Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against

Domnall Care Home

NIPSO Reference: 17241

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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.

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY

1. I received a complaint regarding the actions of Domnall Care Home, Belfast (Domnall). The complaint related to the care and treatment received by the late mother of one of the complainants during the period 10 September to 21 October 2013 while resident in Domnall. The patient died in April 2014 aged 84 in the Ulster Hospital Dundonald.

Issues of Complaint

2. I accepted the following issues of complaint for investigation:

- Whether the care and treatment provided to the patient in Domnall was reasonable and appropriate

3. The complaint was also about the care and treatment the patient received while a patient with the South Eastern Health and Social Care Trust (SHSCT - Case reference 14634) and regarding the actions of the Belfast Health and Social Care Trust (BHSCT, Case reference 16708). I have investigated and reported on these complaints under the respective case numbers.

Findings and Conclusion

4. I have investigated the complaints against Domnall. I have found there to have been a failure in the care and treatment received by the patient in relation to:

i. A failure to meet fluid target levels (Paragraph 68)
ii. A failure on two occasions (17 September 2013 and 17/18 October 2013 to take earlier action to arrange for the patient's transfer to hospital (Paragraphs 101 and 102)

I have found maladministration in relation to

i. A failure with regard to record keeping concerning toileting needs (Paragraph 66)

I am satisfied that the failure in care and treatment and maladministration caused the patient to experience injustice. I am also satisfied that these failings would have

caused the complainants to experience the injustice of anxiety and distress.
In recognition of the failures in the care and treatment and for the maladministration identified I recommend that the complainants receive an apology from Domnall together with a payment, in solatium, for £500.

I also recommend, by way of service improvement that Domnall introduce a system whereby a record for those residents on special diets, is maintained of the food offered and the amounts consumed and instances when personal care is refused. I also recommend that, if not already in place, a system be introduced to record the toileting needs of residents including a care plan assessing urinary or bowel needs as highlighted by the nursing IPA at paragraph 66 of this report. Domnall should provide me with an update with regard to these recommendations within 3 months of the receipt of this report.

THE COMPLAINT

5. The main issue of complaint was in relation to the care and treatment received by the patient, while resident at Domnall from 10 September 2013 until 21 October 2013.

6. The patient suffered from long standing poorly controlled type 2 diabetes and hypertension, and was in receipt of regular dialysis therapy. She underwent a below knee amputation of her left leg in August 2013 in the Royal Victoria Hospital, Belfast, due to diabetic vascular disease. She was transferred to the Ulster Hospital, Dundonald (UHD) and subsequently discharged from there to Domnall on 10 September 2013. She was assessed at the neurovascular clinic on 20 September 2013 following a presumed TIA (Transient Ischaemic Attack) and she subsequently suffered a stroke in mid-October 2013. Following this stroke, the patient was readmitted to UHD on 21 October 2013 where she remained until she passed away in April 2014 at the age of 84. During this period of time she received dialysis, usually for 3 days per week, in the Renal Unit of UHD.

Issue of complaint

7. The issue of complaint which I accepted for investigation was:

- Whether the care and treatment provided to the patient in Domnall from 10 September 2013 until 21 October 2013 was reasonable and appropriate

8. The complainants provided a comprehensive and extensive narrative of the care and treatment which the patient received in Domnall and raised numerous individual points and questions which they considered should be answered during the course of this investigation. I also note that no formal complaint was made to Domnall regarding the care the patient received during the period 10 September 2013 to 21 October 2013. The first letter of complaint to Domnall from the complainants was dated 21 April 2014, six months after the patient was readmitted to UHD and following her death. I refer to Article 30(6) of the above Act which states that 'the procedure for conducting an investigation is to be such as the Ombudsman considers appropriate in the circumstances of the case'. Accordingly, it is for me to

determine the significance of the various elements in a complaint. Neither a complainant nor those complained of can have the final decision in relation to the specific questions which are to be addressed, the manner and extent of the investigation, or be involved in determining my conclusions. Consequently, I determined that the investigation would focus on the overall reasonableness of the care and treatment received by the patient covering the broad areas of concern raised by the complainants rather than the multiple individual queries which were raised. Additionally with regard to my findings and conclusions, I noted that aspects of the complaint, covering many areas of care in Domnall, related to the content of conversations which occurred with members of Domnall staff. At this stage, I should inform the complainants of my difficulty in coming to conclusions based on a version of an unrecorded or undocumented discussion. Generally without objective corroboration, I am unable to make a definitive judgement as to what exactly was said during the course of conversations.

9. I determined that the investigation would consider the issues of complaint under the following general headings;

- Diet
- Personal Care
- Dressing of Wound
- Toileting
- Pressure Sores
- Constipation
- Stroke Care
- Management

INVESTIGATION METHODOLOGY

10. In order to investigate this complaint, the Investigating Officer obtained from Domnall all relevant clinical documentation together with Domnall's complaints file. Domnall also provided written responses to investigation queries.

Independent Professional Advice Sought

After further consideration of the issue of complaint, I obtained independent professional advice from independent professional advisors (IPA's) covering the following clinical areas:

Nursing – A Consultant Nurse for older people in a NHS Trust. She has clinical experience across acute care and care homes including expertise in caring for frail older people with complex needs.

Diet –Senior Dietitian, MNutr (Master of Nutrition 2010). She is a specialist dietitian with experience managing both adult and pediatric patients providing a range of oral, enteral and parenteral nutrition support and therapeutic diets.

I received clinical advice to inform my investigation of this complaint.

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

Relevant Standards

12. 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.

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

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

The specific standards are those which applied at the time the events occurred and

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

which governed the exercise of the administrative and professional judgement functions of those organisations and individuals whose actions are the subject of this complaint.

14. The specific standards relevant to this complaint are:

- www.medicines.org.uk/emc/medicine/28134#Clinical-Precautions
- NMC Code of Conduct 2008
- www.nhs.uk/act fast/pages/know-the-signs
- //pathways.nice.org.uk/pathways/stroke

Relevant extracts of these documents are referenced in this report.

15. 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 considered to be relevant and important has been taken into account in reaching my findings.

INVESTIGATION

16. The main issues of complaint centred around the care and treatment received by the patient at Domnall on a number of subjects. These are considered at numbers 1 – 8 under the following headings

1. Diet

Detail of Complaint

17. The complainants stated that Domnall continued to supply the patient with an incorrect diet even after notification of the correct dietary advice from dieticians and the family to the detriment of her wellbeing.

Evidence Considered

18. I noted the following Domnall documentation:

Document titled 'Dietary recommendations for [patient]' – dated 11 September 2013 from the UHD Renal Dietitian. There was a handwritten note at the bottom of this document dated 14 September 2013 stating 'copy given kitchen staff'

Document titled 'Diet Requirements' – An undated document stated 'Special Diet' and had the word 'Diabetic' circled. There was also a hand written notation stating 'Type 2 diabetic, low potassium diet'.

Resident Progress Report – Dated 13 September 2013, stated 'received call from renal unit while [patient] is there, advising to be very strict with the fluid restriction 500ml to 700ml. Also advised us not to give juices or Coke during the night if her BM is low, as she is in fluid restriction……'

Trust Dietary Record – While a resident at Domnall, the patient remained under the care of the SHSCT Renal Dietitians. As such records continued to be made by the Trust regarding her dietary requirements.
11 September 2013 – 'transferred to Domnall Intermediate care Home. Contacted Staff Nurse…Explained diet advice sheet and fluid allowance….sent list in post…'
12 September 2013 – '….Domnall phoned. Explained principles of diet. She reports patient's appetite small…'
20 September 2013 – Renal Unit. Pt requesting to s/w (speak with) renal dietitian. Appetite 'brilliant' enjoying food @ Domnall eating full meals.'

Domnall's Response

19. With regard to diet on discharge from UHD, Domnall stated that it received notification that the patient was on a diabetic diet with a fluid restriction of 700ml over 24 hours. The patient's daughter then provided to Domnall a copy of the diet sheet used at home and this was supplemented with information supplied by the Trust dietitian. Domnall stated that the only concern raised regarding diet was a call from the renal unit at UHD on 13 September 2013. This was to ask staff to ensure that a strict fluid restriction was maintained and that coke/juice should not be given to the patient should blood sugars be low during the night.

20. In responding to a request for records relating to the patient's diet, Domnall supplied a copy of its electronic records (the resident touch report) showing food and fluid given to the patient. However it was unable to locate paper food record charts detailing how much of any meal that the patient ate or what she specifically ate.

