Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Culmore Manor Nursing Home

NIPSO Reference: 17497

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

I received a complaint about the actions of Culmore Manor Nursing Home concerning the care and treatment it provided to the complainant's late mother (the patient).

I accepted the following issues of complaint for investigation:

i. Whether the Home administered the patient's Quetiapine in accordance with what was prescribed?
ii. Whether the complainant's concerns about the level of sedation administered to his mother from 18 January 2016 were adequately addressed by the Home?
iii. Whether the patient received the appropriate diet from the Home from January 2016?
iv. Whether the Home's communication with the family regarding the changes to the patient's medication on 18 January 2016 was appropriate and reasonable?

I investigated the complaint and did not find any failures in care and treatment in relation to the administration of Quetiapine, the Home's actions in relation to addressing the complainant's concerns about this drug, and the diet the patient received in the Home.

I have not found maladministration in relation to the Home's communication with the family on 18 January 2016. However I consider the Home failed to have recorded a discussion with the patient about what information she wanted communicated to her son. I did not identity an injustice to the complainant arising from this failure.

THE COMPLAINT

1. I received a complaint about the actions of Culmore Manor Nursing Home (the Home) in relation to the care and treatment provided to the complainant's late mother. He complained that he was concerned with the level of sedation provided to her in the Home as he repeatedly found her drowsy and hard to wake. He stated that since 18 January 2016 he had raised concerns with the Home about over-sedation of his mother and fears that she may have aspirated due to this. He believed his concerns were ignored and he stated his mother was 'rushed' to Altnagelvin Hospital from the Home with aspiration pneumonia[1] on 20 February 2016 and passed away the following day. In particular he believed that the drug Quetiapine[2] was the cause of his mother's over sedation and that his concerns were ignored.

Background

2. The patient became a resident of the Home on 20 December 2012. Prior to this, she was an inpatient in Altnagelvin Hospital following a cardiac arrest, resulting in hypoxic brain injury and cortical blindness. The patient had a medical history of breast cancer, hip replacement, pneumonia, vascular disease, osteoarthritis, anxiety and low mood. She experienced ongoing visual and auditory hallucinations which necessitated input from the Western Health and Social Care Trust (The Trust) Community Mental Health Team.

Issues of complaint

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

    - Issue one: Whether the Home administered Quetiapine in accordance with what was prescribed?

[1] Aspiration pneumonia is a complication of pulmonary aspiration. Pulmonary aspiration is when you inhale food, stomach acid, or saliva into your lungs. You can also aspirate food that travels back up from your stomach to your esophagus

[2] This medication is used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder). Quetiapine is known as an anti-psychotic drug (atypical type)

- Issue two: Whether the complainant's concerns about the level of sedation administered to his mother from 18 January 2016 were adequately addressed by the Home?

- Issue three: Whether the patient received the appropriate diet from the Home from January 2016?

- Issue four: Whether the Home's communication with the family regarding the changes to the patient's medication on 18 January 2016 was appropriate and reasonable?

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Home all relevant documentation together with the Home's comments on the issues raised. This documentation included information relating to the handling of the complaint and the patient's relevant medical and nursing home records.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice from an Independent Professional Advisor (IPA). The IPA is a Consultant Nurse (RN, BA (Hons), MScm PGCert, HE) for older people with 30 years experience working in acute, community and nursing home sector.

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

Relevant Standards

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

   The general standards are the Ombudsman's Principles[3]:

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

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

9. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

10. As part of the NIPSO process, a draft copy of this report was shared with the Home and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations.

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

THE INVESTIGATION

Issue one: Whether the Home administered the patient's Quetiapine in accordance with what was prescribed?

Detail of Complaint

11. The complainant stated that the Trust's mental health team previously prescribed his mother Quetiapine as she had episodes of intermittent hallucinations. He complained that this drug was recommenced on 18 January 2016 following his mother's return from a period in hospital; however he was unaware of this until 31 January 2016. Having researched this drug, the complainant stated that his mother was very drowsy since she recommenced this drug and he believed this was the cause of her drowsiness. The complainant stated he objected to the Home's suggestion that his mother's usage of alcohol caused her drowsiness and that this was an attempt to avoid blame.

