in Appendix 5 ("Performance Notice") to the Provider setting out the details of the Unsatisfactory Performance, a timescale for rectification and any implications of any failure to rectify the Unsatisfactory Performance in full or in part or to the standard required by the Trust…'

120. I note that the Trust's Care Home Contract outlines steps which may be taken by the Trust if the Provider fails to rectify Unsatisfactory Performance referred to. These steps include the suspension of admissions and the rescission of the contract.

Trust Records

121. Following a request, the Trust provided a copy of the minutes of the contract review meeting which took place in respect of Dunmurry Manor on 23 September 2016. The minutes indicate that an interim manager of Dunmurry Manor was present with a representative from Runwood Homes. The minutes record that the topics covered included incidents and complaints. In respect of both of these it is noted '*none reported – should have been as Belfast noted receipt of large numbers'.* Further, under the subject heading of 'operational issues' it is noted in *'Incident Reporting / Complaints reporting – Home needs to send these in…as Belfast had received large numbers and SET [South Eastern Trust] had none.'* I further note the records refer to the last RQIA inspection and that there was an 'overview of inspections/areas for concern' and '5 recommendations and 2 requirements' on foot of this inspection. The minutes also record that the agreed actions of Dunmurry Manor following the review, were due on 30 September 2016. Finally I note that under the subject of 'any other business' is stated '*home bringing in a service improvement manager / governance'* and '*home bringing in a HR Support Manager – NI / patient experience'.*

Trust's Response to investigation enquiries

122. The Trust stated '*at the time of this placement, all homes across the SEHSCT area were issued with the regional contract for Nursing and Residential Care Home Contract (sic.) and at each year, an annual assurance process was completed, to check RQIA registration status, RQIA enforcement action and insurance status. Each home in the Trust area had an annual contract review meeting with the Trust, covering a range of issues, such as review of placements, risk and governance*

review, policies and procedures, incidents and complaint, quality monitoring, safeguarding activity, service user feedback, business continuity, operational issues, RQIA inspections and outcomes, finance and equipment…'

123. The Trust also stated *'…all placements in a Nursing or Residential home are overseen by a Trust social worker, supported by a multidisciplinary team. The care needs of all residents are determined by this team and the social worker shares the assessment documentation with the person's chosen home. The social worker/key worker would have been the key point of contact for the home in relation to that individual and they would have had the responsibility to determine on an ongoing basis if the home was meeting the resident's needs, in line with the Trust assessment…'* The Trust was asked by which standard the Social Worker determines if the placement is meeting the resident's needs. The Trust stated that it '*follows departmental guidance for patients transferring into a placement in a care home…'*

124. The Trust was also asked if it had in place a quality manager in relation to care home placements arranged through the Trust. The Trust stated that it did not *'…however, every service user placed by the Trust in a care home has an aligned social worker/keyworker who will monitor and review the placement…'*

125. The Trust was asked if it was informed of requirements or recommendations made by the RQIA following an inspection. The Trust stated that it '*has access to the full inspection reports when they are published on the public facing website or upon request when needed for the Trust to respond to a failure to comply after the reports have been formally issued…'*

126. The Trust was also asked to clarify the meaning of the references to 'should have been' within the contract review meeting minutes provided. The Trust said '*this means that the South Eastern Trust had become aware that the home was reporting incidents to the Belfast Trust and not the South Eastern Trust…'* The Trust stated that it became aware of this at the meeting itself. The Trust also provided clarity in relation to the action points outlined at the contract review meeting, and stated '*the Assistant Director of Older People, at the time, had oversight of the actions*

requested. Subsequently the actions were not completed to the satisfaction of the Trust and a Serious Concerns meeting was arranged and following this the Trust escalated this to the Chief Executive of Runwood…'