Dietitian IPA and Domnall's response to IPA

21. The Dietitian IPA was asked to comment on whether the diet provided to the patient whilst she was a resident in Domnall Care Home was correct, reasonable and appropriate, given her medical condition. The Dietitian IPA advised that there were limited records within the electronic 'Resident Touch Report' entries, however she did note that 'porridge' is regularly documented as being taken for breakfast. Other than this, the Dietitian could see one entry detailing wheaten bread being taken on 12 September 2013 and a small number of other foods detailed including sandwiches, diabetic custard and yogurt.

22. The Dietitian IPA advised that wheaten bread and yogurts were unsuitable for the patient, as outlined in the dietary advice sheets provided by the dietitian (due to their potassium content). Orange juice is also documented throughout the electronic patient records as being taken. However, this is sometimes interchanged with diluted juice. The Dietitian IPA advised that this difference may be down to the individual inputting the information, however, if pure orange juice was given, then this is also against the dietetic and low potassium dietary advice.

23. However, after reviewing the renal dietetic notes from UHD, the Dietitian advised that there were no concerns documented by the renal dietitians that the patient was receiving unsuitable foods. Her potassium levels were within range, suggesting good compliance with the recommended potassium restriction and that suitable foods were being eaten. The patient's diabetes control was also regularly reviewed by medical teams and diabetes specialist nurses. It is documented by the renal dietitian on 20 September 2013 that the patient's appetite was 'brilliant' and that she was enjoying the food provided by Domnall Care Home.

24. The complainants were concerned that the patient was being inappropriately provided with chips, breaded fish, wheaten bread, cheese, beans and soup. The Dietitian IPA advised that, aside from wheaten bread on 12 September 2013, she could not find evidence in the reports provided that any other of these above foods were given. These foods have a high potassium content, which would make them

unsuitable for patients requiring a potassium restriction. Some of them are also high in salt which should also be limited in renal patients, and those on an oral fluid restriction. Tomato soup is high in potassium and should be avoided, soup should be included as part of an oral fluid restriction. However, the Dietitian IPA advised that on occasions dietary restrictions may be relaxed depending on blood results on the advice of the renal dietitians. Overall without copies of the menus, or examples of the foods taken by the patient at meals times, the Dietitian IPA advised that it is difficult to say whether the meal options were suitable. Because dietary intake has an impact on both diabetes control, and blood potassium levels, it would have been reasonable to record specific foods, particularly during the assessment period. This would have enabled feedback to managing clinical teams and to whether further dietary intervention, or medication increases were required in the event of abnormal results in either of these clinical conditions. However, dietetic record show that dietary assessment of the patient was taken during dialysis sessions, and additionally the patient was able to recall her dietary intake. There is also evidence of telephone calls from the dietitians to Domnall, to discuss the patient's dietary intake and regarding oral nutritional supplements.

25. Overall the Dietitian IPA advised that Domnall were provided with information to support renal dietary advice for the patient. Unfortunately, due to limited recording of meals and snacks provided to her, the Dietitian IPA was unable to comment as to how fully this advice was adhered to. There were a small number of occasions, where unsuitable foods were offered, but the Dietitian was unable to comment as to how frequently this may have occurred. The patient was under regular review by renal specialist dietitians, who were happy with the composition of her diet. Normal potassium levels suggested good compliance and that she was in receipt of a low potassium diet. The Dietitian IPA suggested that as a service improvement that Domnall should record dietary intake for patients requiring therapeutic diets and under the care of a dietitian. Domnall had no comment to make on the Dietitian IPA's advice when I shared it prior to the completion of this report.

Analysis and Findings

26. The patient suffered from a number of ailments, two of which were type 2 diabetes and renal failure. As such she required a diabetic special diet with

restrictions to her potassium intake. During her residency at Domnall, the patient continued to receive dialysis in UHD, usually for three days per week and she remained under the care of the renal dietitians. The complainants stated that the patient received an incorrect diet in Domnall despite being in receipt of dietary advice and that the diet which she received was detrimental to her wellbeing.

27. The Dietitian IPA explained how certain foods should be avoided for a person with the patient's conditions. These foods, which the complainants specifically named as being offered to the patient, included chips, breaded fish, wheaten bread, cheese, beans and soup. Domnall were unable to source paper food record charts detailing the amount and content of any meals which the patient ate and there is limited information within the resident touch reports. Nonetheless, during the period in question, the patient continued to receive dialysis and remained under the care of the Trusts renal dietitians. As such her blood was continually monitored and potassium levels checked. The renal dietitians also completed dietary assessments during dialysis sessions and the patient was able to recall her dietary intake. The Dietitian IPA advised that her review of these records, and particularly the blood results showing potassium levels to be within the normal range, showed evidence that a suitable diet was being followed. The renal dietetic notes also evidenced that no concerns were raised by the SEHSCT concerning the type of food that the patient was consuming. I also noted the record documented by the dietician on 20 September 2018 when the patient stated that her appetite was 'brilliant' and that she was enjoying the food provided by Domnall.

28. Having considered the advice of the Dietitian IPA, it is clear that Domnall did not record on a regular and systemic basis the patient's dietary intake. However taking into account the regular blood and potassium levels recorded by the Trust, I am satisfied that overall the patient was not provided with an unsuitable diet while resident in Domnall. The fact that her potassium levels remained within the normal range during this time supports this. The complainants may continue to dispute the food choices which the patient was offered and the types of food which she consumed, however having examined the documentary and medical evidence, I am satisfied that the patient suffered no detriment to her wellbeing as a result of her dietary intake. Furthermore I am satisfied that correct dietary advice was supplied to

Domnall by the SHSCT before the patient's transfer to Domnall and during her stay there. **I do not uphold this element of the complaint.**

29. I do however note the comments of the Dietitian IPA that it would have been reasonable for Domnall to record the patient's specific food intake, especially during the early assessment period of her residency. This would have enabled further dietary intervention or medication increase should any of the blood results have proved abnormal or if potassium levels changed. Thankfully this did not prove necessary, however as a learning point I consider that Domnall should, if not already in place, introduce a system whereby a record for those residents on special diets, is maintained of the food offered and the amounts consumed.

2. Personal Care

30. The complainants were concerned about the level of personal care the patient received in Domnall.

Detail of Complaint

31. The complainants were specifically concerned about the amount of full body washes the patient received and of a failure of a moving and care plan on 29 September 2013 when the patient fell. They complained that the patient did not receive a shower on 3 October 2013 as stated in Domnall records. They also complained that minimal bodily cleaning was carried out, her face and back were washed with a cloth and with regard to the application of creams.

Evidence Considered

Domnall's Response

32. Domnall stated that the patient was in the home for rehabilitation purposes and would have been encouraged by staff to assist in the personal care process. Showers weekly or more often should be offered within the care home and apologies were made when this had not taken place. On interview staff confirmed that the patient did refuse a shower on 3 October 2013.

Clinical Records

Domnall Care Plan – '[Patient] safely performs self-care activities. Optimum level of hygiene is maintained while maximizing her ability'

Resident Progress Report - daily entries have been completed 10 September 2013 to 21 October 2013 relating to personal care. The entry for 3 October 2013 states 'Personal Hygiene: Shower

Admission record – 10 September 2013 'she is mobilised with rotunda X 2 staff'

Resident Care Plan – completed for the patient by Domnall including the Falls Risk assessment

Incident Report – 29 September 2013 (19.31), '[Patient] was being assisted to transfer by SCA… and CA … by the use of rotunda to go to the toilet when she suddenly lost power and slowly sat herself down to the ground. No marks/injury noted at that time. Had to hoist her back to bed as she was unable to weight bear. Clinical obs stable.'

Resident Progress Report – 3 October 2013 (11.45) – 'assisted with washing and dressing X 2 staff'

Resident Touch Report – (10.24) 'Personal Hygiene: Shower

Belfast Heath and Social Care Trust - Complaints correspondence

Nursing IPA and Domnall's response to IPA

33. The Nursing IPA reviewed the care home records. She advised that the records which she expected to see were present together with evaluation records. The Resident Touch Report categorises the care given into 'body wash' or 'shower'. For all dates there are entries relating to personal care, including 'Personal Hygiene: Body Wash' with the name of the carer or nurse recorded against each entry. An entry is recorded for each day. None of the entries states that personal hygiene was refused. There are also daily entries relating to oral care and grooming. The Nursing IPA advised that there is no mention in either the care plan or the care record of creams applied.

34. The Nursing IPA advised that she concluded that the care records evidence that body washes were provided daily throughout the patient's stay in Domnall and that this was reasonable and appropriate care.