Evidence Considered

The patient's clinical records

12. I note the contents of a letter from the patient's Consultant Psychiatrist to her GP dated 21 December 2015 following a visit to the Home on 9 November 2015. This states her current dosage of Quetiapine was 25mgs nocte[4] plus 25mgs as required for agitation. I note the following extracts from this letter: *'…I spoke with [the] nurse on duty at the time before interviewing [the patient]. [She says she] continues to have periods were she will call out and appeared to be seeing things including people in her room. She is unclear if the regular Quetiapine at night-time has helped with the frequency of this but has noted*

[4] Every night

that a prn Quetiapine has been very effective in reducing [her] agitation when these episodes occur. [She felt that her] mood was largely unchanged from where it has been…

…<u>Impression</u>

The overall impression is that [the] psychotic symptoms appear to have responded well to the low dose of Quetiapine.

<u>Plan</u>

- *Given the fact that nursing staff do use prn dose with her on occasion I would advise introducing a small morning dose 12.5mgs to see if this restricts the use of the prn more. I advise no other changes to her medications…'*

13. I have also reviewed the patient's MARS for the period 21 December 2015 to 20 February 2016. I note her Quetiapine was withheld on 30 December 2015 following an instruction from her GP as she was being treated for a respiratory tract infection. The patient was admitted to hospital on 6 January 2016 and returned to the Home on 13 January 2016. Her GP contacted the Home on 18 January 2016 and gave an instruction to recommence her Quetiapine (12.5mgs in the morning and 25mgs at night).

14. I have included a table below to further outline the changes in the patient's dosage of Quetiapine.

Date	**Dosage**	**Comments**
Prior to Oct 2015	25mgs NOCTE 25 mgs PRN	Family were informed
9 Nov 2015	Review by Dr […]Recorded in nursing home notes that he will increase Quetiapine to 12.5mgs mane in addition to 25mgs NOCTE	Family not informed of this change.
21 Dec 2015	Dr […] advises GP to	

	introduce a 12.5mgs AM dose to restrict the use of the PRN dose	
30 Dec 2015	GP instructs care home to withhold Quetiapine	
6 Jan-13 Jan 2015	The patient in hospital	
18 Jan 2016	GP instructs care home to introduce Dr […] recommendation of 12.5mgs AM	
18 Jan -20 Feb 2016	12.5mgs AM 25mgs NOCTE	

The Home's response to investigation enquiries

15. The Home provided a history of the patient's administration of Quetiapine. It stated the patient was prescribed Quetiapine 25mgs at night and 25mgs PRN[5] prior to October 2015. These were accurately documented on the medication administration records (MARS). The Home stated that in the period 26 November 2015 to 29 December 2015 the MARS documents on all but two nights the patient received the 25mgs dose at night. However she did not receive any administration of the PRN dose. The Home referred to the Consultant Psychiatrist's instruction letter of 21 December 2015 and stated the dose was therefore not altered until then. The Home added that Quetiapine was withheld from 30 December 2015 after an instruction from her GP.

16. The Home explained that by the time the patient returned from hospital in January 2016 the dose change was in place and the PRN dose was discontinued. The Home further stated that at no time between 26 October 2015 and 18 January 2016 did it administer any PRN dose of Quetiapine. The Home added there was no legal prescription in place for the administration of

[5] As required

PRN Quetiapine from December 2015. Following the patient's return from hospital on 13 January 2016, the Home stated that the dose of 12.5mgs Quetiapine in the morning and 25mgs at night was recommenced on 18 January 2016 following a phone call from her GP.

Independent Professional Advice

17. Following an initial review of the records by the Home, the IPA stated the MAR records were incomplete for the period 21 December 2015 to 20 February 2016. The Investigating Officer subsequently obtained these missing records from the Home and these were provided to the IPA. The IPA clarified her advice upon receipt of these records.

