Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Northern Health and Social Care Trust

NIPSO Reference: 21518

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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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SUMMARY

I received a complaint about emergency respite care in a nursing home (NH) sourced by the Trust for the resident, who is the complainant's mother. The resident has Alzheimer's disease and tended to wander round the NH and seek to exit. Her Care Plan stated that the resident could not be left alone due to her level of disorientation and high level of care required and that she would be at risk if outside alone.

There were five incidents recorded over an eight-day period, two when she entered another room, one when she was located on the stairs and two when she exited the building through the fire door. She also sustained injuries in the nursing home, including extensive bruising, which the Trust could not explain. The complainant was not satisfied that a Safeguarding Investigation carried out by the Trust adequately addressed the cause of these injuries.

In issue one I found that the Trust key worker (SW) took adequate steps to determine that the NH was suitable for the resident's needs.

In relation to issue two I considered that the SW took appropriate action to ensure that the NH remained suitable for the resident's changing needs.

Issue three investigated *w*hether the Adult Safeguarding investigation was carried out in accordance with Trust policy and procedures. I considered the Trust broadly followed policy and processes when commencing the investigation. However, I found that the investigation report provided no insight into how the resident was able to walk about inside the home unaccompanied, and to exit the NH by the fire door despite the clear statement in the existing Trust care plan that she could not be left alone due to the level of disorientation and high level of care required.

I noted that it was unclear from the records whether this was a joint Safeguarding investigation with the PSNI or a single agency PSNI investigation. This is a failing in record keeping.

I considered that these failings caused the complainant to experience the injustice of

uncertainty and distress regarding the cause of the bruising that was identified when the resident left the NH. I upheld this element of issue three of this complaint and recommended that the Trust provides the complainant with a written apology.

I also recommended that the 'Methodology' and 'Recommendations and Action Planning' sections of the Trust investigation report and strategy discussion minutes should contain more detail about the scope of the investigative process, evidence gathering, the next steps and the timescales.

The Trust accepted the findings and recommendations.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) regarding emergency respite care sourced by the Trust for the resident. The resident is the mother of the complainant. The complainant stated that the resident sustained injuries in the Nursing Home (the NH). She was not satisfied that a Safeguarding Investigation carried out by the Trust addressed the cause of these injuries. The remedy the complainant is seeking is an investigation into her issues of complaint.

Background

2. The complainant's mother was aged 71 in December 2018. She had dementia and her husband was her main carer. He required periods of respite care for his wife. The social work records on 20 December 2018 record that her husband sought a three-week break over the Christmas period. The Social Worker (SW) tried a number of nursing homes to find one appropriate for the resident's needs. It became clear on 21 December 2018 that the resident required a home suitable for residents living with dementia. The NH had a room available and the resident's husband agreed to this placement. The resident moved in the following day, 22 December 2018.

3. As part of its investigation, the Trust reviewed the records from the NH. These demonstrate that the resident was mobile and prone to wandering while in the NH. The resident entered the room of another resident at 23.20 on 22 December 2018. Staff found her on the floor of a different resident's room at 01.45 on 23 December 2018. The following day, 24 December 2018, staff discovered her in the car park at 13.20. I note that the GP called on 24 December 2018 and requested a urine sample. The GP prescribed Diazepam medication of 2mg twice a day short term for agitation. I note that staff found the resident going up the stairs at 19.00 on 27 December 2018. On 29 December, the urine sample provided on 24 December 2018 demonstrated a likely infection and the GP prescribed antibiotic medication.

4. On 29 December 2018, the resident exited through the fire exit again, and her

family made the decision to remove her from the NH. On 31 December 2018, when the resident's package of care at home resumed, a care worker observed a number of bruises on the resident's body. The SW made an urgent referral to the District Nurse to carry out a skin assessment and body mapping. Following an assessment by the District Nurse, the Trust instigated an Adult Protection Investigation.

Issues of complaint

5. The issues of complaint accepted for investigation were:

Issue one: Whether the SW took adequate steps to determine that (the NH) was suitable for the resident's needs?

Issue two: Whether the SW took appropriate action to ensure that the NH remained suitable for the resident's changing needs?
(This will include who is accountable for making sure she got 1:1 care)

Issue three: Whether the Safeguarding investigation was carried out in accordance with Trust policy and procedures?

(This will include the steps taken by the Trust to establish how she sustained her injuries)

INVESTIGATION METHODOLOGY

6. This investigation relates to the actions of the Trust. In this report, I will refer to the Police Service of Northern Ireland (PSNI) and the NH where appropriate; however, these bodies are not the subject of this complaint. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice (IPA) Sought

7. After further consideration of the issues, I obtained IPA from an independent social work advisor (ISWA), a qualified social worker with experience across a range of disciplines including adult services and elderly care

   I enclosed the IPA received at Appendix three to this report.

8. I included the information and advice that informed the findings and conclusions within the body of this report. The ISWA provided 'advice'; however how I weigh this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

   The general standards are the Ombudsman's Principles[1]:

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

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

    The specific standards and guidance relevant to this complaint are:

    - **Northern Ireland Social Care Council The Standards of Conduct and Practice for Social Workers (the NISCC standards);**

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

- **Mental Health and Older People Services Procedure for Request and Management of a Bespoke Care Package (the Bespoke Protocol);**
- **The Northern Health and Social Care Trust Placement Policy: Nursing Home and Residential Accommodation [NHSCT/09/105 (2008)] (the Placement Policy); and**
- **Adult Safeguarding Operational Procedures; Adults at Risk of Harm and Adults in Need of Protection 20 April 2017 (the Safeguarding Procedures)**
- **The Northern Ireland Adult Safeguarding Partnership Protocol for Joint Investigation of Adult Safeguarding Cases August 2016**

11. In investigating a complaint of maladministration, my role is concerned primarily with an examination of the administrative actions of the Trust. It is not my role to question the merits of a discretionary decision taken unless that decision was attended by maladministration.

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

13. 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.

THE INVESTIGATION

Issue one: **Whether the SW took adequate steps to determine that (the NH) was suitable for the resident's needs?**

Detail of Complaint

14. The resident's husband asked the SW to source emergency respite care at very short notice. Some Private Nursing Homes were excluded because of stairs or staff issues, others because they could not provide Dementia care support.

15. Following a number of incidents when staff found the resident wandering unattended both inside and outside the home and sustained significant bruising, the complainant questioned whether the NH was a suitable placement for her mother.

Evidence Considered

Legislation/Policies/Guidance

16. I considered the Trust's Placement Policy that relates primarily to long-term placements. It states '*Accommodation must be registered (RQIA)*[2] *and must be able to meet the assessed needs of the client.'*

The Trust's response to investigation enquiries

17. The Trust explained*:*
'Care Home placements are sourced through the NHSCT 'Brokerage' system. This is a live register of all available care homes, which practitioners will use to determine availability. The 'Brokerage' system contains details of the category of care that a Care Home is registered with. This enables practitioners to make an initial scope of whether they may be in a position to meet the needs of a service user. For example, it would be a requirement that a Care Home would have 'DE' registration to meet the needs of service users with dementia.