35. With regard to the fall that the patient experienced in her bedroom on 29 September 2013, the Nursing IPA considered the handling and falls risk plan completed by Domnall. The Nursing IPA advised that the patient had been assessed

as a low risk of fall. She advised that the records completed constituted a minimum amount of information on the patient's moving and handling needs and her falls risk. The Nursing IPA advised that the patient's moving and handling by nursing staff was reasonable and in compliance with her handling plan and falls risk plan.

36. The complainants stated that the patient did not receive a shower on 3 October 2013 while the records indicated that she had a shower at 10.24. The Nursing IPA advised that it is good practice to be offered a choice of personal hygiene, based on needs assessments and preference. In the patient's case a weekly shower had been planned. Residents have a right to refuse to wash or shower even if this care had been previously planned. Should they refuse this, this right must be respected, unless the person is thought to lack mental capacity to make this decision, in which case a decision on care provision is made in their best interests. There is no record of the patient refusing to accept personal hygiene. The care record for 10 September 2013, on admission, states that 'She can communicate needs, speech clear, vision and hearing fair' which implies that the patient was able to indicate whether or not she wished to accept care that was offered.

37. The Nursing IPA concluded that care planning identified a weekly shower and that this is reasonable practice. However she found one record of a shower being provided. There is evidence that assistance with personal hygiene (usually a body wash) was provided daily, and this would meet minimum personal hygiene needs. It would be reasonable to offer a shower more frequently if the patient requested it, but there is no record of this, nor is there any record of her declining assistance with personal care.

38. I shared the Nursing IPA advice on this issue with Domnall prior to the completion of this report. It commented on the advice from the Nursing IPA that she would have expected the care home to have identified on a daily basis whether a body wash was the residents choice or not. Domnall stated that all procedures within the care home would be carried out in agreement with the resident and at no time would it advocate that personal care be carried out against the resident's wishes. As such the detail expected in the IPA's report would not be routine.

Analysis and Findings

39. There were a number of aspects to the element of this complaint regarding personal care. I considered these aspects of complaint within the general context of the overall standard of care experienced by the patient and have not overly focused on the individual specific instances referenced by the complainants. I consider each in turn below.

40. The complainants asserted that Domnall made an incorrect statement by stating that the patient received full body washes every day. They contend that the presence of pressure sores indicated that the patient's personal care with regard to washing was inadequate. The Nursing IPA examined the nursing records maintained by Domnall. She advised that properly, both a plan of care, stating the patient's level of requirement for assistance, and a record of the care provided, was maintained. The resident progress report includes entries relating to each day of the patient's residency, from 11 September 2013 through to 21 October 2013 describing the provision of care. The Nursing IPA concluded that the care records evidence that body washes were provided daily and that this was reasonable and appropriate care. I agree with this assessment. Furthermore I cannot correlate the fact that the patient had pressure sores with a complaint that she did not receive a daily body wash. Pressure sores are ulcers which develop on the skin of patients who are immobile. The presence of pressure sores is not generally associated with lack of cleanliness. I consider the element of this complaint relating to pressure sores at a later part of this report.

41. The complainants also stated that Domnall records indicated that the patient had a shower on 3 October 2013 but that this shower did not take place. They disputed Domnall's statement that the patient refused a shower on this date. I noted the entry in the Resident Touch Report for 3 October 2013, which stated at 10.24 (*personal hygiene – shower*). Within this record there is one other reference to the patient having a shower. This is the entry for 29 September 2013 at 12.05. I noted the entries in the patient's care plan and admission statement whereby she stated that

she preferred a shower to take place in the mornings but these records did not specify if this was preferred daily, weekly or otherwise. In the patient's case it appeared that a weekly shower had been planned and I agree with the IPA that this is reasonable practice. The records indicated that the patient received two showers during the six weeks she was in Domnall. During the course of local resolution Domnall accepted that the shower on 3 October 2013 did not occur but informed the complainants that it had been refused by the patient. There is no record in the documentation of the patient refusing to accept personal hygiene, either a shower or a body wash.

42. At this distance in time I cannot state with any definitive certainty what occurred on 3 October 2013 with regard to whether or not the patient refused to have a shower. It may be that a shower had been planned and this was recorded in the Resident Touch Report before the time it was due to take place. The patient may then have refused a shower for whatever reason, or she may not. I simply cannot make this determination as to the content of any conversation occurred. In any event Domnall accepted that the patient did not have a shower at this time.
With regard to the issue of whether or not a patient has refused a procedure, Domnall informed me that all procedures were carried out in agreement with the resident and at no time would it advocate any form of personal care being carried out against a residents wishes. I fully agreed with this concept however I would suggest that Domnall introduce a means of recording specific instances where residents indicate that they do not wish for a procedure to be carried out. Having said that and within the overall context of the totality of the personal care which the patient received while a resident in Domnall, I note that the Nursing IPA advised that the level of body washes which were carried out represented reasonable and appropriate care. **I accept this advice and therefore do not uphold this element of the complaint**.

43. The complainants also took issue with what they termed to be a 'ludicrous shambles of contradictory statements relating to the 29 September 2013 when the moving and handling care plan obviously failed'. This is in reference to an incident at 17.31 on that evening when according to the incident report completed by Domnall, the patient '…suddenly lost power and slowly sat herself down on the ground…..' I

asked the Nursing IPA for advice on the standard and content of the moving and handling care plan and the falls risk assessment completed for the patient. The Nursing IPA advised that the records concerning this aspect of the patient's care constituted an acceptable level of care planning for safe moving and handling. The patient was also assessed as being at a low risk of fall and the falls risk assessment was updated during her residency. The Nursing IPA advised that the falls risk care plan specified appropriate falls risk reduction interventions.

I noted the incident report completed on 29 September 2013 described that the patient was being assisted to the toilet by two named care assistants with the use of a rotunda (a patient transfer aid device). I considered that this was in compliance with the care plan completed for the patient on admittance to Domnall 'she is to mobilise with rotunda x 2 staff.', 'requires the use of transfer device and assistance'. Thankfully the patient did not suffer an injury as a result of this incident, the incident report noted 'no marks/injury noted at that time'.

44. The complainants infer in their complaint that the fact that this incident occurred 'obviously' represented a failure in the moving and care plan. I do not share this view. It is evident from an examination of the patient's medical history that she had considerable health problems. Her mobility and balance would also have been compromised by the below knee amputation she had experienced less than two months previously. I recognised and accepted that it is impossible to prevent all incidents similar to that experienced by the patient on 29 September 2013 with elderly, ill persons. A moving and care plan can only minimise the risks to patients, the very fact of its existence cannot eliminate the risks altogether. The Nursing IPA advised that the patient's moving and handling by nursing staff was reasonable and in compliance with her handling plan and falls risk plan. I accepted this advice.

3. Dressing of Wound

45. In this regard, the complaint was in relation to record keeping and the standard of wound care.

Detail of Complaint

46. The complainants stated that staff neglected the amputation wound leaving it

with no dressing and also complained of the standard of dressing changes and the quality of care in wound dressings.

Evidence Considered

Domnall's Response

47. Domnall stated that at no point was there any evidence to suggest that the patient's wound was neglected.

Belfast Health and Social Care Trust

48. I examined correspondence from the BHSCT to the complainants during the course of its investigation into this element of the complaint.

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Clinical Records

Domnall Resident Care Plan – '[patient] has wound on amputated left knee (wound number one). Care plan outcome: to facilitate wound healing or improvement. To prevent further skin breakdown. To prevent infection. To improve skin integrity. Patient will report increased comfort.'

Domnall Resident Progress Report:

10 September 2013 - '[patient] has a wound in her left leg, on the amputated leg. (is all necrotic and the actual regime is to be dress with Inadine but tomorrow N will come to see her. [Patient] also has a wound on second right toe and small wound on right heel. Also noted red area on groins.'

12 September 2013 – 'received phone call from N yesterday re: dressing materials, she advised to apply Algivon honey on the necrotic areas and Mesorb on other wounds. She asked me if I have seen the wounds and I told her I haven't. She said she'd seen it anyway. She also stated that she will just come to see [patient] on Monday at 1000

Domnall Resident therapy report - includes 3 entries relating to advice received from the TVN.

16 September 2013 - 'Seen by N, please see MDT notes

24 September 2013 - 'Review of necrotic wound to left stump. Eschar beginning to soften but even with 1mg [patient] is in a lot of pain as even with soaking off with

saline Algivon adhering. To change dressing to Atrumen 10cm by 10cm spread with a liberal amount of Activon honey tube, then Mesorb 15 by 10 cm. Please change every 2 days. Continue with 1mg of Oramorph prior to dressing change.
8 October 2013 - 'Seen by N this afternoon, cleanse and continually soak with saline until dressing almost falling off itself. Clean with saline and dry with gauze. Honey around broken edges of wound then apply Actiform cool adhesive leaving backing on, apply Activheal foam to secure. Tubifast to outside. Note use plenty of saline to soak wound. TCN to review again on Monday afternoon. Redress alternate days'

Evaluation history wound left knee - records evaluation of the wound on four occasions (19 September 2013, 21 September 2013, 28 September 2013 and 3 October 2013) in which there is reference both to dressings following TVN advice.