127. The Trust was asked to provide the contract review meeting minutes prior to September 2016. The Trust stated '*there are no contract review notes before this date'.* The Trust later confirmed that there were no contract review meetings prior to this date. The Trust also said that it '*first started to issue performance notices to care homes in June 2019 and since then a total of 8 were issued to care homes with care commissioned by the Trust'.*

128. In relation to issues spanning across several HSC Trusts, the Trust stated '*in 2016 there would not have been regular liaison between Contract Management Teams across Trusts in relation to care homes. Any discussion would have taken place at an operational level among the relevant professional staff. This has now changed and where the South Eastern Trust has concerns in relation to a care home, alerts are issued to all Trusts via the Contracts Department and vice versa'.*

129. As part of the investigation, the Investigating Officer and Director of Investigations met with the Interim Assistant Director of Service and the Assistant Director of Social Care Procurement, Contracts and Commissioning. In this meeting, the Trust staff highlighted that following the Independent Sector Governance Review in December 2018[19], the arrangements in place within the Trust are quite different to that which was in place in 2016. The Trust staff stated that the recommendations outlined in the Governance Review were implemented, and the Trust now has a dedicated Independent Sector Governance Team, which monitors on a daily basis incidents and reports in relation to care home placements, submitted by key workers. The Trust staff also said that there is now increased liaison with RQIA and other Trusts in relation to issues arising, and a more active follow up of incidents. Finally, the Trust staff referred to the Trust's own escalation approach in relation to concerns arising out of incidents.

[19] A short life group was established in September 2018 by the South Eastern HSC Trust Executive Management Team to undertake rapid progress to provide assurance to Executive Management team as to the quality and safety of services commissioned from the independent sector. The review considered learning from the Home Truths Report and the Department of Health rapid review which preceded Home Truths.

Trust's Independent Sector Governance Review

130. The Trust provided the Governance Review and I note the following relevant findings:

'Whilst there are many committees none has a specific focus on the independent sector and how the Trust discharges its duty of Quality under the 2003 Order'. (page 14)

'*In January 2018 a new incident, complaints and quality monitoring system was trialled whereby all incidents, quality issues regarding care providers and care homes are reported centrally to governance leads and Contracts. A monthly meeting is held to review received returns, identifying trends/themes which can be used to assist with action plans and interventions with independent provider organisations'* (page 35)

'*The Trust currently holds annual contract review meetings with providers, led by the Contracts Department and supported when required by relevant operational staff. However, owing to the large numbers these are completed within an 18 month period. There are also a large number of escalated concerns through RQIA and through identification by the Trust incident reporting process / intelligence which impacts capacity to undertake general reviews.'*

There are escalation meetings following Failure to Comply or other regulatory action by RQIA and Serious Concerns meetings where escalated through the incident reporting process. These meetings are managed in partnership between the Contracts Department and the Operational Manager concerned.

The Trust holds provider forums to share relevant information, attended by both contracts staff and operational community staff.' (page 39)

131. I also note the Governance Review made 11 recommendations including the following which are relevant to this issue of complaint:

'1. The integrated governance structure should be reviewed. This review should consider whether to add a specific committee with the responsibility for the oversight

of the Trust legislative duty of quality with regard to services commissioned from the independent sector or to identify a suitable alternative'.

8. An escalation protocol should be developed to set out what issues should be escalated, triggers for escalation and how and when to implement performance measures such as:
□ Performance notices
□ Concerns meetings
□ Suspensions
□ Withholding payment
□ Contract termination'

132. Finally, I note within the Governance Review, an improvement opportunity was identified in the potential expansion of the pilot process for the reporting of incidents / complaints from independent providers of domiciliary care, residential and nursing homes to all contracts (page 52).