[2] The Regulation and Quality Improvement Authority

A preadmission assessment is completed by the Care Home (in this instance the NH). A copy of this assessment is not held by practitioners in NHSCT. The preadmission assessment was completed by [the NH] on 21 December 2018, which concluded that [the resident] met the criteria for acceptance to the Care Home.

Approval for the placement in [the NH] was agreed verbally by the Community Mental Health Team for Older People Team Leader as the placement was arranged in an emergency situation. The usual process would be that the Named Worker would provide information in writing via a Specialist Summary. However, there is no evidence that this was completed in this case. The most recent Specialist Summary was approved on 8 November 2018, prior to [the resident's] pre-arranged period of respite in [another care home].

18. The Investigating Officer asked the Trust how the SW determined that the NH would be able to deliver the level of care detailed in the Care plan dated 23 November 2018. The Trust replied:

'.., the determination of how [the NH] would deliver care to [the resident] was taken through a preadmission assessment by The NH and also through an assurance that the Care Home had the requisite RQIA registration status to meet the needs of a particular service user group; in the case of the resident, a Care Home with nursing registration for service users with dementia. When the resident was admitted to the Care Home on 21 December 2018, there was no indication that Bespoke 1:1 care was required…Information about the resident's current presentation was sought from the resident's family, GP and staff in the Day Time Therapy Unit. In light of the information gained from those above, a decision was made that due to the resident's presentation, a Dementia Nursing unit would be required, rather than a Dementia Residential unit as was initially thought would be required. This decision making is evidenced in the running records dated 20 December 2018.

Relevant Trust records

Care plan dated 23 November 2018

19. I note the SW scanned the existing Trust care plan to the NH on 21 December 2018, prior to the resident arriving. It is recorded that this care plan was written on 17 August 2018 and updated on 23 November 2018. It records that the resident required assistance by one person for personal care, toileting and transfers. She walked with a rollator and had a history of falls. The care plan also recommended an alert mat. The final section of the care plan 'deprivation of liberty' states:
'[The resident] requires the protection within a safe environment. [The resident] cannot be left alone due to level of disorientation and high level of care required. [The resident] lacks insight into her condition and would be at risk if outside alone. [The resident] lacks capacity to make informed choices and decisions need to be taken in her best interest.'

The SW 'Running Record' 20 December 2018

20. The running record commencing 20 December 2018 notes that the resident was '*unsettled, not sleeping, has an infection, Family not managing and requesting support'*. The SW spoke to the resident's husband who *'presented as very stressed and demanded a 3 week short break.'*

21. This record details that the SW contacted a number of nursing homes by telephone on 20 December 2018 to discuss suitability and availability. She recorded that the resident's husband declined one proposal due to distance. The SW sourced a preferred nursing home but this nursing home subsequently declined due to unexpected staffing difficulties. Others were unsuitable because of stairs. The record shows that the SW sourced a bed at the NH on 20 December 2018. The complainant was informed.

22. The notes record that the SW spoke to the NH Nurse Manager on 21 December 2018 and explained that the resident had an infection with increased confusion. The Nurse Manager agreed to complete the required preadmission forms and advise the SW of the outcome. The Nurse Manager agreed that she

was happy to accept the resident for a short break commencing 22 December 2018. The SW record documents:
'Advised the [Nurse Manager] [the resident] still being treated for infection requiring assistance of 1-2 when mobilising. Agreed admission tomorrow 22.12.18. Family to be informed.'
The SW telephoned the resident's husband and advised him *'the room is downstairs and care home has a key pad to access at front of building.'*

Relevant IPA from the ISWA

23. The Investigating Officer asked the ISWA if the correct procedure was followed to source a nursing home suitable for the resident's needs. He advised:
'The NHSCT Brokerage system outlines availability of beds in care homes in the Trust area. This is viewed as an efficient way of tracking bed availability. This is updated twice weekly.
There is no specific note of the Brokerage System being used to identify availability of homes which could meet the residents' needs. However, the Running Record (notes made by the Social Worker and recorded in the resident's file) refers to an 'Availability Search' (20.12.2020) being implemented'…
Evidence of monitoring by the line manager is noted in the file where the Team Leader co-signs the Request for Bespoke/Bespoke Funding document dated 24.12.2018.

24. The Investigating Officer asked the ISWA if the Trust placement policy was followed. He advised:
'The Northern Health and Social Care Trust Placement Policy: Nursing Home and Residential Accommodation [NHSCT/09/105 (2008)] outlines the key criteria for Trust staff to follow when identifying and placing clients in permanent or temporary residential care. This covers choice, suitability, and registration of any proposed residential placement. The Social Worker followed the policy guidelines. However, circumstances should be noted regarding this particular placement as follows:

Choice

Families are at the core of choosing residential care for their loved ones where the individual lacks the capacity to decide this for themselves. Choice was limited in this case by several circumstances including:

- *The residents needs and the limited number of homes which could support those with Dementia;*
- *The emergency nature of identification of a suitable placement at very short notice;*
- *Family agreement/need (e.g. distance for visiting purposes); and*
- *Various homes staffing arrangements/circumstances particularly as this was the Christmas Holiday period'.*

25. The Trust stated that practitioners in the Trust do not hold a copy of the preadmission assessment completed by the NH. The ISWA was asked if this practice met the required standard. He advised:
*'The preadmission assessment is carried out by and is the responsibility of the care home. In effect this document assesses if the home can meet the potential resident's needs. This assessment is based on the information provided by Social Services and will focus on both physical and mental health issues as well as any circumstances relating to the individual which need to inform the focus and level of care. There is no need for the Trust to hold this information in their files if this has been verified in discussion between the Home and the Trust. There is information in the files that this assessment was carried out. For example, the Trusts internal 'Request for Bespoke Funding/Bespoke Funding' document dated 24.12.18 states that "*Vacancy search was completed and assx (assessment) completed by the manager of the NH completed on 21.12.18 and agreed by Community Mental Health Team for Older People and The Manager of the Home that the NH could meet her (the resident's) assessed needs".

26. The Trust stated that '*approval for the placement in The NH was agreed verbally by the Community Mental Health Team for Older People Team Leader as the placement was arranged in an emergency. The usual process would be that the Named Worker would provide information in writing via a Specialist Summary. However, there is no evidence that this was completed in this case'.*

The Investigating Officer asked the ISWA to advise if it was a failing that the SW did not complete a Specialist Summary in these circumstances. He advised:

'It should be noted that this was an emergency placement. The priority was to ensure that the changing needs of both the resident's husband and the resident were met. Failure to do so would have created a crisis in their lives and placed both vulnerable people in unacceptable levels of danger to their wellbeing. There is an entry in the Social Work notes section that this was agreed verbally. It should be further noted that this crisis presented at the beginning of the Christmas Holiday period when regular services and processes would be less accessible'.