Nursing IPA and Domnall's response to IPA

49. The Nursing IPA advised that she could not find any reference to the patient's wound being left without a dressing. In fact she considered that the advice from the TVN had been very specific regarding the dressing type and its application and she advised that the care plans follow this advice. The Nursing IPA advised that the dressings and records were of a reasonable and appropriate standard. Domnall had no comment to make on the Nursing IPA advice on this issue.

Analysis and Findings

50. In their initial complaint to Domnall of 21 April 2014, the complainants stated that hygiene of the open amputation wound was badly managed as on many occasions the wound was left bare on unhygienic conditions leading to the 'threat of infection'. They complained that the Tissue Viability Nurse dressed the wound correctly but that Domnall staff did not adhere to her approach.

51. The Nursing IPA examined the documentary record maintained by Domnall with regard the patient's wound care. I noted that she could not find any reference to the wound being left without a dressing. I noted that the BHSCT in completing its investigation on this area of complaint similarly did not uncover any evidence of this.

I also noted that no complaint was made to Domnall regarding the wound being left uncovered during the time the patient spent there. The Nursing IPA advised that all of the records she would have expected to find relating to wound care were present. These records were a wound assessment and care plan, wound measurements, specification of the type of dressing and frequency of change together with ongoing evaluations. She agreed with the complainants' impression that the advice received by Domnall from the TVN was very specific regarding dressing type and its application. However the Nursing IPA advised that Domnall care plans followed the TVN advice and she concluded that the dressings and records were of a reasonable and appropriate standard. I also noted that the patient did not experience an infection in her wound and that her pain medication for wound pain was reduced during this time. Taking these facts and the Nursing IPA advice into consideration, together with the fact that no concerns were raised by the TVN concerning wound care and that the records of UHD when admitted on 21 October 2019 concerning the wound show a satisfactory picture, I am satisfied that the amputation wound care provided by Domnall to the patient was reasonable and appropriate. **I do not uphold this element of the complaint.**

4. Toileting

52. This element of the complaint was regarding record keeping and inadequate attention to toileting requirements. I have included in this section of the report my consideration regarding the maintenance of fluid balance in the patient's care.

Detail of Complaint

53. The complainants asserted that the records stated that the patient was generally continent in urine and asserted that as she was in renal failure she was incapable of producing urine. They complained that inadequate attention was paid to the patient's toileting requirements and that they complained of this on a daily basis. They also stated that they doubted that fluid charts existed.

Evidence Considered

54. NMC Record Keeping, Guidance for Nurses and Midwives (2009) - Records should provide an account of the care given, any assessments that have been made as well as the requirements for ongoing care.

Domnall's Response

Domnall stated that the patient did pass a small amount of urine. Due to her fluid restriction, documentation was maintained with regard to daily fluid intake.

Clinical Records

A selection of the references to toileting needs within the clinical records includes;

11 September 2013 - *Assisted to the toilet prior to bed'*

12 September 2013 - *Morning care met with assistance. Toileting needs met*

13 October 2013 - Pad checked /dry. Continence -refused

16 October 2013 - Bowels open medium

Resident Care Plans index (No.4.21) - '[patient] is on a fluid balance chart.'

Care plan outcome –'To assist patient to maintain good balance nutrition and doesn't exceed the fluid balance target'.

Resident Medical Report 14 September 2013 (17:45) 'I also mentioned that she is undergoing dialysis, with fluid restriction of 500 to 700 ml and she is not allowed to drink pure orange juice.'

Dietary recommendations for [patient], 11 September 2013, provided by the Renal Dietitian specifies a fluid restriction of 500 – 600ml daily, and specifies the main aims of the nutrition.

Nursing IPA and Domnall's response to IPA

55. The Nursing IPA did not consider the standard of record keeping with regard to the patient's toileting to be reasonable. She advised that she would have expected to find an assessment document which identified the patient's continence needs including urinary continence promotion or management of incontinence, and bowel care. The Nursing IPA was not able to find an assessment document relating to the patient's urinary continence needs. There was a bowel assessment document which identifies bowel history including incontinence of loose stools, and contextual care information. There was no specific care plan, although a continence assessment is referred to in the 'Residents assessment report'. There were very few entries on the Resident Touch record relating to continence promotion. The Nursing IPA noted that

the Resident Progress Report notes on admission stated *'diarrhea at present'.*

56. Overall the Nursing IPA considered that the available documents and entries do not provide sufficient information about the patient's toileting needs or the care provided.

57. With regard to the matter of fluid intake/restriction, the Nursing IPA advised that the full care plan set out 6 steps for the patient's fluid intake/restriction and its management, specifying the volume (500 – 600ml daily). The Nursing IPA advised that the stated plan outcome was reasonable and appropriate, in that it identifies that there was a fluid restriction and guided the care team not to exceed it. There is a hospital Department of Nutrition and Dietetics Guide on Choosing from Hospital Menu, which is relevant to choosing from a care home menu. It included advice on a low potassium diet, specifying foods and fluids to be restricted or avoided. This included pure fruit juice.

58. The Nursing IPA advised that the documentation evidenced that it is clear the nurses at Domnall were aware of a fluid restriction. However the Resident Progress record was initially inconsistent regarding the range of the fluid restriction. On 10 September 2013 it noted a 700ml restriction, on 11 September 2013 it stated 500ml restriction before stating the correct restriction on 12 September 2013 *'*….on fluid restriction of 500ml to 600ml'.

59. The Nursing IPA advised that the Resident Progress Report and Resident Touch Sheet recorded between them details of the type and volume of fluids on a daily basis, although it was not clear whether the volumes referred to what was offered or whether they referred to what was actually taken. For example, taking five days as a sample:

On 13 September 2013

10:28 Tea 150ml, Orange juice 75ml
11:58 fluid intake refused
13:46 Orange juice 25ml, tea 75ml
15:46 nutritional supplement 100ml
19:25 Tea 200ml

22:58 Water 30ml

Total volume: **655ml**

On 14 September 2013

10:46 tea 75ml, orange juice 75ml

13:52 tea 75ml, custard full

15:41 fluid intake refused

17:50 tea 150ml

18:47 nutritional supplement Fortisip 125ml

20:40 tea 100ml

22:52 water 20ml

Total volume: **620ml plus custard**

On 24 September 2013

10:22 tea 100ml

11:52 fluid intake refused

13:42 orange juice 100ml, tea 50ml

15;34 fluid intake refused

18:00 Nutritional supplement Fortisip 125ml

18:50 Tea 100ml

23:16 water 20ml

Total volume: **495ml**

On 3 October 2013

10:18 Tea 100ml

12:10 fluid intake refused

13:47 Tea 195ml

15:31 fluid intake refused

17:46 tea 145ml

Total volume: **440ml**

And on **19 October 2013**

07:42 water 30ml

10:27 Tea 100ml

13:57 diluted juice 150ml, tea 150ml,

17:36 Fortisip 125ml (2 entries) = 250ml

18:31 tea 100ml, water 150ml
Total: **930 ml**

60. The Nursing IPA advised that the total volumes recorded on the above five days ranged from 440ml – 655ml, with one outlying measure of 930ml, excluding fluids in moist/ wet foods such as custard, porridge. The Nursing IPA advised that there are minor inconsistencies between the totals from the Touch Report and the Resident Progress Report in 4 out of 5 of these entries:

13 September 2013 Touch Report**: 655ml** vs Resident Progress Report: **620ml**
14 September 2013 Touch Report: **620ml** vs Resident Progress Report: **650ml**
24 September 2013 - Touch Report: **495ml** vs Resident Progress Report: **475ml**
3 October 2013 - Touch Report: **440 ml** vs Resident Progress Report: **440ml**
19 October 2013 - Touch Report**: 930ml** vs Resident Progress Report: **675ml**

61. The Nursing IPA advised that the outlying measure of 930 ml is noted to be 'high' but was corrected in the Progress Report: 'this was rechecked with [patient]. Total fluid intake was 675ml'. The Nursing IPA advised that in practice it is quite difficult to be completely accurate with fluid intake measurement as there are 'hidden' fluids in some wet/ moist foods (such as custards, jellies, milk pudding etc), and small volumes may be difficult to measure, therefore the above discrepancy in records of approximately 20 – 30 ml is not necessarily medically significant but it does indicate lack of attention to consistent record keeping. More importantly the Nursing IPA advised that she looked for evidence that the fluid restriction target was being achieved. Assuming that the care team were aiming to apply the 500 – 600ml restriction, the daily volumes recorded on the Resident Progress Report range from 300ml to 675ml (excluding outlier).

