Investigation Report

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

NIPSO Reference: 16874

Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

Publication date: March 2018

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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

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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EXECUTIVE SUMMARY

1. I received a complaint relating to the care and treatment provided to the complainant's late father in Somerton Private Nursing Home, Belfast during October 2014.

2. In considering this complaint I decided to investigate how the Belfast Health and Social Care Trust (the Trust) dealt with the complaint to it on the same subject.

3. I have completed my investigation into the complaint against the Home and issued my report under the reference 17159.

4. I have not made a finding of maladministration against the Trust in its handling of the complaint. I consider that the Trust dealt with the complaint appropriately.

THE COMPLAINT

5. The issue of complaint which I decided to investigate was:

- Did the Trust handle the complaint appropriately?

INVESTIGATION METHODOLOGY

6. In my investigation of this complaint, the Investigating Officer obtained from the Home all relevant documentation, including the resident's medical records. The Investigating Officer also obtained medical records from the Trust together with its complaints file.

7. I have not included 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 has been taken into account in reaching my findings. The complainant and the Home were both given the opportunity to see and comment on a draft of this report before the final version was issued.

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[1]:

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

These are set out in full in the Appendices to this report.

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

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

9. The specific standard and reference relevant to the issue in this complaint is:

- Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning (April 2009, updated October 2013) (the HSC complaints procedure). This is the only complaints handling procedure in Northern Ireland that has a statutory basis.

MY INVESTIGATION

The complaint

10. I received a complaint about the care and treatment provided to the complainant's late father by the Home following a fall there in October 2014. The complainant was also dissatisfied with how the Trust handled her complaint about the Home. Her complaint was supported by her local MLA.

Evidence considered

11. I have considered the relevant standards for complaints handling outlined in the HSC complaints procedure. I have also considered documentation from the Trust's complaints file and related correspondence. I refer to the following extract from the HSC complaints procedure which is relevant to this case:

'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning (*the standard****)***

Paragraph 3.38 – 'A response must be sent to the complainant within 20 working days of the complaint, or where that is not possible, the complainant must be advised of the delay'.'

Letter dated 11 March 2015 to the complainant from the Trust– '*I am writing to advise you that the Trust has commenced a complex Safeguarding Investigation into Somerton Nursing Home. We will have to await the completion of this Safeguarding investigation before we can continue the investigation of your complaint……..*'

Background to the Complaint

12. The complainant's late father was 82 at the time of the complaint. He had a history of numerous recurrent falls, vascular dementia, a previous stroke and ischaemic heart disease.

13. He had been in hospital a number of times throughout 2014, and had been in Belfast City Hospital during September 2014 following a fall at home and delirium. He was unable to return home after discharge from hospital and was admitted to the Home in October 2014. On his third day in the Home he suffered a fall at approximately 03.35 and sustained a bump to the left hand side of his forehead measuring approximately 2 inches in diameter. The night nurse on duty contacted the out of hours doctor (Beldoc) who advised that he be monitored. He stayed in the nursing home day room where he was observed and remained there until 05.00 when he went to bed.

14. The following morning, day staff were concerned by his condition and noted the bump now measured 9cm by 4cm. They contacted Beldoc again and the doctor requested that an ambulance be called. A non-emergency ambulance arrived at 13.00 to take him to hospital.

15. He was admitted through A&E and had a CT scan. However 24 hour neurological observations were normal and he was due to be discharged. Unfortunately he aspirated vomit and commenced an antibiotic treatment, staying in the hospital until he was eventually discharged to a new nursing home in early December 2014. From here he was again admitted to hospital with abdominal pain and aspiration pneumonia three weeks later. His condition deteriorated and sadly he died in early January 2015.

Analysis and findings

16. The complainant made a complaint to the Home in relation to its care and treatment of her late father three days after his fall in October 2014 and received a letter of response dated the same day. This is well within the standard time for response. She remained dissatisfied with the Home's response and complained to the Trust by letter dated 20 February 2015. The Trust carried out an investigation and provided a comprehensive response on 21 May 2015.