18. The IPA explained that prior to 21 December 2015, the patient was prescribed 25mgs at night. From 21 December she was prescribed quetiapine 12.5mgs in the morning in addition to 25mgs at night via an instruction letter. The IPA advised *'From these records it appears by 30th December, the patient was only being given regular quetiapine 25mgs. This accords with the care home manager statement. By 13th January, both doses appear to have been reinstated.'* The IPA also referred to the instruction from her GP on 18 January 2016 to the Home that one Quetiapine 25mgs tablet was to be taken at night and 12.5mgs in the morning (half a tablet). In relation to whether the patient was administered a PRN dose of Quetiapine between 21 December 2015 and 20 February 2016, the IPA advised *'I conclude from the records available, there is evidence that quetiapine was not administered on an 'as required' (prn) basis, but only as a regular prescription.'* The IPA concluded *'There is strong evidence that during 18th January 2016 – 20th February 2016, the medicines were administered correctly.'*

Analysis and Findings

19. The complainant raised concerns that his mother's drowsiness and over-sedation was caused by her Quetiapine, which he later learned had been recommenced on 18 January 2016. The complainant stated he had raised

concerns from this date about her drowsiness and over-sedation. As a nursing home does not prescribe medication, this issue of complaint has sought to establish whether the Home administered the patient's Quetiapine in accordance with what was prescribed from 18 January 2016 to 20 February 2016. Therefore whether it was appropriate for the patient to have been initially prescribed this drug is not the responsibility of the Home and is accordingly outside the remit of this investigation.

20. The investigation of this issue was initially hampered by the lack of available MARS for the stated period. These records were initially not provided to the IPA as the Home indicated they could not be located. The records were subsequently located by the Home and provided to the IPA who provided further comment on receipt of the records. I am therefore satisfied that the IPA's updated advice was based on the full MARS for the stated period of 18 January 2016 to 20 February 2016.

21. I have established that the patient was previously prescribed Quietiapine in relation to her ongoing distress and hallucinations. The doctor reviewed the patient on 9 November 2015 and as a result wrote to her GP on 21 December 2015 recommending a change to Quetiapine (12.5mgs in morning, 25mgs at night and no PRN dose). Due to complications arising from a chest infection resulting in a hospital admission from 6-13 January 2016, this change was not implemented and her Quetiapine was withheld from 30 January 2016. Following the patient's return from hospital, the GP subsequently communicated this change to the Home on 18 January 2016.

22. The IPA has noted from the available records that there was no evidence of a prn dose being given to the patient, which was the intention of her Consultant Psychiatrist. I accept the IPA's advice that the administration of the patient's Quetiapine was reasonable and appropriate. I am satisfied that this drug was correctly administered to the patient according to instruction, which accords with the response from the Home. I have not identified a failure in care and treatment in relation to the Home's administration of Quetiapine to the patient. **I therefore do not uphold this issue of complaint.**

Issue two: Whether the complainant's concerns about the level of sedation administered to his mother from 18 January 2016 were adequately addressed by the Home?

Detail of Complaint

23. The complainant stated that from 18 January 2016 his family raised concerns about his mother's level of sedation as they and other visitors repeatedly found her drowsy and 'hard to wake'. The complainant said they were worried about the potential for her to aspirate and raised these concerns initially with the Home's nursing staff to no avail. His mother was rushed to hospital on 20 February 2016 with aspiration pneumonia and tragically passed away the following day. The complainant said that the Home denied she was drowsy during this period. He also denied that he was supplying his mother with alcohol as stated by the Home. The complainant also said that he found his mother left 'lying flat' in her bed on a number of occasions, which increased her risk of aspiration.

Evidence Considered

The complaint to the Western Health and Social Care Trust

24. I note the complainant submitted a complaint to the Trust on 7 March 2016 and outlined the dates via a timeline in which he raised concerns about his mother's sedation and when she was found to be drowsy. According to the complainant, he raised concerns with the Home's nursing staff initially on 19 and 20 January 2016 and then between 27 and 31 January 2016 he found her to be still very drowsy. On 31 January 2016 he stated he raised concerns again and queried the name of the drug (Quetiapine) and its dosage. He stated a nurse from the Home advised him he should get used to his mother's drowsiness and he was contacted on 5 February 2016 by his mother's Community Psychiatric Nurse (CPN).