27. The Investigating Officer asked the ISWA how suitable he thought the NH was for this resident. He advised:

'The process for seeking and identifying is detailed in the Trust's Placement Policy: Nursing Home and Residential Accommodation NHSCT/09/105 (2008). The NH met the overall criteria of support for a Dementia placement and was the most suitable placement available within the Placement Policy. Suitability was further assessed by the Home's Pre Admission Assessment which confirmed to the Social Worker that the resident's needs could be met.'

Analysis and Findings

28. The complainant's mother was aged 71. She had dementia. Her husband was her main carer. He stated that he was not coping well and required a period of respite care for his wife. The Trust agreed a three-week break commencing 22 December 2018.

29. The Trust outlined the procedure the SW followed using the Trust 'Brokerage' system, which is a register of all available care homes and the category of care they are registered with. The SW tried a number of care homes on the register to find one suitable. She ruled out several for reasons such as the need to use stairs, staff shortage due to sickness absence and the distance from home.

30. It became clear on 21 December 2018 that the patient had become more confused and unsteady, probably due to an infection, and that she required a home that could deliver nursing care as well as residential care for residents with dementia. The Trust explained that the NH had a 'DE' registration, which meant it could meet the nursing needs of service users with dementia.

31. The existing care plan was sent electronically to the NH on 21 December 2018 This stated: *'The resident cannot be left alone due to level of disorientation and high level of care required. The resident lacks insight into her condition and would be at risk if outside alone.'* The care plan also recommended the use of an alert mat under the bed.

32. The SW informed the NH Nurse Manager that the GP was treating the resident for infection and required assistance of one to two people when mobilising. The Nurse Manager completed the required preadmission forms and agreed that she was happy to accept the resident for a short break commencing 22 December 2018. The SW established that the available room was downstairs and there was a key pad to access the door at the front of building. The resident's husband agreed to this admission. I am satisfied that the SW effectively communicated to the NH the resident's needs through several telephone conversations as well as the Trust Care plan which was provided to the NH .

33. The Trust stated that normally the SW would provide information in writing to the Community Mental Health Team for Older People Team via a Specialist Summary but this was not completed in this case due to the urgency of finding an emergency placement. I note that the Trust's internal 'Request for Bespoke Funding/Bespoke Funding' document dated 24 December 2012 states that the vacancy search was completed and the assessment completed by the manager of the NH on 21 December 2108. It records that the Community Mental Health Team for Older People and the Manager of the Home agreed that the NH could meet the resident's assessed needs.

34. I accept the advice of the ISWA that, based on the discussions and documentation recorded, *'The NH met the overall criteria of support for a Dementia placement and was the most suitable placement available within the Placement Policy. Suitability was further assessed by the Home's Pre Admission Assessment which confirmed to the Social Worker that the resident's needs could be met.'*

35. I also accept the ISWA advice that:
'It should be noted that this was an emergency placement. The priority was to ensure that the changing needs of both the resident's husband and the resident were met. Failure to do so would have created a crisis in their lives and placed both vulnerable people in unacceptable levels of danger to their wellbeing.'
It is evident from the 'Running notes' that immediately on receipt of information from the resident's husband the SW made a concerted effort to secure a suitable placement. I am also satisfied that the SW followed the correct procedures to secure this placement for the resident in difficult circumstances. I do not consider that the absence of the 'specialist summary' constitutes maladministration as the decision for the placement and its rationale is well documented and it was important that the referral was expedited. I do not uphold this issue of complaint.

Issue two: Whether the SW took appropriate action to ensure that the NH remained suitable for the resident's changing needs?
(This will include who is accountable for making sure she got 1:1 care)

Detail of Complaint

36. The NH records record that the resident entered the room of another resident at 23.20 on 22 December 2018.

37. Staff found her on the floor of a different resident's room at 01.45 on 23 December 2018. Body mapping and observations identified bruising to her left arm, a scrape on the side of her neck, and blood in her left earlobe. Staff placed a pressure mat under the mattress at 03.20 to alert staff if the patient got out of bed again.

38. The following day, 24 December 2018, staff discovered her in the car park at 13.20. After the NH contacted the complainant to advise her of these incidents, she contacted the SW on 24 December 2018 to express concerns for her mother's safety.

39. The GP also called to see the resident on 24 December. He diagnosed a suspected infection. The GP increased Diazepam medication to 2mg twice a day, short term, for agitation.

40. Staff found the resident ascending the stairs on 27 December 2018 and escorted her back to her room.

41. The resident exited the fire door again on 29 December 2018 and staff brought her back inside. Also on 29 December 2018, a urine sample provided on 24 December 2018 demonstrated a likely infection and the GP prescribed antibiotic medication.

42. The complainant took the resident home on 29 December 2018 because she was not satisfied that the NH could guarantee her safety. Her home carer noticed multiple bruising on the evening of 29 December 2018. The SW asked a District nurse to carry out a mapping exercise on 31 December 2018. She

counted 25 bruises. The complainant wanted an investigation to be carried out to find out how these injuries were caused. I note that, following this assessment by the District Nurse, the Trust instigated an Adult Protection Investigation.

Background

43. The Social work team did not become aware of the incidents described until contacted by the resident's husband and the complainant on 24 December 2018. The SW immediately contacted the NH and subsequently spoke to the Nurse Manager. The Nurse Manager discussed her concerns with the SW that 1-1 supervision was necessary. The SW subsequently applied to the Locality manager for bespoke 1-1 funding for 25 December and 26 December 2018.

44. The SW made the request for 1-1 bespoke care to the Locality Manager on the afternoon of 24 December 2018. The stated aim is '*to provide socialisation, implement distraction techniques whilst engaging [the resident] in purposeful activity. To maximise safety whilst upholding her Human Rights – to support current placement while [the resident] is recovering from an infection, which has impacted on her behaviours. Aim is for bespoke short term to allow for antibiotics and change in meds to take effect*'.

45. The Trust's consideration of the need for bespoke care in the NH includes the *'alternative is to move her to placement with secure doors, in a location further away from family which impacts both her right to Liberty and Right to family life… It is acknowledged that the presence of a bespoke service itself does impact upon [the resident's] Human Rights, however this is deemed proportionate and the least restrictive option.'*

46. The Locality Manager approved funding for six hours on 25 and 26 December 2018 with a review scheduled for 27 December 2018. The SW invited the complainant and the resident's husband to attend the review.

47. The NH was unable to recruit staff to resource the bespoke care. I note there were no incidents on these days. However, staff found the resident going up

the stairs on 28 December 2018 and exiting the unit via the fire exit on 29 December 2018. I note that the NH provided the accident report forms for each of the incidents to the Trust. I included these at appendix eight.

Evidence Considered

Legislation/Policies/Guidance

48. I considered the terms of the Bespoke Protocol (appendix four). One of the stated aims is to **'***Attempt to prevent breakdown in current care arrangements.'* The Protocol states '*Bespoke funding can only be provided on a temporary basis, therefore, a request for funding should be based on a rationale that the funding will cease following further assessment of risk.'*

49. In relation to responsibility for sourcing the additional resource, the protocol states:
'On approval of the bespoke support it is the responsibility of the ***Primary Care Provider*** *eg Care Home or Day Care setting to procure and invoice the Trust for any additional staff required to deliver the bespoke support. Several days of bespoke support would allow time for investigation or treatment of physical factors (e.g. infection or pain). Therefore, could potentially prevent an avoidable hospital admission, readmission or transfer.'*

The Trust's response to investigation enquiries

50. In response to enquiries about care planning, the Trust responded:
'During short periods of respite care, a care home will work to the care plan provided by the Trust. However, if there are instances when there have been significant changes to the care plan during the period of respite care, a Care Home may update the care plan to reflect these changes.'