17. I have examined the Trust complaints file and note that the commencement of the Trust's investigation into the complaint was delayed until a parallel investigation by the Trust on a separate issue into the Home was completed. The Trust stated that an anonymous letter had been received by the Regulation and Quality Improvement Authority (RQIA) concerning the Home which had been referred to the Trust's Adult Safeguarding Team. The concerns raised in the anonymous letter were unrelated to the experience of the complainants' father. However, the Trust stated that it did not wish to compromise the investigation by its Adult Safeguarding team with another by its Quality and Support team. The Trust decided that the safeguarding investigation was to take primacy. I note that the complainant was informed of this delay in a letter dated 11 March 2015. As it was, the Adult Safeguarding Team found no evidence to substantiate the allegations made in the anonymous letter and its investigation concluded in early April 2015. RQIA also carried out an unannounced inspection. The Quality and Support team then conducted its investigation and responded to the complainant on 21 May 2015.

18. At paragraph 11 of this report I note, under the relevant standard, that a response must be sent to the complainant within 20 days of receipt of the complaint and where this is not possible the complainant must be advised of the delay. The complainant was advised of the delay by letter of 11 March 2015 and her complaint was responded to on 21 May 2015, which is clearly outside the 20 day timeframe referred to. However, I consider the standards outlined in the HSC procedure were met. I fully accept that there may be circumstances when complaints handling timescales may need to be exceeded and in this case, given the ongoing complex

investigation, I consider it reasonable that it was felt necessary to conclude that investigation before considering the complaint. **I do not find maladministration in relation to the time taken by the Trust to respond to this complaint.**

19. I note that the investigation relating to the complaint was conducted by three members of the Trust's staff. The Assistant Services Manager for Commissioned Services led the investigation assisted by a clinical nurse coordinator and a quality coordinator. The investigation consisted of reviewing the Home's nursing notes and assessments, obtaining and reviewing documentation relating to telephone calls and advice received from the Trust out of hours service (Beldoc). The Investigating Panel interviewed staff. There was also a recorded meeting with the Home manager and a review of national guidelines concerning the treatment of head injuries. I note that Trust staff met with the Home manager on 7 May 2015 to discuss good practice in relation to neurological observations and provided literature regarding this to be displayed on the staff noticeboard. I have considered the response from the Trust to the complainant dated 21 May 2015 and having studied its contents, I am satisfied that the Trust did provide a reasonable level of detail in its response and that clinical questions raised by the complainant about the care provided to her father was given.

20. The Trust's letter of 21 May 2015 concluded by stating that if the complainant had any further concerns, she could contact the Trust which would facilitate a meeting with the Home. The complainant telephoned the Trust on 29 May 2015 to take up that offer of a meeting. There then followed a protracted period of time during which the precise issues the complainant wished to discuss were obtained by the Trust and unsuccessful attempts were made to arrange a suitable time to meet the complainant and her sister. The meeting was to include the Home manager and Trust staff. I am satisfied that genuine efforts to arrange an earlier meeting did take place but that this did not prove possible. The meeting was eventually held on 21 October 2015 and the complainants' issues of concern were discussed. The Trust issued the minutes of the meeting on 13 November 2015 and referred the complainant to my Office if she remained dissatisfied with its response. I have considered the progress of this complaint through the Trust's complaints process. I have also considered the detail of the meeting and the Trust's correspondence with the complainant. I am satisfied that her complaint was properly addressed and that

genuine efforts were made by the Trust to resolve her concerns as required by the HSC complaints procedure which is aimed at providing 'an opportunity for the complainant and the organisation to attempt a prompt and fair resolution of the complaint'. The detail and level of response the complainant received together with the meeting facilitated by the Trust and held with senior managers from the Trust and the Home manager reflects in my view a concerted attempt to resolve her concerns. Having investigated the complaint about the care and treatment provided to her late father by the home, I am satisfied that the Trust's response to the complainants' allegations about the Home was comprehensive and accurate. **I find no maladministration by the Trust in its handling of this complaint. I commend the Trust for the comprehensive nature of this investigation.**

CONCLUSION

21. I have investigated the complainants' concerns about how the Trust handled her complaint regarding the actions of the Home. Following my detailed investigation I make no findings of maladministration and overall I consider that that the Trust conducted the investigation into the complaint appropriately and thoroughly and its actions in attempting to resolve the issue met the standards of the HSC complaints procedure.

MARIE ANDERSON
Ombudsman

March 2018

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.