Less than 500ml – 10, 12, 17, 18, 20, 24 September 2013; 3, 6, 7,9,11,14,16,18 and 19 October 2013
500ml – 600ml – 21, 22, 25, 27, September 2013; 1, 2, 8, 12, 13 and 20 October 2013

Greater than 600ml – 13, 14, 15, 16, 26, 28, 29, 30 September 2013 and 5 and 15 October 2013

62. The Nursing IPA advised that this shows that whilst on 10 days the target of 500 – 600 fluid restriction was achieved, on 15 days there was a shortfall and on 10 days it was exceeded. The majority were therefore not within satisfactory range.

63. The Nursing IPA concluded that the care team were aware of the fluid restriction and that a reasonable and appropriate attempt was made to monitor it. There were some inconsistencies in record keeping regarding the volumes offered/taken, but these were not significant. More significantly, there was evidence that the target fluid restriction was not met in 25/35 records (either due to shortfall or excess), and that the care team failed to adhere to guidance that orange juice should not be given. In these respects, the care given was not reasonable or appropriate.

64. I shared the Nursing IPA advice on this issue with Domnall prior to the completion of this report. It agreed with the comment regarding inconsistencies within the recording of the volume of fluids. It commented that on 6 of the days where the 24hr total was less than 500mls were days when the patient was on dialysis and would have been absent from the home for a number of hours.

Analysis and findings

65. I note that the complainants, during the local resolution process, complained that toileting was an issue during the patient's time in Domnall. They stated that the patient was 'immersed in faeces up to her waist' on her first day there and that there were continual problems with delays in bringing her to the toilet. They also contended that 'the patient under no circumstances passed urine while in this establishment as this was a bodily function that had ceased many years ago'. In investigating this aspect of the complaint, I note that a complaint relating to this issue was not made to the manager or deputy of Domnall at the time and was not made until after the patient's death six months later. I also noted that it was noted in the documentation that the patient had diarrhea on admission. This was stated to be a side effect of antibiotics the patient had been prescribed in hospital. During the

course of the BHSCT investigation of the complaint regarding this matter, Domnall acknowledged and apologised for an incident following admission, when the patient was incontinent prior to a family visit. However there is no documentation suggesting that this was a continuing problem. I comment further on the standard of record keeping in following paragraphs but in the absence of records suggesting that the patient's access to the toilet was delayed, I cannot make a finding on this issue. With regard to the complainants' contention that the patient passed no urine at all and had not done so for years, I am satisfied that this was not the case. The patient did suffer from renal disease and may have had issues with urine production, nonetheless an examination of the clinical records from both Domnall and UHD evidenced that the patient did produce urine, if only in limited quantities. My examination of this issue focused on the standard of records maintained by Domnall relating to continence and the question of fluid balance maintenance.

66. The Nursing IPA advised that she did not consider the overall standard of record keeping with regard to the patient's toileting to be reasonable. While the records provided by Domnall did include a bowel assessment document and contextual care information, there was no specific care plan assessing the patient's urinary or bowel continence needs. Additionally, the documents which were available and the entries within them did not provide sufficient information about the patient's toileting needs or the care provided. I agreed with the Nursing IPA advice in this regard and consider this failure to constitute maladministration and to be contrary to the Principles of Good Administration – Getting it right. I also consider that this failure in record keeping was contrary to the NMC Record Keeping, Guidance for Nurses and Midwives (2009) whereby Records should provide an account of the care given, any assessments that have been made as well as the requirements for ongoing care. It is my view that any failure in maintaining records impedes the thorough, independent assessment of the care provided to patients. I consider this to have caused the patient the injustice of not having her continence needs properly documented. It would also have caused the complainants the injustice of worry and annoyance regarding the care the patient received.

67. In relation to the fluid restriction, I accepted the Nursing IPA advice that the records evidenced that Domnall were aware that a fluid restriction should be in

place, despite inconsistencies in the records during the first three days as to the level of this fluid restriction. The records also demonstrated that there was a high degree of inconsistency in achieving the level of fluid required, with either too much or too little fluid being recorded. The figures showed that on 10 days, the target of 500 – 600 fluid restriction was achieved, but on 15 days there was a shortfall and on 10 days it was exceeded. Therefore on 25 out of 35 days recorded the target fluid restriction was not met. Domnall have stated that 6 of the days, where the 24hr total was less than 500mls, were days that the patient was on dialysis and was absent from the home for a number of hours. Even if these days are excluded from the calculations, the result is still that on more than half of the days recorded, the patient's targeted fluid restriction was not met.

68. I accepted the Nursing IPA's conclusions that Domnall was aware of the fluid restriction and that a reasonable and appropriate attempt was made to monitor it. However I consider that the failure to meet the target fluid level for over half the days recorded constituted a failure in the care and treatment which the patient received. I consider this failure to have caused the patient the injustice of not having her fluid restriction adhered to and I consider it to have caused the injustice to the complainants of upset and uncertainty as to the treatment received by the patient.

5. Pressure Sores

69. This element of the complaint regarded actions taken to prevent bedsores.

Detail of Complaint

70. The complainants stated that the patient was neglected in relation to positioning which led to discomfort and the development of bed sores which had to be treated in UHD.

Evidence Considered

Domnall's Response

71. Domnall stated that it maintained full documentary evidence with regard to treatment of pressure sores and the improvement these had made prior to discharge. Domnall stated that there was evidence that preventative dressings had been put in place by staff in the dialysis unit and that the patient had been provided

with a pressure relieving cushion.

Clinical Records

72. **Braden Assessment Tool (**a score based means of assessing risk of pressure scores) **-** 1 October 2013, score of 15 was attributed to the patient (an at risk score is between 15 - 18).

Resident Care Plan number 7 – '[patient] has a pressure sore on her right lower abdomen/skinfold wound number one' and '[patient] has a pressure sore on left side of her buttock wound number two'.

Care Plans - Care plan re wound left side buttock, Care plan re wound right foot, Care plan re wound skin fold, discontinued care plan wound right heel.

Evaluation history - Evaluation history wound left side buttock, Evaluation history wound left thigh, Evaluation history wound right foot, Evaluation history wound skin fold.

Touch record and Resident Progress Record – The Touch record contained daily entries relating to transfers and handling and entries made that were specific to the pressure area care, for example:

18 October 2013 - 11:06 turning pressure relief given, 23:18 pressure relief given

19 October 2013 - 07:17 pressure relief given, 14:44 pressure relief given

20 October 2013 - 19:42 pressure relief given

The Resident progress record included summary entries on most days regarding provision of pressure relief, for example:

05 October 2013 - 'pressure relief given'

30 October 2013 - 'repositioned on alternate side'

Nursing IPA and Domnall's response to IPA

73. From her examination of the documentation and records provided the Nursing IPA concluded that reasonable and appropriate assessment and care planning were carried out with regard to pressure sores and that there were consistent records that

assistance was provided with repositioning, moving and pressure relief including turning, throughout the patient's stay at Domnall. Domnall had no comment to make on this aspect of the Nursing IPA advice.

Analysis and conclusion

74. I accept the Nursing IPA advice that reasonable and appropriate care plans and records were maintained in relation to the prevention, care and treatment of bedsores. These included the Braden Assessment carried out on 1 October 2013 which indicated that the patient fell into the higher category of risk for pressure sores. I noted a response to the complainants from both Domnall and the BHSCT, and from the records, that on admittance to Domnall the patient had red areas on her lower back. On 27 September 2013, a Grade 1 -2 pressure sore was noted on the posterior aspect of her left thigh. This was treated both in Domnall and while the patient was in the dialysis unit. The patient was also assessed by an occupational therapist and a high grade static cushion was prescribed and received. The Nursing IPA advised that the records evidenced that assistance was provided to the patient with repositioning, moving and pressure relief including turning, throughout her stay in Domnall. The investigation carried out by the BHSCT into this area of complaint concluded that by 14 October 2014, the pressure sore wound had reduced in size. I consider that the causes of the development of pressure sores is multifactorial. The fact that a pressure sore develops in a patient is not of itself evidence of neglect. I accept the advice of the Nursing IPA that reasonable and appropriate assessments and care planning were carried out and that assistance was provided with repositioning, moving and pressure relief. **I do not uphold this element of the complaint.**

6. Constipation

75. The complainants raised an issue regarding medication and treatment the patient received for constipation.

Detail of Complaint

76. The complainants stated that Imodium was prescribed incorrectly as they consider that it was inappropriate for the patient's condition. They also complain that there was a failure to administer an enema despite it being prescribed. They also

state it was untrue the patient had refused medication.