CPEA Report

133. I considered the CPEA Report in its consideration of matters relating to this issue of complaint. I note the following relevant extract:

'53. The CE of RQIA referred to paragraph 14.3 of the policy in correspondence of 9 February 2018 to the HSCTs: "I believe the RQIA and Trusts could and should be working more effectively to share information on trends identified in individual homes or groups of homes and would like to discuss with you how best to formalise this. RQIA cannot analyse every incident…but intelligence on trends would be very useful in planning inspections. I am aware that Trusts report at a strategic level to the HSCB as part of the Delegated Statutory Functions return and whilst there is some value in this for RQIA, it is not detailed enough for our purposes. I am aware of the responsibility noted in the safeguarding policy on those who monitor and manage contracts "to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract" (9.1) …these audits would be a valuable source of intelligence to RQIA... POINT TO CONSIDER – Learning and Change - A QMR appears to apply when the matter is deemed a management,

practice or complaint/grievance type issue that is referred to the provider to address…'

Interview with Care Manager

134. The CM was asked about the quality monitoring process as it was in 2016. The CM said he would have discussed this with his manager [Primary Care Manager (PCM)] and with the home if more information was required. He would then have completed a quality monitoring proforma and this would be sent to his PCM who then escalated the matter through the channels to the contracts team. The CM outlined that there were no quality monitoring forms completed in respect of this case.

135. The CM was also asked about his role in monitoring and reviewing the quality of care. The CM said this is done through phonecalls and personal visits. The CM said as per ISO standards it would be usual to record all conversation and information received on a Rec 3 document that would have been filed in section B of the care management file, adding it would be expected that the nursing home would include the introduction of equipment or indeed any actions in an individual's care plan and this would be communicated to staff.

Response to draft investigation report

136. In response to the sharing of the draft investigation report, the Trust said *'the Trust considers that the remit of quality monitoring process in (sic.) not fully understood. If incidents of care falling below Trust standards were noticed or reported to the Care Manager but not deemed a VA/ASG issue, the quality monitoring process would have been instigated, but as the issues within the report may have been a Vulnerable Adult issue, it was deemed to be more appropriate for the Vulnerable Adult process to be used. At no time was quality monitoring process used as a means of reporting concerns. I enclose a copy of our Quality Monitoring Form for your information.'*

Analysis and Findings

137. I note the complainant raised concerns about the Trust's obligation to her mother in ensuring that the quality of care provided to her, was adequate. The 2003 Order reflects that this obligation is a statutory one. In considering this issue of

complaint, it is clear that the quality monitoring landscape has changed significantly within the Trust. This change has come about following the publication of Home Truths and the Trust's own Governance Review.

138. I note that in 2016, there was a framework in place for the monitoring of the quality of care within care home settings. I note that this framework was embedded within contract management and relied on the reporting of incidents to the Care Manager/key worker. I note that the process included a discussion with the care provider and onward referral to the Trust's contract team. However, there was no central recording or trend identification carried out in relation to the information gathered. I found no evidence of collaborative working between departments within the Trust. It is notable that there was no one person or team with oversight over quality issues raised. I also note that incidents were considered at annual contract review meetings, which by the Trust's own admission were occurring approximately every 18 months. The investigation uncovered that in respect of Dunmurry Manor, the first such contract review meeting did not take place until September 2016, two years after Dunmurry Manor opened to residents. I note at this meeting it was identified that incidents occurring within Dunmurry Manor had been reported to the Belfast Health and Social Care Trust, but not to the (South Eastern) Trust. The Trust were unaware of this and this points towards poor information sharing across Trusts with interests in the same care homes.

139. The Trust also relied heavily on the RQIA as regulator to report and escalate incidents of concern. However, the RQIA carry out biannual inspections and therefore their role in monitoring quality on an ongoing basis, is limited. The investigation found no evidence of co-operation and sharing of information between the Trust and RQIA. The CPEA report reflects that this would be welcomed by RQIA. It is also worthy of note that the 2003 Order places clear emphasis on the role of the Trust.

140. I note that prior to June 2019 the Trust did not issue any performance notices however since then it has issued eight. I also note that the Trust did not have a contract review meeting in relation to Dunmurry Manor until 2016, two years after it opened. I consider residents and their relatives would expect the Trust to use the full

range of options open to it to ensure that vulnerable individuals in care homes receive appropriate care. I was concerned that prior to 2019 the Trust had not used the range of options open under its contract to secure necessary improvements.