51. In relation to the Bespoke Care, the Trust explained:
'The Bespoke Protocol outlines the requirement for the Care Provider to source the Bespoke worker …NHSCT were aware on 24 December 2018 that the NH

were experiencing challenges to engage a worker. A contingency plan of contact with Dalriada Urgent Care, should the situation remain untenable, was advised...

As part of the Bespoke procedure there is an expectation that this is reviewed regularly. In the case of the resident, it was agreed a review would be completed on 27 December 2018. During review, as the resident was not displaying any behaviours linked to the reason for the Bespoke, it was agreed that it would be stood down.

No further investigation was completed to determine the reason why the Bespoke was not sourced. Given it was the Christmas period, there was an acceptance that The NH had made every effort to source the worker but were unsuccessful.'

Relevant Trust's records

The SW Running Records

52. It is recorded on 24 December 2018 that the SW Team leader took a call from the resident's husband who '*presented in a distressed and angry manner'* as a result of the incidents that had occurred. He '*stated that in his opinion the Home staff had not provided the level of care and supervision that his wife required.'*

53. It is recorded that the SW took a call from the complainant, also on the morning of 24 December 2018, who was *'very upset*' and '*concerned about her mother's safety in the NH'.* The SW telephoned the NH Nurse Manager who *'expressed concern regarding potential for the resident to exit the unit via the fire exit'* and requested a bespoke service.

54. The record on 24 December 2018 shows that the SW discussed the Nurse Manager's request for bespoke care with her team leader and that they jointly completed the funding request before discussing and agreeing the arrangement with the Locality Manager. The Locality Manager '*requested completion of behaviour charts, fluid and dietary monitoring and completion of care review by the named worker on 27.12.18.'* The team leader recorded that she contacted the NH to inform them of this.

55. The next entry is dated 27 December 2018 and relates to the Community Mental Health Team for Older People Review 27 December 2018 (see appendix 14).
The SW recorded that the resident's husband called to inform her that he and the complainant would not be attending the review because they were unwell. The SW '*explained the importance of the review taking place given incidents that occurred.'*

56. The records show that the complainant visited the resident on 27 December 2018 immediately after the review took place and subsequently spoke to a duty SW on the phone to express concern about her care.

57. The notes show that the SW called the resident's husband on 27 December 2018 and recorded that he was '*keen for the resident to return home as he feels he will be able to manage after the short break in the NH. He stated he would like to consider permanent placement for future'.* The record shows that the resident's name was added to the waiting lists of two local care homes with her husband's consent.

58. The SW telephoned the complainant on 28 December 2018 to discuss the concerns the complainant had expressed to the duty SW the previous day. It is recorded that she was '*outraged at what she discovered*'. The complainant informed the SW she had submitted a written complaint to the NH and had contacted the RQIA. The SW agreed to the complainant's request for a move to another named nursing home. Unfortunately, when contacted that nursing home did not have a vacancy. The SW secured a placement at a different care home but the complainant rejected it because it was too far from home.

59. On the afternoon of 28 December 2018, the Team Leader recorded a conversation with the NH Nurse Manager who informed her that she had now sourced bespoke care for the resident. The record states:
'*On basis of discussion with [the locality manager] and given lack of behavioural charts and any further recurrence of exit seeking behaviour by [the resident], I advised [the Nurse Manager] that the Trust would not be in*

agreement to fund the bespoke. I reiterated that the bespoke had only been agreed for over Christmas and not ongoing, given no recurrence of exit seeking behaviours.
The Nurse Manager advised that "the family are here" and confirmed that she was going to let them know that the bespoke was not going ahead.'

60. The NH called the SW on 28 December 2018 to inform her that the resident '*was discovered going up stairs and was assisted back down.'*

61. The next records are dated 31 December 2018 when a District Nurse rang the SW to report that the resident had multiple bruising. The team leader spoke to the Nurse Manager who explained that the resident had exited the building again on 29 December 2018. When informed, her family came to take the resident back home. The Nurse Manager stated '*the main issues highlighted by the [complainant] were the fall and bruising her mother sustained.'*

Community Mental Health Team for Older People (CMHTOP) Review 27 December 2018

62. I included extracts from the CMHTOP Review 27 December 2018 at appendix 14.

Regional Emergency Social Work Service (RESWS)

63. I included extracts from the RESWS at appendix 15.

The IPA from the ISWA

64. The Investigating Officer asked the ISWA if, once a placement is agreed, the SW has any ongoing responsibility to ensure it remains appropriate. He advised:
'The Social Worker has responsibility to ensure the safety and care of those on their caseload regardless of their circumstances or location until such time as this is transferred. This may include transferring the case to other more

appropriate care management within the Trust as circumstances change. (For example, if an individual is admitted to hospital it might be appropriate to transfer the case to a hospital Social Worker)'. He also advised:
'It is the responsibility of the Home to ensure that they have both the staffing and equipment to meet the needs of those in their care or who are assessed as needing care'.

65. The Investigating Officer asked the ISWA about communication between the NH and the SW about the incidents on 22 and 23 December 2018. He advised: once the SW became aware of the incidents on 22 and 23 December 2018, she '*spoke with the home and practical steps were put in place to monitor the resident more closely such as a bed sensor mat and closer supervision.'*

66. The Investigating Officer asked the ISWA if the Trust followed the Bespoke Protocol for 1-1 care. He advised that '*An appropriate application was made via the Trust Bespoke Protocol for further support'.*

67. The Investigating Officer asked the ISWA if the resident should have been moved to a care home that could resource the 1-1 care she needed that the NH could not provide on 25 and 26 December 2018. He advised:
'As 1:1 care had been identified for the resident it would be appropriate to ensure that this is provided to ensure her continued health and wellbeing in a facility which could provide this. However, several factors need to be considered in how best to meet this identified need. These include:
The resident's emotional and physical health and how a move to another home might affect her.'

68. The Investigating Officer asked the ISWA to comment on how the Trust considered the resident's Human Rights. He advised:
'The Trust acknowledges that the bespoke package did impact on the resident's rights but that the decisions made were deemed proportionate and the least restrictive option. This appears to indicate a consideration of Human Rights which balanced with addressing the resident's needs.

It is further noted that the Trust indicates that part of the decision making process was guided by the consideration to allow the resident to remain in the Home because a location further away from the family would impact on "her Right to Liberty and Right to Family life".'