The patient's nursing home records

25. I have reviewed the patients daily communication records on the dates that the complainant outlined that he raised concerns with the Home's nursing staff. The record of 19 January 2016 contains no notes to indicate that the complainant visited his mother or raised concerns with staff. On 20 January 2016, it is recorded that the complainant visited his mother in the afternoon and that staff had queried her alcohol intake due to an empty wine bottle left in the fridge and would monitor this. However there is no record that the complainant raised concerns with staff on this occasion. On 31 January 2016, it is recorded that the complainant visited and queried whether the medication she had been recommenced on (Quetiapine) was making her drowsy. The complainant was advised to speak to his mother's GP regarding this. He was reassured that the Home would continue to observe his mother but staff felt *'she is responsive and not overly sleepy'*. The complainant stated he would research this medication and the Home agreed to inform the CPN regarding his concerns.

CPN records

26. I have reviewed the CPN records during this period. I note the Home contacted the CPN on 1 February 2016 and relayed the complainant's concerns regarding his mother's medication and drowsiness. The CPN agreed to discuss this directly with the complainant and did so via a telephone call on 5 February 2016. He was advised the issue would be discussed at the MDT meeting on 9 February 2016. The Consultant Psychiatrist considered the concerns raised by the complainant and the views of Home staff and recommended that the patient remained on the dose of Quetiapine.

The Home's response to investigation enquiries

27. The Home stated the Trust report compiled between June and September 2016 acknowledged that the complainant and family had spoken to staff about the administration of Quetiapine. The Home stated the report also

acknowledged that the multi-disciplinary team (MDT) had these concerns referred to it by Home staff and in addition the complainant was advised to speak to his GP directly. The Home stated the perception of the family to the levels of consciousness of the resident were clearly at odds with the professional opinion and documented evidence of Home staff and members of the MDT who assessed the patient. The Home added concerns of the staff and the MDT reflected in the report regarding the consumption of alcohol and the facilitation of family members in providing this.

28. In relation to the complainant's belief that he raised concerns on 19 and 20 January 2016, the Home stated there is no record of discussion between nursing staff and the family regarding drowsiness in the nursing records. The Home stated there is a record of a visit on 20 January 2016 but no mention is made of these concerns. The Home referred to a meeting on 21 January 2016 between the patient's CPN and Social Worker which did not discuss concerns of drowsiness but agreed to monitor her hallucinations and to discuss her consumption of alcohol with her son.

Independent Professional Advice

29. The IPA referred to entries in the patient's nursing records such as repositioning charts, fluid balance charts, care plans and daily records. The IPA noted concerns raised by the Home regarding her use of alcohol and advised *'This suggests to me that the staff were actually being very cautious about what substances [the patient] consumed, and the potential effects on her. Drowsiness would be an obvious potential effect of alcohol, as well as a potential effect of her treatment. I note in passing that the following treatments may all cause drowsiness: Baclofen, Quetiapine, Loratadine, Zopiclone.'* The IPA noted entries in the daily care record prior to this period that refer to the patient being sleepy or drowsy and having a chest infection for example on 27 and 28 December her co-codamol was withheld due to drowsiness. The IPA concluded that *'no concerns were recorded by staff regarding excess drowsiness during this particular period (ie from 19th January) apart from one care plan evaluation entry in which the prescription is on hold due to*

drowsiness. She otherwise appears to have been taking diet and fluids at appropriate times, occasionally refusing them, and to have received care on regular repositioning. The care plan also identifies risk factors such as alcohol.'