141. The First Principle of Good Administration, 'Getting it right', requires public bodies to act in accordance with the law 'and with regard to the rights of those concerned'. On the balance of the evidence regarding the measures in place at the relevant time, I am satisfied that the Trust did not meet this standard and I consider the failings constitute maladministration. I find the lack of specific governance structure remarkable in the context of the use of public funds, and the involvement of the most vulnerable members of society. I therefore **uphold** this element of the complaint. I find that had there been an appropriate governance structure in place at the time of the resident's placement, quality issues pertaining to Dunmurry Manor may have been brought to prominence sooner. I am therefore satisfied that as a result of these failings, the complainant suffers the injustice of frustration.

142. While concerned about the length of time that it took for the Trust to put in place the necessary steps to underpin the statutory duty contained in the 2003 Order, I am pleased to note that following the Governance Review, which was preceded by Home Truths, the Trust has implemented many changes to the governance framework around the area of quality in care homes. I note that the arrangements for reporting incidents were already in place at the time of the Governance Review report, albeit on a trial basis. I also note that the new structure consists of a dedicated governance team who centrally collate and examine reports made by key workers in relation to quality issues. This team reports upwards through the Trust via a monthly independent sector meeting and a quarterly Governance forum. The findings of Governance Review and changes recommended indicate that reform of this area was clearly required, and is a further indication that the system in place prior to 2018 was not satisfactory. I am particularly pleased to note that the Trust now has in place its own escalation procedure, outwith the RQIA's inspection timetable. I consider that this a positive step as the Trust is better placed to respond to issues of quality in a timelier manner. However, the CPEA Report would indicate that more can be done in terms of the definition of when a concern is related to quality. I await with interest the outcome of the CPEA review in its totality.

143. The CM in this case also informed the investigation that quality monitoring was carried out on an ongoing basis through telephone conversations and visits to the setting. Such issues are recorded within a resident's records. I reviewed the resident's records in this case and have not found evidence that the quality of care was monitored on an ongoing basis. I accept that when issues were raised, the CM gave consideration to them, and in consultation with Dunmurry Manor staff, attempted to resolve such issues either by an amendment to the care plan or by putting additional measures in place. However, I consider that in order to fulfil the requirement to monitor quality on an ongoing basis (and not ad hoc when issues are presented) the Trust ought to have practices in place to record the proactive and ongoing consideration of quality. I make an observation that had there been such practices in place, the Trust may have been already aware of issues about the correct reporting of incidents, prior to the contract review meeting.

144. I consider that the lack of records in relation to the consideration of the quality of care provided to the resident is contrary to the Third Principle of Good Administration, 'being open and accountable', in particular by keeping good records. I consider the failure to keep such records constitutes maladministration and caused the complainant to suffer the injustice of uncertainty regarding actions taken by the Trust to monitor the quality of care provided to her mother on an ongoing basis. I find that the quality of care provided was an issue in this case given the concerns raised by the Consultant Psychiatrist to the safeguarding team[20]. I therefore **uphold** this element of the complaint. In this regard, I commend to the Trust the 'Records Matter' publication jointly issued by this Office, in conjunction with the NIAO and the Information Commissioners Office (ICO) as a valuable resource for all staff.

CONCLUSION

145. The complainant submitted a complaint to my office about the social care the Trust provided to her late mother in the preparation and management of her transfer

[20] See appendix four

to Dunmurry Manor, and in fulfilling its obligation to ensure the placement met her late mother's needs.

146. The investigation found no failings in relation to the following issues raised by the complainant:

- The Trust ought to have informed the complainant regarding concerns about Dunmurry Manor (paragraph 53);
- Family involvement in the pre-admission assessment (paragraph 50), and
- The Trust's planning of the resident's care (paragraph 75).