69. The Investigating Officer asked the ISWA's opinion on the review of 27 December 2018. He advised:
'As the resident had settled and was presenting no concerns, this was the current situation and her instances of falling had disappeared. It appeared that changes in medication had addressed this concern. Therefore, the right decision at this stage was to deem 1:1 was no longer an identified need.
The review covered the salient issues and concerns regarding the resident's circumstances, health, and wellbeing. A falls risk assessment would have been unlikely to have provided any further information not already available to inform decision making about the resident's care. There is a contingency plan provided to the Dalriada Unit who provide out of hours services. In The resident's case this detailed key information which could be followed up by contact with key contacts listed in the document. As such it provided adequate information to address contingencies which might arise.'

Analysis and Findings

70. My consideration of issue one determined that the Trust SW took adequate steps to determine that the NH was suitable for the resident's needs. The NH was provided with a care plan dated 23 November 2108 that stated:
'[The resident] requires the protection within a safe environment. [The resident] cannot be left alone due to level of disorientation and high level of care required. [The resident] lacks insight into her condition and would be at risk if outside alone.'

71. I note that the resident entered the room of another resident on 22 December 2018 at 11.20. The accident report records that a member of staff observed her and immediately removed her back to her own room. Just over two hours later, staff found her injured on the floor of another room. Later that day, at 13.20, she exited through the fire door, which is alarmed. The family informed the SW

of these incidents on 24 December 2018.

72. The SW established that the NH placed a pressure mat under the resident's bed following the fall on 23 December 2018 to mitigate the risk of her getting up during the night unsupervised. However, the NH was concerned about the resident's exiting the NH through the fire door and sought additional funding to resource additional staff to provide the resident with greater supervision. The SW acted quickly to provide funding for six hours on each of Christmas day and Boxing Day, with a review arranged for 27 December 2018. The SW asked the NH to complete behaviour charts as well as fluid and dietary monitoring charts during the period of bespoke care. I consider that these actions were appropriate and timely measures to mitigate the risk of harm to the resident.

73. In relation to responsibility for sourcing the additional resource, the protocol states:
*'On approval of the bespoke support it is the responsibility of the **Primary Care Provider** eg Care Home or Day Care setting to procure and invoice the Trust for any additional staff required to deliver the bespoke support. Several days of bespoke support would allow time for investigation or treatment of physical factors (e.g. infection or pain). Therefore, could potentially prevent an avoidable hospital admission, readmission or transfer.'*

74. I accept the advice of the ISWA that *'It is the responsibility of the Home to ensure that they have both the staffing and equipment to meet the needs of those in their care or who are assessed as needing care'.*
This complaint concerns the actions of the Trust not the NH. However, I note the NH was unable to source staff to provide the bespoke care on 25 and 26 December 2018, which is understandable, in view of the short notice and the Christmas period. I consider, for the same reasons, that the Trust's ability to move the resident to another NH was not a practical option at that time. I note that the SW tried to source another nursing home but was unable to do so at that time. I welcome the fact that the SW provided a contingency plan to the Dalriada Unit who were to provide out of hours services in the event of any further injuries. I note that the NH recorded no incidents during this period;

therefore, there is no evidence that the resident suffered any harm as a result of the absence of bespoke 1:1 care on 25 and 26 December 2018.

75. I accept the advice of the ISWA that
'As 1:1 care had been identified for the resident it would be appropriate to ensure that this is provided to ensure her continued health and wellbeing in a facility which could provide this. However, several factors need to be considered in how best to meet this identified need. These include the resident's emotional and physical health and how a move to another home might affect her.'

76. The Bespoke Protocol states '*Bespoke funding can only be provided on a temporary basis, therefore, a request for funding should be based on a rationale that the funding will cease following further assessment of risk.'* In line with the terms of the protocol, the SW scheduled a review for 27 December 2018.

77. The SW completed a 'Community Mental health team for Older People Review' on 27 December 2018. The family was unable to attend this review. The SW found the resident was more settled and, in her opinion, no longer requiring 1.1. The SW noted that Chair and bed sensor alarms were in place.

78. I accept the advice of the ISWA that
'As the resident had settled and was presenting no concerns this was the current situation and her instances of falling had disappeared. It appeared that changes in medication had addressed this concern. Therefore, the right decision at this stage was to deem 1:1 was no longer an identified need.'

79. The complainant visited the resident on 27 December 2018 after the review had taken place and contacted the SW to express concerns about her mother's care. It is unfortunate that the complainant was not able to attend the review, which would have been an appropriate forum to address any concerns. The SW was not available on 27 December 2018 but telephoned the complainant the next day and discussed the findings of the review with her and her issues of

complaint. The SW agreed to the complainant's request to contact a preferred care home to arrange a transfer, but that care home did not have a vacancy. The SW offered another placement but the complainant rejected this as it was too far from home. I consider that the SW listened to the complainant and acted upon her concerns promptly and in accordance with the NISCC standards of conduct. The record shows that she acted appropriately to address the resident's needs and to respect the wishes of the complainant and her father and I do not uphold this issue of complaint.

80. Unfortunately, the resident exited the fire door again on the morning of 29 December 2018 but staff quickly returned her to the home and I am pleased to note she suffered no harm. However, this resulted in the complainant removing the resident from the home that afternoon and the commencement of a safeguarding investigation. I considered this in issue three below. I believe that this complaint demonstrates the fine balance of addressing the resident's needs while respecting her Human Rights, particularly the Right to Liberty.

Issue three: Whether the Safeguarding investigation was carried out in accordance with Trust policy and procedures?
(This will include the steps taken by the Trust to establish how the resident sustained her injuries)

Detail of Complaint

81. The Adult Safeguarding Investigation closed on 9 August 2019. The complainant contacted the Trust on 12 and 13 September 2019 to state that she was dissatisfied with the outcome. The Trust asked an experienced Adult Safeguarding Practitioner who was not involved in the investigation to review the process. The Trust wrote to the complainant on 18 September 2019 to advise her of this. The Trust wrote to the complainant again on 23 October 2019 to inform her that the independent Adult Safeguarding Practitioner *'accepted the findings of the original process'* and that the Safeguarding review had concluded.

82. The complainant said that the Safeguarding process '*found some recommendations and action points'* but believed there were issues outstanding. The Director of Investigations informed the complainant which of these issues were outside the scope of this investigation and the rationale for that decision. The focus of this investigation is the steps taken by the Trust to establish how the resident sustained her injuries.

Evidence Considered

Legislation/Policies/Guidance

83. I considered the Protocol for Joint Investigation of Adult Safeguarding Cases August 2016 which '*aims to provide a framework within which the HSC Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm/abuse constitutes a potential crime'.*

84. I also considered section 11.5 of the Safeguarding Procedures which states:
    - Agree the most appropriate way of responding to the concerns identified, e.g. Single agency PSNI investigation; Single agency HSC Trust investigation; Joint Protocol investigation; disciplinary investigation; family group conference; care planning; risk management meeting; or formal complaint in order to create and implement a protection plan. The detailed rationale for this decision must be recorded and will be subject to audit.
    - Where a decision has been made that an investigation will take place, agree an investigation plan to include timescales for same and how it should be conducted and by whom.
    - Agree a clear rationale for the actions to be undertaken and by whom.