Evidence Considered

Domnall's Response

77. Domnall stated that Imodium was prescribed by the staff in the renal unit of UHD due to the diarrhea the patient was experiencing while taking antibiotics. It stated that the progress notes of 16 October 2013 clearly state that the patient was offered an enema but refused. Domnall used an electronic recording system so a note relating to this could not have been made post discharge, as alleged by the complainants. Domnall also stated that nurses only administer medications prescribed by GP's or consultants.

Clinical Records

78. **Domnall Medication Administration record –** In the medication profile section of this form there is an entry 'Flexi ready to use enema. Use as directed.' The next section to show if and when this was used is left blank. The medical profile section is undated however the entry is made in between other medications being prescribed on 10 September 2013 and 17 September 2013.
Loperamide 2mg is also shown with directions 'take two capsules with first loose motion then one capsule, max 8 per day'. The following entries are either left blank or have a staff initial followed by a circled letter 'N' indicating not administered.

Resident Progress Report – 11 October 2013, 'Dr B prescribed enema for patienth's constipation'. 16 October 2013 at 04.58, …'offered to do enema but [patient] refused as claims no need for this at the moment, comfortable'

Nursing IPA and Domnall's response to IPA

79. The Nursing IPA advised that Imodium (also known as Loperamide) is used for treatment of diarrhea/loose stools. It works by reducing the speed at which the gut contents are propelled, and firms up the stool by increasing the reabsorption of water. There are no special precautions for use with elderly patients or renal patients, but Imodium is contraindicated in cases where patients have pseudomembranous colitis, which is a severe acute inflammation of the bowel that is associated with the use of broad-spectrum antibiotics.

80. On the patient's medication chart dated 13 September 2013, Loperamide (Imodium) 2mg is prescribed with directions to be administered after every loose motion max 8 per day. On this medication chart a number of other medications were listed, none of which was an anti-biotic. The patient's hospital notes show she had been treated with Flucloxacillin up until the point of transfer on 10 September 2013. On this date there is an entry in the progress notes that the patient had 'diarrhea probably secondary to Fluclox reviewed by MO proceed with D/C'. It is therefore possible that the patient had pseudomembraneous colitis and in that case, Imodium would be contraindicated. However as the Nursing IPA had not been supplied with records of the administration of the prescribed medicines, she could not comment on whether the nursing staff at Donmall actually administered Imodium to the patient. The Nursing IPA advised that there is a warning on the Summary of Product Characteristics for Loperamide against using it in severe constipation. Administration of Loperamide in these circumstances would be likely to make the constipation worse. Because it is intended to treat diarrhea / loose stools, it should not be administered concurrently with laxatives that are intended to treat constipation. Movicol and senna are both commonly used laxatives that are usually safe to treat constipation in elderly patients. Movicol is usually administered as a powder that is mixed with water. It works by softening the stool and increasing its volume, which enables the gut to propel the stool more effectively. There is no contraindication for renal patients. Senna works differently, by stimulating the bowel itself rather than affecting the properties of the stool. Movicol and senna may be used concurrently for constipation treatment. From the prescription list provided and quoted above, on 25 September 2013 the patient was prescribed a different laxative, Lactulose 10ml twice a day. There is no record of Movicol or senna being prescribed at that time. However, if they were prescribed, it would be appropriate to administer them for constipation and if taken correctly and in conjunction with adequate diet and fluids it is likely that they would relieve the problem.

81. With regard to the use of an enema the Nursing IPA advised that enemas are prescribed as part of treatment of severe constipation, in most cases as a one-off or time limited treatment. The complainants stated that the patient had 'a large compacted amount of faeces which was the cause of the agony'. The Nursing IPA

advised that if this was the case, then an enema[2] would be an appropriate treatment as it clears the lower part of the bowel/rectum. Enemas are not usually effective for constipation that occurs higher up the bowel, laxatives such as Movicol or senna being used. In this case the Nursing IPA advised she could not tell from the records received if an enema was administered or not. However there was evidence that the nurse had consulted with the patient regarding her bowel symptoms.

82. In response to the sharing of the Nursing IPA advice Domnall stated that the Imodium was prescribed to the patient by a doctor from the renal unit. Domnall also stated that Imodium was not supplied at home level. I was provided with a copy of the medicines administration record in confirmation of this. I was also informed that there is an entry in the progress notes from staff that on 16 October 2013 an enema was offered but refused.

Analysis and conclusions

83. There are two aspects to this element of complaint. The first is the complainants' concern that an enema was not administered to the patient despite it being prescribed. They also refuted any suggestion that the patient may have refused to have the enema administered. Secondly they complained that the patient was prescribed Imodium (Loperamide). They stated that it is inappropriate to prescribe this medication to someone who is receiving antibiotics.

84. In relation to their complaint as to what medication was prescribed for the patient, I am satisfied that Domnall's role in this would have been minimal. Within the confines of a nursing or care home, medication is prescribed by clinicians in primary health care such as GP's, or by clinicians in secondary care from hospitals. Nursing staff or managers in nursing and care homes do not prescribe medication. Their responsibility is to administer the medications prescribed by others. I am also aware that many medications when prescribed, do not have be taken, but rather are prescribed on a 'use if needed' basis.

[2] A procedure in which fluid is passed into the rectum through a tube inserted into the anus.

85. The Nursing IPA has advised that enemas are prescribed for treatment of severe constipation. Enemas are appropriate treatment for clearance of constipation from the lower part of the bowel but are not usually effective for constipation which occurs higher up the bowel. For this type of constipation laxatives such as Movicol or senna are used. I note that both these medications were prescribed for use with the patient.

86. The complainants stated that an enema was prescribed but not administered to the patient for constipation. I note the records suggest that an enema was prescribed on 11 September 2013 by a doctor but was not used. The records also state that the patient refused the use of an enema on 16 October 2013. The complainants refute this stating that the patient did not refuse treatment. Having examined the documentary evidence, I am satisfied on the balance of probabilities that the patient did refuse the use of an enema on this occasion, however I cannot conclude with any certainty as to her reasoning behind this decision. I do however note that the entry in the records detailing this was made at 04.58 in the morning and that the patient was described as being comfortable at this time. I also note from the records that the patient's bowels had opened on a number of occasions in the preceding days. On the overall question of bowel management, I am satisfied that Domnall managed this appropriately. I note that the patient was reviewed by a doctor three times over a nine day period in relation to her bowel symptoms and appropriate medications prescribed. I am satisfied that Domnall consulted with the patient regarding her bowel symptoms, recorded her bowel movements and discussed the treatment with the GP's treating her. **I do not uphold this element of the complaint.**

87. With regard to the prescription of Loperamide, I am satisfied that this was not prescribed by Domnall staff. I accept the advice of the nursing IPA that its use would have been contraindicated for patients in receipt of antibiotics or those with pseudomembranous colitis[3]. I note that the patient did have diarrhea in her first few days resident in Domnall, which may have been an indicator of having pseudomembranous colitis, however this was not positively diagnosed. I note that on the patient's medication chart, no antibiotics were listed. I also note and accept the

[3] An inflammation of the bowel associated with the use of broad spectrum antibiotics

conclusion of the Nursing IPA's examination of the clinical records that while Loperamide may have been prescribed, the evidence indicates that it was not administered during this period. **I do not uphold this element of the complaint.**

7. Stroke Care

88. The complainants stated that there was a lack of awareness shown by Domnall with regard to the potential of the patient having a stroke on 19/20 October 2013.

Detail of Complaint

89. They complain that the patient was neglected by Domnall on 19/20 October 2013 in that signs and symptoms of a stroke were not treated with the urgency required and there was a delay in getting the patient to hospital. They also complain that the patient's daughter was left to escort her mother to hospital when they assert it was clearly an emergency situation.

Evidence Considered

Domnall's Response

90. Domnall stated that at no time did its staff ignore a request from a GP to have the patient moved to hospital. It did acknowledge that there was a miscommunication between Domnall and the GP prior to the patient being transferred to hospital. The patient then returned to the home in the early hours of the morning with a diagnosis of possible TIA. At this stage all the patient's bloods were normal. Domnall stated that staff were fully aware of the patient's decline in health and stated that the evidence shows that staff were proactive in liaising and acting on the advice of the GP, Out of Hours, and doctors in the renal unit and A&E.