30. In relation to the complainant's concerns that his mother was 'lying flat', the IPA advised that the communication record dated 8 February documents that he complained to the nurse why his mother was lying flat but does not elaborate on whether she was lying flat or not. The IPA referred to the care plan dated 13 September 2015 which specifies *'please ensure head of bed is upright'.* The IPA advised *'this positioning is good practice in preventing chest infection and reducing any risk of aspiration.'* The IPA advised *'It's not possible to conclude from this whether she was lying flat on 8th February other than her son's word on this. Other entries in the care record give an indication that the staff were providing appropriate care regarding the patient's positioning on other occasions including sitting her upright, and that she was sufficiently alert to be offered diet and fluids.'* The IPA was satisfied the Home had planned care for her positioning and correct consistency of, diet and fluids. The IPA advised *'I conclude from this that the care home were taking appropriate steps to reduce the risk of her suffering an aspiration pneumonia.'*

Analysis and Findings

31. I have found no evidence to corroborate the complainant's view in relation to the concerns raised with Home staff, specifically on the 19 and 20 January 2016. I note the Trust's investigation arrived at the same conclusion. It is clear the complainant did raise concerns with the Home on 31 January 2016 and queried whether Quetiapine was causing his mother to be drowsy. The Home referred his concerns to the CPN who arranged a multi-disciplinary review of his mother's medication. I accept the advice of the IPA that no such concerns were recorded by staff regarding excess drowsiness, except on 31 January 2016.

32. In relation to his concerns that he found his mother to be lying flat on

occasions, although I have no reason to doubt the complainant's view I have found no records to support that this occurred on 8 February 2016 or on other occasions. The IPA has advised that staff were providing appropriate care regarding the patient's positioning in bed and were taking appropriate steps to reduce the risk of aspiration pneumonia. I accept this advice.

33. Although I have no reason to doubt the complainant's view that he raised concerns on 19 and 20 January 2016, due to the lack of supporting evidence I am unable to conclude whether or not he did raise such concerns. I can however conclude that he raised concerns on 31 January 2016 with the Home. I am satisfied that the Home took appropriate action in responding to these concerns by referring the matter to the patient's CPN in a timely fashion. I am also satisfied that the Home took appropriate steps to reduce the risk of aspiration pneumonia, however despite these efforts the patient sadly passed away on 21 February 2016. I have not identified any failures in care and treatment in relation to this aspect of the complaint. **I therefore do not uphold this issue of complaint.**

Issue 3: Whether the patient received the appropriate diet from the Home from January 2016?

Detail of Complaint

34. The complainant stated that he was concerned with his mother's diet and fluid levels within the Home, due to the linkage with aspiration pneumonia. The complainant indicated he was particularly concerned with the appropriateness of her diet from 14 January 2016 following her return to the Home from hospital.

Evidence Considered

The patient's medical records

35. I have examined the patient's Speech and Language Therapy (SALT records) during her time in hospital from 6 January to 13 January 2016. A SALT assessment on 12 January 2016 recorded the following recommendations, *'liquids: normal with valved cup as visual impaired'* and *'diet: normal all food cut up into 15mm as precaution.'* On 14 January 2016 SALT issued the following instruction to the Home: *'Further to our phone call today I can confirm that [the patient] had a swallow assessment on 12/01/16 in AMU[6] Altnagelvin. There was no evidence of significant dysphagia[7] but I did feel that she might benefit from using a valve cup so a drink safe cup was provided. She should continue on normal liquids and her normal diet with all food cut up into 15mm pieces and should any further swallowing difficulties arise she can be referred to Speech and Language Therapy…'*

The Home's response to investigation enquiries

36. The Home explained that in the period prior to the patient's hospital admission in January 2016, her care prescription as assessed by nursing staff in the Home was to provide finger foods and closed beaker drinks. The Home stated there were no restrictions on her diet other than this and no textured diet was required. This was followed and her diet included cereal, a range of meat products, biscuits, porridge and chips. The Home added support was offered by staff for food that the patient could not eat independently. In relation to the SALT instruction on 14 January 2016, the Home stated the SALT guidelines did not alter the food provided by the Home and therefore no changes were made with the exception of a change of beaker for drinks.

[6] Acute Medical Unit
[7] *Dysphagia* is the medical term for swallowing difficulties. Some people with *dysphagia* have problems swallowing certain foods or liquids, while others can't swallow at all.