85. The ISWA referred to extracts of the Safeguarding Procedures (section 12.2) as follows:
    'The investigation should take the form of an assessment of risk and needs. This will inform the review and updating of the interim protection plan…Provide an investigation report for case conference/review. This report must include an

analysis of the findings and a conclusion and recommendations….The investigation report must reach conclusions on the balance of probability, determining whether harm occurred.'

GP record 24 December 2018 and 29 December 2018

86. As part of the investigation, the Trust obtained received a letter dated 28 February 2019 from the resident's GP. This is included at appendix nine. The NH staff did not inform the GP on 24 December 2018 that the resident had fallen.

NH records

87. As part of the investigation, the Trust obtained copies of the accident report forms from the NH (Appendix eight). These are summarised below:
    i. 22 Dec 18 23.20, last observed 23.15. The resident was seen going in to another resident's room and removed.
    ii. 23 Dec 18 01.45, last observed 1.20. The resident was recovered on the floor of another room and was injured. Water was spilled and a bedside table overturned. All lights were off and the door was closed.
    iii. 23 Dec 18 13.30 (last observed not completed). The resident exited the fire door, ran along the side of the building and was found in the car park.
    iv. 27 Dec 18 7.00 (last observed not completed). The resident was found halfway up stairs. She was brought upstairs and back down in the lift.
    v. 29 Dec 18 10.50, last observed 10.40. The resident opened the fire door and went outside.

Trust Care plan dated 23 November 2018

88. See paragraph 19 for details.

Relevant Trust's records

89. The Trust provided records relating to the Adult Safeguarding Investigation.

90. I note that a District Nursing Sister (DNS) completed a Regional Adult

Protection Procedures Referral/Screening Information form (APP1) on 31 December 2018. This followed an urgent referral from the SW following a report from the resident's care assistant (HCA) who reported bruising on discharge from the NH. The DNS and the HCA visited the resident and carried out body mapping at 16.10 on 31 December 2018. The form and body mapping were shared with the Designated Adult Protection Officer (DAPO) on 3 January 2019. The DAPO asked the SW team leader to arrange for the CPN to visit the NH to view records.

91. The SW team leader's 'running record' records a discussion with the complainant on 7 January 2019 seeking an update on the investigation. She expressed her concern that the investigation would not reveal the '*truth'* about how the bruises were caused. The records show that the resident's husband telephoned on 11 January 2019 expressing similar concerns.

92. The Trust provided the minutes of the strategy/case discussion meeting (APP5) on 17 January 2019 (amended on 31 January 2019 at a case review). I attach this at appendix ten. Those in attendance at the meeting were the DAPO, the SW, the SW team leader, the Community Psychiatric nurse (CPN) who undertook the investigation, the manager of the NH, a minute taker and the complainant.

93. The minutes record that the CPN had visited the NH *'and pulled information from their daily notes'* detailing the significant events from 22 December 2018 to 31 December 2018. The minutes also record concerns from the complainant about matters other than the bruising, including the adequacy of the body mapping and recording of reasons for administration of medication. The minutes record ten action points under the heading 'Revised Care Plan' to address the complainant's concerns. It is recorded that the NH manager *'apologised to [the complainant] for not getting things right in her mother's case'.*

94. I considered the Adult Protection Report on the Investigation (APP7) dated 17 January 2019 (appendix 11)**.** The Investigating team comprised the SW, the

SW team leader, the DAPO and the CPN. The Investigation Methodology section of the report consisted of a summary of the significant events collated by the CPN from the NH records. I note that the guidance for what to include in the methodology section states:
'How were the concerns investigated? Include details of any capacity/consent issues, interviews conducted, documentation reviewed, outcome of JP/PSNI investigations etc.'

95. The 'Lessons learned' section of the APP7 recorded:
- *'GPs to be fully informed if a resident falls and may have personal injuries so the individual can be physically examined*
- *Care home staff to respond timely to door alarms and assistive technology to reduce the risk of falls and exit seeking behaviours.*
- *Care Plans to include use of assistive technologies.*'

The investigation was noted to be "ongoing".

96. A Detective Sergeant (DS) assigned to the case completed a Joint Protocol – Adult Protection (AJP1) form on 31 January 2019. This records that concerns were first reported to the PSNI on 30 December 2018 by the complainant. The AJP1 records '*caller advised that unless we have something to suggest there is anything criminal ongoing police would not get involved… caller advised it can be recorded for information at present.'*

97. It is recorded that the DAPO contacted the DS on 27 January 2018. They agreed that a joint investigation would take place '*to establish that either abuse has or has not occurred'.*

98. A case review was carried out on 31 January 2019 by the DAPO who concluded that she '*was referring the case back to the PSNI for investigation under single protocol'.*

99. In response to enquiries, the Trust stated:
'It is evident from records that this investigation remained open under joint protocol – whilst there may have been a thinking from DAPO on 31.1.19 that it

may be under single investigation it is evident it remained as joint' and 'the APP5's 13.3.19 and 9.8.19 evidence the investigations completed'.

100. The Trust provided the Strategy discussion minutes (APP5) from a meeting on 13 March 2019 (appendix 13) which was described as '*structured to manage discussion of all the queries raised'* by the complainant. The complainant attended. The minutes record discussion about her concerns about Medication, falls, Communication, Reporting and Body maps and bruising. I note that the APP5 of 13 March 2019 states that the PSNI representative *was 'in attendance to gather information as he is conducting his own investigation for the PSNI on behalf of the family'.*
Under 'Other Actions' it is noted that *'the case is still open under joint protocol with the PSNI'.*

101. The minutes of 13 March 2019 record the involvement of the RQIA as follows: '*RQIA do not undertake investigations but, as part of the most recent care inspection of the NH, the Falls Procedure was reviewed. RQIA identified some deficits in the Procedure which should be considered as part of a policy review. This included:*
    - *A lack of guidance for nursing staff to ensure that a care plan is devised for the management of those patients deemed at risk of falls;*
    - *Guidance for staff on the management of a suspected or confirmed head injury, including the completion of Central Nervous (CNS) observations; and*
    - *Guidance for staff on the reporting of notifiable events to RQIA.'*

    The minutes record that RQIA would follow this up.

102. The Trust's records contain an email from the complainant dated 21 May 2019 which stated that the complainant had many unanswered questions, including: *'How long did my mum lie on the floor? Why did my mum get out twice and found in the car park? Why was my mum upstairs unattended, why when my mum was discovered on the floor with blood to her ear, neck feet and shoulder scrapes and a table overturned, water spilled!!!! Did nobody get my mum a doctor and when the doctor came the following day did no one tell her about my*

mum's bruising. As discussed my mum came out of this home with a total of 27 bruises, we don't know why.'