Clinical Records

91. Resident Progress Report –

20 September 2013 (19.47), 'just came back from dialysis offered her supper and give her oral medications at 7:30. [Patient] verbalises and the daughter noticed that she had slurred speech; obs taken 132/61, 77 pulse rate 96% O2 saturation, temp 35.8, top to toe assessment done able to move all etremeties (sic) but noted that she has some problem with her speech, reassured her and on call Doctor contacted daughter aware of same. Awaiting for the Doctor to call back'

(20:38) ‘received phone call from [Dr A] and informed of same; advised to send to hospital for investigation query stroke, daughter informed, transfer form, copy of TVN re Wound and medication given to her daughter’.
(04.01) Diagnosis of possible TIA which has resolved itself…[Patient] returned to Domnall at 0430 assisted to bed….’

Resident Progress Report - 17 October 2013, (12.10) Physio came concerned re [patient]; states her speech slurred and pins and needles in left hand, obs taken….speech appeared clear at this time but states she is tired. Will observe today’.
(17.42) [Dr B] returned my call at 17.50 re [patient] c/o pins and needles in left hand and side of left face…….observe overnight and he will see her tomorrow…’
18 October 2013 - (01.01) Dr C telephone advice at 01:1 to ‘assess [patient] and see if she can move her legs, hands and feet anyone touching her. [Patient] verbalized that she could feel my touch and she also managed to raise both hands and legs. Also [patient] said she had less pain than earlier. Dr C had also suggested that bloods to be done but after I informed her about the bloods ordered by the Diabetic Team she then said to wait for the results first and to monitor [patient] and call the GP if she deteriorates’.
UHD - (11.10) Phone call from daughter. Raised concern about [patient] ‘not being herself’, tingling sensation on arms and felt strange on face yesterday evening. Raised concern to Domnall staff…..advised that we will assess [patient] upon arriving to the unit and if needed will ask MO to assess.
(19:04) telephone call from the Dialysis unit to advise that the patient had left side body weakness and was for further observation over the weekend.

19 October 2013 – **Domnall Resident Progress Report**
‘4.30pm received a phone call from the Dialysis Unit advised that [patient] has left side body weakness including facial, for further observation over the weekend and to monitor again on Monday’

21 October 2013 – (19.01) ‘Spoke to daughter, [patient] will be admitted to UHD for CT scan due to left side weakness’.

SEHSCT Patient Record - 21 October 2013 – 'Seen by Stroke team, admitted to Ward 23. CT brain done post dialysis'

Nursing IPA and Domnall's response to IPA

92. The Nursing IPA commented on the care and treatment the patient received in Domnall when she showed signs of suffering from a stroke on 20 September 2013 and the time taken to get her to hospital. The Nursing IPA advised that she would expect care home staff to identify the signs of potential stroke, as these are well known by the acronym FAST (Face-Arms-Speech-Time) and include:
Face – has their face fallen on one side? Can they smile?
Arms – can they raise both arms and keep them there?
Speech – is their speech slurred?
Time to call 999 if you see any single one of these signs of a stroke.

93. From the clinical records the Nursing IPA advised that the nursing staff noted the sign of slurred speech, but did not apply FAST correctly. Their response was to take observations (which was correct action, although they did not check blood sugars to rule out hypoglycaemia) and to notify the doctor, but they did not immediately call 999. The nurse should have taken the initiative to apply FAST and call the ambulance. Instead they waited for the Doctor to respond, which took over an hour. The Doctor then directed them to send the patient to hospital.

94. With regard to timing and arranging appropriate treatment, possible stroke symptoms must be acted on immediately as there is a relatively short treatment window (3 hours from onset of symptoms) should a thrombolytic stroke (i.e. a stroke caused by a blood clot) be diagnosed. The Nursing IPA concluded that nursing staff did not correctly identify the signs that the patient may have been having a stroke, that the call to the out of hours Doctor was not an appropriate action, and there was an inappropriate delay in arranging transport to hospital: an ambulance should have been called as soon as possible after possible signs of stroke were observed.

95. The Nursing IPA advised that the Resident progress report of 19 October 2013 suggests that the patient may have had a TIA, as the symptom (blank stare) resolved after a few seconds. This pointed to the likelihood that the patient had either

experienced stroke or TIA during the period of 19 and 20 October. Whilst there is evidence of observations being taken, and dialogue between the care home and the GP, there is no evidence of awareness of FAST or application of systematic assessment of these symptoms by the care team. Subsequently on 21 October 2013 the hospital (UHD) record states 'developed L arm weakness over? 3-4 days' and on 22 October 2013 the hospital records confirm the diagnosis of Ischaemic stroke. This suggests that earlier action on the part of the nursing home and GP were indicated i.e. to send the patient to hospital for investigation of possible stroke.

96. Concerning the complaint that it was the patient's daughter who escorted her mother to hospital whenever signs of a stroke were apparent, the Nursing IPA advised that in her opinion a nurse escort from the care home should have been sent with the patient. This is because although if the patient deteriorated during the transfer to hospital, the paramedic/ambulance crew role is to provide emergency treatment, it is still good practice for the nurse to accompany their patient, to provide additional information about care needs, comfort the patient and support the family carer.

97. Overall with regard to stroke care, the Nursing IPA concluded that there were a number of omissions in the overall care and treatment provided in respect to stroke. The application of FAST by the care team and failure to transport the patient to hospital in a timely manner for further investigations. In response to the sharing of the Nursing IPA advice Domnall stated that it appreciated the comments that FAST was not applied correctly. However with regard to 20 September 2013, it noted that nursing staff did complete a full clinical assessment of the patient at the time. It stated that blood sugar was taken and it would have fully expected a 999 call to have been made if the patient's condition had deteriorated or further signs of a stroke had presented. It noted that the patient was assessed in the hospital and discharged within hours with a diagnosis of a TIA. With regard to the events of 20 October 2013, Domnall stated that staff were aware that the patient was experiencing TIA's. This was also noted by the renal dialysis unit staff who contacted Domnall and requested that she be observed over the weekend. At no point did renal unit staff refer the patient for further treatment. In relation to the patient's transport to hospital Domnall stated that it is not practice for a nurse to escort a patient to hospital. Care homes

adhere to strict staffing levels and if staff were permitted to escort patients to hospital, unsafe staffing levels would be left in the home. On this occasion the patient's daughter had informed staff the evening before that she had arranged an appointment the next day at the walk in TIA[4] clinic. Staff attempted to arrange for transport but with the short notice this was not achieved.

Analysis and conclusion

98. The complainants raised an issue regarding what they term 'the inattentive attitude of staff of Domnall in the awareness of a serious situation to a patient in their care'. This is in reference to the events of 20 September 2013 and 18 October 2013 to 21 October 2013.

99. On 20 September 2013 the patient was noted to experience a period of speech difficulty while a patient at Domnall at approximately 19.30. A doctor was telephoned but this telephone call was not returned until 20.38. The Doctor advised that the patient be taken to hospital for investigations. However there appears to have then been confusion as to who would arrange an ambulance with Domnall assuming the doctor would do this. The complainants stated that it was not until 22.45 that an ambulance arrived.

100. The Nursing IPA has advised that nursing staff did not correctly identify signs that the patient may have been having a stroke and that rather than calling a doctor, an ambulance should have been arranged by Domnall as soon as possible after possible signs of a stroke were observed. All of this led to a delay in the patient arriving in hospital. The Nursing IPA concluded that when nursing staff first noted signs of slurred speech indicating a possible stroke, they correctly took observations, but did not apply the FAST guidelines appropriately which would have been to arrange the patient's transport to hospital as soon as possible. I agree with this assessment.

101. I note that the patient was discharged from UHD in the early hours of the next morning with a diagnosis of a possible TIA. However when the slurred speech was

[4] Transient Ischaemic Attack – a brief interruption of blood supply to the brain

noted at 19.30, nursing staff were not to know if the patient was suffering from this or a full blown stroke. In instances such as this the guidelines are clear and symptoms should be acted upon immediately. I consider the failure to arrange for the patient's immediate transfer to hospital on 20 September 2013 to represent a failure in her care and treatment. I consider that this caused the patient the injustice of not having her symptoms investigated in hospital within an appropriate time. I consider that the complainants also suffered the injustice of anxiety and distress over the consequences to the patient of this failure in care and treatment. In a separate report on this incident I found that the decision to discharge the patient the following morning back to Domnall, was appropriate as at that time there was no practical treatment which the patient could receive as an in-patient.