Independent Professional Advice

37. The IPA referred to the swallow assessment on 12 January 2016 and the email to the Home dated 14 January 2016. The IPA advised that this confirms the hospital record dated 12 January 2016 which also records *'no sign of aspiration.'* The IPA also referred to the Home's description of the patient's diet and advised that *'The patient's diet in the home was appropriate and reasonable for her condition, and complied with advice provided by the SLT on safe swallowing.'*

Analysis and Findings

38. The complainant raised concerns about the adequacy of her mother's diet while she was a resident in the Home. I note the SALT had not noted any significant dysphagia when the patient was assessed on 12 January 2016 at Altnagelvin Hospital. The SALT did however make some recommendations which were communicated to the Home on 14 January 2016. I accept the advice of the IPA that her diet was appropriate and reasonable and complied with SALT advice. I am satisfied that there is no evidence to suggest that the patient's diet in the Home increased her risk of aspiration pneumonia. I have not identified any failures in care and treatment in relation to this issue of complaint. **I therefore do not uphold this issue of complaint.**

Issue 4: Whether the Home's communication with the family regarding the changes to the patient's medication on 18 January 2016 was appropriate and reasonable?

Detail of Complaint

39. The complainant said that despite raising concerns about his mother's drowsiness, he only found out from the nursing home staff on 31 January 2016 that her medication had been changed on 18 January 2016. This resulted in him questioning whether Quetiapine had been causing her drowsiness as he had noticed his mother being drowsy from around this time. The complainant stated he had never been informed previously of his

mother's medication but was informed when she was put on antiobiotics.

Evidence Considered

The patient's nursing home records

40. As stated earlier in this report, the patient's GP contacted the Home on 18 January 2016 and gave an instruction to recommence her Quetiapine (12.5mgs in the morning and 25mgs at night). On 31 January 2016, it is recorded that the complainant questioned whether this medication was making her drowsy.

The Home's response to investigation enquiries

41. The Home stated that there is no written evidence that the recommencement of Quetiapine on 18 January 2016 was communicated to the family in the care evaluations or Next of Kin communications. The Home added there is a reference to a visit by the complainant on 20 January 2016 however the only interaction between staff and the complainant at this time was in relation to concerns raised about the consumption of alcohol. The Home stated there is no formal policy or procedure for communicating medication changes to the family. The Home added it may be assumed that considering the level of communication with the family at that time, staff would have discussed the recommencement with the family however there is no documentary evidence to support this assumption.

42. In relation to whether the patient had capacity to be informed of her medication changes, the Home stated staff are not suitably qualified to complete a formal capacity assessment. The Home added that it can be presumed with the previous medical history and documented evidence of hallucinations that the patient's ability to receive, retain and process information regarding her medication changes would have been compromised.

Independent Professional Advice

43. The IPA advised *'This question hinges on the question of whether [the patient's] wishes regarding communication about her treatment between the care home and her son were identified, considered and appropriately recorded.'* The IPA further advised that *'It would however have been good practice for the Home to assess her mental state, determine her wishes if possible and to identify appropriate communication pathways including what information to disclose and to whom.'* The IPA advised that her admission documentation suggests she could engage in discussions and retain information however there is also numerous references to her alcohol consumption, hallucination and verbal aggression. The IPA advised *'It would appear from these records that it would have been appropriate to attempt a basic discussion with [the patient] to identify to whether she would like her treatment discussed with her son. However I did not find any entry about this.'*

44. The IPA referred to entries in the communication records in February 2016 that indicate the Home was aware of his concerns regarding medication although it is unclear whether it had asked his mother's permission to do so. The IPA advised *'My opinion is that the home or GP would not be expected to inform [the complainant] of the medication change, unless indicated from assessment of his mother's mental capacity and wishes. The care home should have recorded whether they had identified if [the patient] could make decisions about her treatment and care was discussed with her son, and if so, whether she gave permission for her treatment and care to be discussed with her son. There is no record that this was done. There is no evidence of protocol or guidance on how the staff should communicate with the next of kin regarding treatment changes. There is therefore no direct evidence that they should have informed him, but it would be best practice to have carried out these underpinning steps.'*

45. In response to the IPA, the Home stated *'We acknowledge that there is critical feedback to the home in respect of the communication with those deemed as significant others (family) in regard to the changes in the medication and*

would state that the changes in medication (in particular the restart of an originally prescribed medication quetiapine) would not usually necessitate immediate communication to the family in all circumstances, but that we should have ascertained and do now with the commencement of our care prescription and consultation programme determine what information a family wish to have shared with them, how often and in what means.'