103. The Trust provided a record of a meeting on 30 May 2019 attended by the DAPO, the TL, the Locality manager and the complainant to discuss these concerns. They discussed and agreed the minutes of the previous strategy meeting. The record concluded '*at the conclusion of the PSNI investigation the Trust may have further enquiries to complete'.*

104. The Trust provided the minutes of a strategy meeting on 9 August 2018 (Appendix 5). The complainant attended. The PSNI representative did not attend. They record that the PSNI met with the Trust on 24 July 2019 and concluded 'no criminal intent was found so the case was closed by them. The DAPO '*could not give [the complainant] a definite opinion on why all the bruising happened' and 'recommended that the case would close under Adult Safeguarding'* (appendix 12)**.**

Relevant IPA from the ISWA (appendix three)

105. The Investigating Officer asked the ISWA whether the Trust carried out the Safeguarding investigation in accordance with Trust policy and procedures. He advised:
'A Regional Adult Protection Procedure (APP1) referral was implemented by the Trust on 31.12.18. This was carried out by a professional Trust based Health Care Assistant (HCA). It detailed extensive bruising to her body including her hips, legs arms and shoulders. The HCA accompanied by a District Nurse completed a body mapping exercise detailing the resident's injuries.'
'The key processes for addressing the particular circumstances of this case were carried out by The Trust. These included:
- *Informing the family and the GP of the circumstances;*
- *Informing the PSNI of the incident; and*
- *Informing RQIA of the investigation.*

A Designated Adult Protection Officer (DAPO) was appointed by the Trust to lead on this safeguarding investigation. The Investigation was to be carried out by the resident's named Social Worker. This reflects adherence to the procedures and policies contained in the Adult Safeguarding Operational Procedures.'

106. The mapping exercise carried out on 31 December 2018 recorded 25 bruises. The Investigating Officer asked the ISWA if the Safeguarding investigation dealt adequately with the likely cause of these bruises. He advised that the Adult Protection Report on The Investigation (APP7) dated 17.1.19 did not address why the resident fell:
'The mapping exercise was noted and attached to the report. There was little analysis or commentary in the report. There is no evaluation of the information or assessment of the assumption that the resident's injuries were accidental.'

107. The ISWA also advised:
'Concerns about medication were investigated and there was no evidence that the resident was overmedicated. This is noted in The Trust's Strategy/Case Discussion Minutes 17.1.19. This part of the investigation was carried out by a Community Psychiatric Nurse who also reviewed the medication process for other residents with Dementia and noted no concerns. The GP had prescribed Diazepam 'as and when needed'...
The investigation gives detail on bruising, lack of supervision leading to absconding and falls. It gives no analysis of this information.'

108. The Investigating Officer asked the ISWA if the Safeguarding Investigation addressed why instructions in the care plan were not followed. He advised that **'***The Adult Protection Report dated 17.1.19 gives no explanation for this. This should have been addressed as part of the Investigation.'* In relation to steps taken from 27 December 2018 to prevent further falls, the ISWA advised that the report recorded ***'****a chair and a bed sensor alarm were being used as a safeguard at this point'.*

109. The ISWA was asked if the Safeguarding Investigation reached a satisfactory conclusion about whether harm occurred. He advised:
'The Safeguarding information given does note that harm occurred on more than one occasion. It does not give any detail as to why this might have occurred and reach any conclusions as to whether this was one or a combination of accidental injury , neglect, poor management of the resident's needs or might have been deliberate.'
'There is little detail in the report which indicates what lessons were learned regarding the incidents surrounding the resident's care. Some note is made of changes to practice, for example, better use of technology, better information given to the GP and better response from the Home staff. None of these reflect any consideration as to guidelines regarding access to suitable homes in emergencies, timely investigation as to incidents that have occurred and how these can be avoided in the future for other potentially vulnerable adults.
The Safeguarding Procedures were followed, and all appropriate interested parties were identified and included in the investigation process. However, evidence gathering methodology was not identified and key staff in the home were not interviewed. Consideration of the facts/evidence identified was not robust and lacked detailed assessment and presented no analysis'.

110. The ISWA also advised:
'The Investigation is taken to have been closed at a Strategy Case Discussion meeting chaired by the Designated Adult Protection Office on 01.02 2019. The minutes from this meeting relate to a brief discussion which gives no interpretation of the limited information provided. It concludes that The Designated Adult Protection Officer "closed the meeting and advised that she was referring the case back to the PSNI for investigation under single protocol" No reason or rationale for this decision is noted in the minutes.'

Analysis and Findings

111. The Trust care plan was scanned to the NH on 21 December 2018, prior to the resident's arriving the following day. This care plan originally dated 17 August 2018 was updated on 23 November 2018. It was prepared in relation to a

previous period of respite care. It recorded that the resident required assistance by one person for personal care, toileting and transfers. She walked with a rollator and had a history of falls. The care plan recommended an Alert mat. The care plan states *'[The resident] requires the protection within a safe environment. [The resident] cannot be left alone due to level of disorientation and high level of care required. [The resident] lacks insight into her condition and would be at risk if outside alone.'* I would therefore expect that an Adult Safeguarding review would consider to what extent this level of care was delivered and if appropriate, the reasons why it was not delivered. I accept the advice of the ISWA that:
'The Safeguarding information given does note that harm occurred on more than one occasion. It does not give any detail as to why this might have occurred and reach any conclusions as to whether this was one or a combination of accidental injury, neglect, poor management of the resident's needs or might have been deliberate.'

112. I note that a District Nursing Sister (DNS) completed a Regional Adult Protection Procedures Referral/Screening Information form (APP1) on 31 December 2018. She visited the resident and carried out body mapping. On 3 January 2019 she shared the form and body mapping with the DAPO who instructed the CPN to visit the NH to view records. I therefore consider that Adult Safeguarding policy and Procedure was instigated promptly on receipt of the report from the resident's care assistant (HCA) about the resident's bruising.

113. The minutes of the strategy/case discussion meeting (APP5) on 17 January 2019 record that the CPN obtained information from the NH detailing the significant events from 22 December 2018 to 31 December 2018. I welcome the learning in the minutes which record ten action points to address in the revised care plan. These include the use of a sensor mat and ensuring that the resident will have no access to stairs.

114. I also considered the 'Lessons learned' section of the APP7 dated 17 January 2019:
    - *'GPs to be fully informed if a resident falls and may have personal injuries*

so the individual can be physically examined

- *Care home staff to respond timely to door alarms and assistive technology to reduce the risk of falls and exit seeking behaviours.*
- *Care Plans to include use of assistive technologies.*'

The investigation was noted to be "ongoing".

I consider these initiatives represented good practice in relation to future care planning. However, I accept the ISWA advice that there was scope for further learning such as '*consideration as to guidelines regarding access to suitable homes in emergencies'.*

115. I note that the Trust and the complainant informed the PSNI of the complaint and the PSNI and the DAPO agreed that a joint investigation would take place '*to establish that either abuse has or has not occurred'.* A case review was carried out on 31 January 2019 by the DAPO who concluded that she '*was referring the case back to the PSNI for investigation under single protocol'.*

116. However, I note that the Strategy discussion minutes from a meeting on 13 March 2019 recorded that *'the case is still open under joint protocol with the PSNI'.* The Trust subsequently confirmed to my Investigating Officer that the investigation remained open under joint protocol. I note that a PSNI representative attended the meeting on 13 March 2019. The minutes state '*The PSNI is carrying out its own investigation …Following investigation the case will be reviewed by Supervising Sergeant and Inspector.'*

117. The Trust stated that *'the APP5's 13.3.19 and 9.8.19 evidence the investigations completed'* under the Joint Protocol however the minutes of 13 March 2019 state that the PSNI was '*carrying out its own investigation'.*
I received no further records evidencing the joint investigation after 13 March 2019. A PSNI representative did not attend the meeting on 9 August 2019. I therefore consider that the records are unclear as to whether this was a joint investigation with the PSNI or a single investigation by the PSNI. A detailed rationale for the decision ought to have been recorded in line with the Safeguarding Procedures (see the extracts in paragraph 84).