147. The investigation found the following failures amounted to maladministration:

- Failure to provide the required information to the complainant regarding care home placements at the appropriate time (paragraph 49);
- Failure to provide appropriate rationale for the decision to 'screen out' the safeguarding referrals (paragraph 110);
- Failure to have an adequate governance structure in place in relation to the monitoring of quality in care homes (paragraph 141), and
- Failure to keep an appropriate record of the monitoring of quality of care in care homes (paragraph 144).

148. I am satisfied that as a result of these failings, the complainant sustained the injustice of loss of opportunity, uncertainty and frustration.

149. The investigation found failures in the social care provided to the resident as follows:

- Failure to take reasonable steps in gathering information prior to taking a screening decision (paragraph 113)

150. I am satisfied that as a result of these failings, the resident and complainant sustained the injustice of loss of opportunity in having the safeguarding concern fully considered by the Trust.

151. I also made a number of observations in my consideration of this complaint:

- Trust to reflect on the appropriateness of keeping measures put in place following a safeguarding concern, under specific review
- Trust to reflect on the drafting of reasons cited for screening out of adult safeguarding reports
- Trust to reflect on the roles of Trust staff in reviewing measures put in place to mitigate risks to residents following safeguarding referrals
- Trust to consider whether this was an appropriate forum to discuss the concern, with other people present in the room

Recommendations

152. I make the following recommendations:

- The Chief Executive of the Trust provide 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 maladministration/failures identified (within **one month** of the date of my final report)

153. I consider there were a number of lessons to be learned which provide the Trust with an opportunity to improve its services:

- I recommend that the Trust carry out a random sample audit of social care files of residents transitioning to permanent placements, commissioned by the Trust, within the last 3 years. The audit should consider whether residents/families were provided with information to assist them with this difficult transition. The Trust should take action to rectify any identified trends or shortcomings and advise me of the outcome of the audit.

- I am pleased to note that the Trust provided recent training to staff within the safeguarding team regarding the screening process and the importance of recording the rationale for a decision, reflecting the appropriate guidance and standards. I recommend the Trust provide me with evidence of the training provided between December 2018 and December 2019, together with its strategy to keep these training topics refreshed.

- I recommend that the Trust provide me with documentary evidence of the internal audit carried out by the Adult Safeguarding Specialist, and the recommendations which the Trust said are included in the CPEA report.

- I recommend that the Trust provide meeting minutes of last two meetings related to the monthly sector meeting and quarterly governance forum.

- I recommend that the Trust consider the inclusion of specific quality consideration at care review meetings.

- I recommend that the Trust provide updated basic evidence gathering training to safeguarding staff. I welcome that the Trust has committed to bringing this suggestion forward to the regional Adult Safeguarding Change Programme.

154. I recommend that the Trust implements an action plan to incorporate these recommendations and should provide me with an update **within three 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). In the event of any of the above recommendations conflicting with those of 'Home Truths' or the CPEA Report, the Trust should communicate this to my Office.

Observation

Taking the decision to move a family member into residential care particularly where the person has lost capacity and their views cannot be sought is a very difficult process for a family. I would encourage Trusts to ensure that families are given as much support and information as possible during this process. While individuals involved in health and social care may be aware of the roles performed by the various staff members involved, this may not be the case for many families.

Where during a placement a family have concerns about the quality or safety of care, safeguarding or a complaint it is imperative that information is available so that families are aware of the role of various organisations and therefore who they should approach. There is a need for clear information that helps families get to the right

place for their concerns to be dealt with quickly and effectively. This would assist with providing the reassurance that families need when they entrust the care of a much loved family member to others. From my experience of dealing with complaints in this area, clarity and agreement on the roles of the various organisations involved is necessary and should be made available.

MARGARET KELLY
Ombudsman **March 2021**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.

- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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

APPENDIX TWO

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being Customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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