The Trust's response to investigation enquiries

46. The Investigating Officer sought clarification from the Trust regarding whether the patient was assessed as having capacity. The Trust provided a response from the doctor who assessed her, who stated that the patient completed a mini mental state examination (MMSE) on two occasions and on both occasions she showed evidence of deficits in short term memory, attention and some disorientation to time. However the doctor explained; *'The MMSE is not a test of capacity but can be used alongside an assessment of capacity to demonstrate deficits in areas relevant to capacitous decision making. There is no score on an MMSE that would allow us to determine automatically whether someone has capacity, or not, for a certain decision. At various assessments GW is recorded as demonstrating some insight and understanding of her symptoms and illness. On 26.3.15 she told a nurse that visions of a man in her room "could be all in my head as I have brain damage". On 9.11.15 she was able to tell me that she was in the nursing home because she had brain damage as a result of a cardiac arrest. This level of understanding may have been in keeping with a degree of decision making capacity about her illness and her care. In contrast to this she was reported to become extremely distressed at times due to her hallucinations which could indicate a lack of insight into the nature of her symptoms at certain times of the day. It is certainly possible that GW had fluctuating capacity over the period she was involved with our service. With regard to the period at the beginning of 2016 it would be difficult to be clear whether she had or lacked capacity. Physical ill health may have impacted further upon her presentation during this period.'*

Analysis and Findings

47. In relation to whether the complainant was informed of his mother's recommencement of quetiapine on 18 January 2016, I have found no evidence that this information was communicated to him. As part of my investigation, I noted the Home completed a 'Resident Details' form for the patient upon her admission to the Home in December 2012. However the section entitled 'capacity status' was not completed.

48. I note the Home has stated it is not its responsibility to undertake a formal capacity assessment as staff are not suitably qualified. I accept the advice of the IPA that there is no evidence the Home discussed with the patient what information she wanted discussed with her son. I consider the Home failed to have recorded a discussion with the patient about what information she wanted communicated to her son. The Home has acknowledged the comments of the IPA in this regard and stated it has now rectified this issue with the commencement of a care prescription and consultation programme

49. It is therefore not clear whether the Home considered the patient to have capacity to make decisions about her care. I have considered the advice of the IPA and the comments of the patient's doctor. I acknowledge that the patient had some impairment as a result of her brain injury and no formal capacity assessment was undertaken. I conclude on the evidence available it is likely she could have expressed her views on the sharing of information with her family. However I consider it is difficult to determine whether she would have consented to sharing information about her medication with her family. I note the complainant was recorded as his mother's next of kin. I also note that he regularly attended his mother's care reviews and it was recorded her relationship with her family was good and they visited frequently. I have found no evidence to suggest that the patient would not have consented to this information being shared.

50. From a review of the nursing home records, I acknowledge that the complainant was informed by the Home when his mother was prescribed antiobiotics by her GP. However he was not routinely informed about her

other medications, including when they were withheld and recommenced. I do not consider therefore he had a reasonable expectation that he would be informed of a change to her Quetiapine on this particular occasion. I accept the advice of the IPA that the Home would not have been expected to inform him of such a medication change as there was no previously recorded discussion with the patient. I do not consider the lack of communication with the family on 18 January 2016 regarding the recommencement of Quetiapine constitutes maladministration. **I therefore do not uphold this issue of complaint.**

CONCLUSION

51. The complainant submitted a complaint to me about the actions of Culmore Manor Nursing Home in relation to the care and treatment provided to his late mother.

52. I have investigated the complaint and I have not found any failures in care and treatment in relation to the administration of Quetiapine, the Home's actions in relation to addressing the complainant's concerns about this drug, and the diet the patient received in the Home.

53. I have not found maladministration in relation to the Home's communication with the family on 18 January 2016. However I consider the Home failed to have recorded a discussion with the patient about what information she wanted communicated to her son. I did not identity an injustice to the complainant arising from this failure.

Paul McFadden
Acting Ombudsman **March 2020**

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.