118. Principle three of the Principles of Good Administration, 'Being open and accountable' includes 'giving reasons for decisions' and 'keeping proper and appropriate records.' I find that this poor record keeping amounts to maladministration.

119. The SW records state that the PSNI case closed having identified insufficient evidence of deliberate intent to harm. The criminal burden of proof is 'beyond all reasonable doubt'; however, the test for the Adult Safeguarding is 'on the balance of probability'. Therefore, the purpose of the PSNI investigation differs from that of the Trust's investigation into the family's complaint. The Trust has not shared with me the PSNI rationale for closing the case. However, I did not consider that the PSNI's decision to close the case because of lack of evidence precluded the Trust's continuing with elements of the investigation, under either Adult Safeguarding or the Trust's Complaints procedures, as requested by the complainant.

120. The complainant emailed the Trust on 21 May 2019 with several unanswered questions, including:
'How long did my mum lie on the floor? Why did my mum get out twice and found in the car park? Why was my mum upstairs unattended, why when my mum was discovered on the floor with blood to her ear, neck feet and shoulder scrapes and a table overturned, water spilled!!!! Did nobody get my mum a doctor and when the doctor came the following day did no one tell her about my mum's bruising. As discussed my mum came out of this home with a total of 27 bruises, we don't know why.'

121. The Trust arranged a meeting on 30 May 2019 to discuss these concerns. The record concluded '*at the conclusion of the PSNI investigation the Trust may have further enquiries to complete'.* I note that this meeting did not address the concerns raised by the complainant on 21 May 2019, preferring to rely on the outcome of the PSNI investigation alone. I am critical of the Trust that these issues raised by the complainant, which were very important to her, were never fully investigated. I would have expected questions such as how quickly NH staff responded to the fire exit door and bed sensor mat alarms.

122. I established that staffing issues prevented bespoke one to one care being delivered on 25 and 26 December 2018. There was no record that any incidents occurred during this period. However, I note that neither the SW review on 27 December 2018 nor the Adult Safeguarding Investigation report of 17 January 2018 mentions staffing levels as a contributory factor or an issue requiring further investigation.

123. I note that the minutes of a Strategy meeting on 9 August 2018 record that the PSNI met with the Trust on 24 July 2019 and concluded '*no criminal intent was found so the case was closed by them'.* The DAPO also recommended that the case would close under Adult Safeguarding. The minutes record that the '*Trust does not have all the answers as to where [the resident's] bruising happened'.* I accept the advice of the ISWA that:
'Evidence gathering methodology was not identified and key staff in the home were not interviewed. Consideration of the facts/evidence identified was not robust and lacked detailed assessment and presented no analysis'. I am critical that while the Trust identified what happened and when it happened, a more robust investigation was not carried out to identify why it happened.

124. The 'Adult Safeguarding Operational Procedures; Adults at Risk of Harm and Adults in Need of Protection' states **'***The investigation report must reach conclusions on the balance of probability, determining whether harm occurred.'* The Trust stated that further enquiries may be made after the conclusion of the PSNI investigation. The Trust did not provide evidence of any further enquiries made to address the outstanding concerns articulated in the complainant's email of 21 May 2019.

125. I therefore determine that the Trust carried out the Safeguarding investigation broadly in accordance with Trust policy and procedures. However, the investigation was not sufficiently thorough to establish how the resident was able to wander alone and how she sustained the extensive bruising identified by the body mapping. Principle six of the Principles of Good Administration is 'Seeking Continuous Improvement'. This includes '*ensuring that the public body*

learns lessons from complaints and uses these to improve services and performance'. It is a failing that the complainant was left with so many unanswered questions. This caused her the injustice of distress regarding the cause of her mother's injuries.

126. I therefore partially uphold this issue of complaint.

CONCLUSION

127. I received a complaint about a period of emergency respite care sourced by the Trust in December 2018 for the resident. The actions of the NH are outside the scope of this investigation.

128. I did not find any failings in relation to issue one 'Whether the Trust SW took adequate steps to determine that the NH was suitable for the resident's needs?'

129. I did not find any failings in relation to issue two 'Whether the SW took appropriate action to ensure that the NH remained suitable for the resident's changing needs?'

130. In relation to issue three, 'Whether the Safeguarding investigation was carried out in accordance with Trust policy and procedures?' I considered that the Trust broadly followed policy and processes when commencing the investigation. I welcomed the recommendations made to improve the resident's care plan for her future benefit. However, I was concerned that the investigation report provided no insight into how the resident was able to walk about inside the home unaccompanied and to exit the home by the fire door, despite the clear statement in the existing Trust care plan that she could not be left alone due to the level of disorientation and high level of care required.

131. I noted that there are mitigating factors in this case. Those listed by the ISWA about the difficulty finding a suitable placement include:

- *The resident's needs and the limited number of homes which could support those with Dementia;*

- *The emergency nature of identification of a suitable placement at very short notice;*
- *Family agreement/need (e.g. distance for visiting purposes); and*
- *Various homes staffing arrangements/circumstances particularly as this was the Christmas Holiday period'.*

132. I noted that it was unclear from the records whether this was a joint investigation with the PSNI or a single PSNI investigation. This was a failing in record keeping.

133. I considered that these failings caused the complainant to experience the injustice of distress and uncertainty regarding the cause of the bruising that was identified by the Care worker on her mother's body on the day she left the NH and subsequently by the body mapping completed by the DNS on 31 December 2018.

Recommendations

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

135. I further recommend for service improvement and to prevent future recurrence that the 'Investigation methodology' section of the APP7 includes greater detail in order to reflect the Trust guidance which states:
'How were the concerns investigated? Include details of any capacity/consent issues, interviews conducted, documentation reviewed, outcome of JP/PSNI investigations etc.'
This additional information would provide clarity on the scope and sufficiency of the investigative process and help the investigative team to identify whether further enquiries are necessary as part of evidence gathering.

136. I also recommend that the 'Recommendations and Action Planning' section of the APP7 is fully completed to indicate the next steps in the investigative

process and the timescales.

137. 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 this report. The action plan should detail how the Trust has communicated the learning from this complaint to staff carrying out Adult Safeguarding investigations. The Trust should support the action plan with evidence to confirm that appropriate action has been taken including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms that indicate that staff have read and understood any related policies.

Margaret Kelly **July 2021**
Ombudsman

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.