102. A similar situation arose between 17 October 2013 and 18 October 2013. The patient attended for dialysis from Domnall on 18 October 2013. UHD noted at this time, that the patient had left side face numbness extending to her left arm. It was also noted that she had had these symptoms for two days. On 17 October 2013 and 18 October 2013 the patient had been noted by Domnall to be exhibiting similar symptoms to those experienced on 20 September 2013, which is pins and needles in her hand and face and slurred speech. This time again the patient had her observations taken and a doctor was telephoned. The Nursing IPA has advised that these symptoms pointed to the likelihood that the patient had experienced another TIA or a stroke. I agree with the Nursing IPA advice that earlier action on the part of Domnall was indicated in these circumstances and that arrangements should have been made to send the patient to hospital earlier. In another report on the circumstances of this complaint, I noted that the patient, because of her renal disease was not a suitable candidate for receipt of clot busting drugs. However this fact was not known to Domnall and I consider this further instance of a failure to arrange for the patient's immediate transfer to hospital to represent a failure in her care and treatment. I consider that this caused the patient the injustice of not having her symptoms investigated in hospital within an appropriate time. I consider that the complainants have also suffered the injustice of anxiety and distress over the consequences to the patient of this failure in care and treatment.

103. The complainants stated that Domnall did not organise and arrange transport

for the patient to hospital and to appointments. The Nursing IPA has advised that during ambulance transfer it is good practice for a nurse from a home to accompany a patient, to provide information regarding care needs and to provide support to the family. In response Domnall has stated that a nurse escort to hospital is not the practice within any of its care homes. Care homes have strict staffing levels and to permit staff to leave to provide hospital escorts would leave potentially unsafe staffing levels. Domnall referred to the NI Nursing Home Standards and Nursing Home Regulations in making its point. With regard to the failure to provide transport for the patient to attend the TIA clinic, I was informed that Domnall only were informed of this clinic the day before the appointment and did not have time to arrange transport. I accept the points made by Domnall in this regard and make no criticism.

8. Management

104. The complainants made a complaint regarding the overall management of the patient while resident in Domnall

Detail of Complaint

105. They complained of the overall standard of record keeping at Domnall and of a reluctance to relate to the concerns that they raised. Within this area of complaint I have also included an examination of the rehabilitation potential of the patient while resident at Domnall.

Evidence Considered

106. Domnall's Response

Domnall stated that all of its nurses are registered with the NMC and they have a responsibility to ensure that all records are completed accurately and contemporaneously.

Clinical Records

107. 4 October 2013 – 'MDT update: for discharge Thursday 17th October. To order profiling bed, air mattress, air cushion, mayfair commode. OT will liaise with care manager to decide whether a Rotunda or stedy will be ordered for use at home'.

8 October 2013 - ‘assisted by two staff for all transfer, visited by Physio today advised to use the hoist if the staff and [patient] has difficulty of standing and they will provide an amputee sling,…’

9 October 2013 – ‘while assisting her to the chair, she complained of severe back pain and could not stand for long. She lost strength on her right leg and nearly falling, me and Ca Brenda placed her quickly on the commode. She was hoisted to sit on the chair. Physiotherapist aware about poor mobility’.

10 October 2013 – ‘used x 2 staff for all transfer’

11 October 2013 - MDT Meeting Update ‘Rehab team is concern about [patient’s] deterioration in terms of transfers; Dr B prescribed enema for [patient’s] constipation; awaiting vascular appointment; to continue on rehab; to be reviewed next week for future plans’

Nursing IPA and Domnall’s response to IPA

108. I asked the Nursing IPA for her view on efforts by Domnall to assist the patient in her rehabilitation after surgery. I was advised that the Nursing IPA noted from the Resident Progress record that there were regular MDT (Multi-Disciplinary Team) updates at which Domnall recorded communication with physiotherapy, and updates on the patient’s current level of function. The Nursing IPA advised that there was no reference to the patient’s rehabilitation being curtailed. She advised that there is evidence that the care provided was modified in response to changes in the patient’s functional status. When I shared this advice with Domnall it had no further comment to make.

Analysis and Conclusion

109. The complinants expressed their dissatisfaction with the care and treatment the patient received whilst resident at Domnall. They complained of the standard of documentation maintained and of a reluctance to act on their concerns. They stated that they are not satisfied that Domnall accepted or understood their concerns.

110. Based on the advice of the Nursing IPA and from an examination of the documentation, I have commented in the previous paragraphs on my findings and conclusion on various aspects of the care and treatment the patient received in Domnall. I have also commented on the standard of documentation. With regard to the rehabilitation potential of the patient while resident in Domnall, I note the statement of the complainants that one of the reasons that Domnall had been chosen to care for the patient was that rehabilitation of patients was promoted. In making a determination on this issue, I am conscious of the numerous ailments which the patient suffered from, together with the fact that she had had a very recent below knee amputation. I am also conscious of the comparatively limited time that the patient spent as a resident of Domnall within which to promote rehabilitation. In a separate report I have commented on the limited rehabilitation potential which existed due to the patient's comorbidities. Nonetheless, I recognise the very real desire which existed with the complainants for the patient to physically recover to the extent that it would be possible for her to return home. I also recognise their deep disappointment that this did not occur. However I accept the advice of the Nursing IPA that Domnall did hold regular MDT meetings concerning the patient and that there was an appropriate level of engagement with physiotherapy, the TVN, Occupational Therapist and GP who provided updates on the patient's current level of function. I accept the view of the Nursing IPA that it was not a case of the patient's rehabilitation being curtailed, rather the care she was provided was modified in response to changes in her medical and physical status. I make no criticism of Domnall in this regard.

111. There is no doubt that the complainants are unhappy with the care provided to the patient by Domnall and have an issue with comments which they stated were made by staff. In their letter of complaint they alleged that 'fabricated untruthful comments' were made to them by the management of Domnall. As referenced in previous paragraphs of this report I have difficulty in making judgements on the content of unrecorded conversations and the differing interpretations and perceptions which parties to such situations can give, particularly relating to the meaning and the exact words used during those conversations. I note that there is no written contemporaneous evidence in the care records to assist me in my consideration of this issue and no formal complaint was made to Domnall until six

months after the patient had left its care. Without objective corroboration, I am unable to make a definitive judgement as to what exactly was said with regard to the 'fabricated untruthful comments' which the complainants allege were said.

112. I have also reflected on how Domnall investigated the complainants' concerns when received. I have considered the detail of Domnall's responses to the complainant's comprehensive and detailed letters of complaint and their responses to Domnall's replies. Overall I am satisfied that their complaint was properly addressed by Domnall and that genuine efforts were made to resolve their concerns. The detail and level of response which the complainants received together with a meeting, has satisfied me that a serious attempt was made to resolve their concerns. I also note that when they remained dissatisfied with Domnall's response, their issues of complaint were subsequently also investigated by the Belfast Trust. I find no maladministration by Domnall in its handling of this complaint.

CONCLUSION

113. I shared a copy of a draft investigation report into this complaint with Domnall and with the complainants. Domnall accepted the findings and conclusions and had no further comment to make. The complainants provided detailed comments on the content of the draft report. I have given their comments serious consideration, however save for minor amendments, I have not changed my findings and conclusions.

114. This has been an extensive and time consuming investigation involving the engagement of independent professional advice. I have investigated the complaints against Domnall. I have found there to have been a failure in the care and treatment received by the patient in relation to:

i. A failure to meet fluid target levels
ii. A failure on two occasions to take earlier action to arrange for the patient's transfer to hospital

I have found maladministration in relation to:

iii. A failure with regard to record keeping concerning toileting needs

I am satisfied that the failure in care and treatment and maladministration caused the patient to experience injustice. I am also satisfied that these failings would have caused the complainants to experience the injustice of anxiety and distress.

Recommendations

115. In recognition of the failures in the care and treatment and for the maladministration identified I recommend that the complainants receive an apology from Domnall for the maladministration and the failures in care and treatment identified together with a payment, in solatium, of £500.

116. I also recommend, by way of service improvement that Domnall introduce a system whereby a record for those residents on special diets, is maintained of the food offered and the amounts consumed and instances when personal care is refused. I also recommend that, if not already in place, a system be introduced to record the toileting needs of residents including a care plan assessing urinary or bowel needs as highlighted by the nursing IPA at paragraph 66 of this report. Domnall should provide me with an update with regard to these recommendations within 3 months of the receipt of this report.

117. I have no doubt that the complainants will be disappointed at some of my conclusions in relation to their complaints, however, I hope that they will accept that I reached my conclusions only after the most careful consideration of all the evidence and of their detailed submissions.

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.