Investigation Report

Investigation of a complaint against Comber Care Home

NIPSO Reference: 201917232

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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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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 201917236
Listed Authority: Comber Care Home

SUMMARY

I received a complaint about the care and treatment Comber Care Home (the Home)[1] provided to the complainant's mother (the resident) on 27 June 2020. In particular, the complainant believed the position of her mother in the bed and the manner in which staff fed her mother, contributed to her choking and vomiting. She raised further concerns about the manner in which staff moved her mother in the bed.

The investigation examined the details of the complaint, the Home's response, relevant records and relevant local and national guidance. I sought independent professional advice from a Consultant Nurse.

The investigation found that the Home did not follow Department of Health Care Standards for Nursing Homes and other relevant guidance on 27 June 2020 with respect to correct positioning of the resident for feeding. The resident should have been positioned at the head of the profiling bed with the bed in an upright position. Instead, the resident was placed at the foot of the bed with pillows propping her up. The resident vomited when she was being fed which I considered on the balance of probabilities was as a result of her choking on her food. I also found that a staff member used the same spoon to feed the resident each course of her meal without washing it between courses. The investigation found that when moving the resident in the bed to ensure she was upright, the overall practice of staff was unsafe. The investigation found the record keeping on this date was of a poor standard. I considered how the care home had regard to the human rights of the resident and concluded that they do not have appropriate regard for her right to respect and dignity.

[1] Comber Care Home is part of Four Seasons Healthcare Group

The investigation found the failures identified caused the complainant, her sister and the resident distress. I recommended the Home apologises to the complainant and her sister. I also recommended actions for the Home to take to prevent the identified failures from recurring.

THE COMPLAINT

1. I received a complaint about the care and treatment Comber Care Home (the Home) provided to the complainant's mother (the resident) on 27 June 2020. The complainant submitted the complaint on behalf of her mother, who sadly passed away 14 July 2020.

Background

2. The complainant said that her mother had been a resident of the Home for seven years. Her mother, a double above knee amputee, had dementia and was at '*end of life care*'. The Home had a care plan for feeding the resident, stating that she must be fed in an upright position. There was a risk assessment in place for choking.

Issue of complaint

3. The issue of complaint accepted for investigation was:

   Was the resident provided with appropriate care and treatment on 27 June 2020?

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 Home's handling of the complaint.

Independent Professional Advice Sought

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

Consultant Nurse, RGN, BA (Hons), MSc, PGCert (HE); with over 30 years nursing experience; specialising in the care of older people, holding a range of clinical and academic posts**.**

I enclose the clinical advice received at Appendix two to this report.

6. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'. However, how I 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 specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[2]:

   - The Principles of Good Administration
   - The Principles of Good Complaint Handling

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

   The specific standards relevant to this complaint are:

   - The Nursing and Midwifery Council's Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (NMC Code);
   - Department of Health Social Services and Public Safety, Care Standards for Nursing Homes April 2015, (DoH, Care Standards)

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

- Public Health Agency, Nutritional guidelines and menu checklist for residential and nursing homes, March 2014, (PHA Nutritional Guidelines);
- National Institute for Health and Clinical Excellence (NICE) guidance on nutrition support in adults (CG32), February 2006, (NICE CG32); and
- Manual Handling Operations Regulations (Northern Ireland) 1992, (Manual Handling Regulations).

9. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

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

INVESTIGATION

Issue: Was the resident provided with appropriate care and treatment on 27 June 2020?

Detail of Complaint

11. The complainant said her mother, the resident, had been moved to another room to facilitate deep cleaning of her own room. In the temporary room, care assistants placed the resident in bed the wrong way round, with her head at the foot of the bed but propped her up with pillows so she was comfortable. The complainant's sister was outside the Home, visiting the resident through the window and she witnessed the events.

12. At lunchtime the nurse arrived to feed the resident. Instead of changing the resident's position in the bed, she propped her up in the bed with pillows and began feeding her. The resident refused the soup and the nurse continued to the pureed main course. According to the complainant's sister, the nurse kept spooning the food into the resident's mouth without encouraging her or checking that the food had been swallowed. The complainant's sister said that

the resident then choked and was sick. Care assistants helped to clean the resident and more pillows were used to prop her up. The staff then tried to move the resident up in the bed in a manner that the complainant believed was '*uncomfortable and disrespectful of a 93 year old who was extremely frail'*. The complainant's sister said that she was '*extremely shocked and distressed by what she saw'*.

Evidence Considered

Legislation/Policies/Guidance

13. I referred to the following policies and guidance, which were considered as part of investigation enquiries:

    - The NMC Code;
    - DoH Care Standards;
    - PHA Nutritional Guidelines;
    - NICE (CG32);
    - The Home's Choking Risk Assessment; and
    - The Home's Nutrition Policy.

Relevant extracts from the guidance are enclosed at Appendix three to this report.

The Home's response to investigation enquiries

14. The Home questioned staff involved in the incident and in its response to the complaint, the Home stated, '*it was accepted that [the resident] had been put in the bed the wrong way round'*. It also explained that staff '*had positioned pillows behind [the resident's'] back to ensure she was in an upright position*'. The Home explained, '*If she had been sitting in an upright position supported by pillows this would not have been any different than the back of the bed being raised*'.

15. It also stated that the resident was coughing prior to being fed and '*did not appear hungry for her lunch'*. The Home further stated '*On the day in question it was noted she had ate her breakfast but would not open her mouth for any of her lunch despite numerous attempts*.' And '*She did not take anything'*.

16. The Home stated that the resident did not choke but instead '*vomited some brownish fluid mixed with whitish coloured phlegm'*. According to the Home, '*this does not appear to have been a choking episode as no food had been eaten at lunchtime'*.

17. The Home explained that the nurse admitted to using the same spoon to feed the resident her lunch and supplement. The Home said '*[the nurse] did state that the same spoon was used for which she apologised'*. The Home state that it is unclear why in the first response to the complainant, the Home Manager '*states that the same spoon wasn't used'*.

18. The Home stated that the staff did not move the resident in an inappropriate manner. According to the Home, the staff interviewed about the incident were asked directly '*if they had hooked their hands under [the resident's] arms and under her legs to lift her up the bed, they appeared surprised by this question and said that they would never use this type of technique*'. The Home stated that '*this would not be a technique that any of our staff would be taught or one that is permitted'*.

Relevant care records

19. A summary of the relevant care records is enclosed at Appendix five to this report. These include extracts from:
    - The Resident's care plans;
    - The Resident's malnutrition risk assessment;
    - The Resident's medical records; and
    - The Resident's daily food and drinks intake chart.

Relevant independent professional advice

Care Plan Four and Choking Risk Assessment

20. In relation to care plans, the IPA advised that Care Plan four (prepared on 20 June 2020) aimed to '*maintain good nutritional intake' documented that '[the resident] should be upright, awake and alert for oral intakes…[the resident] is at high risk of choking and has history of an episode requiring intervention…staff*

to check that [the resident] has cleared her mouth before taking next spoon of food or sip of drink'.

21. The IPA advised the Home's Choking Risk Assessment for the resident was described a medium risk with a score a total of 48. The IPA advised a MUST Score[3] indicated that the resident was at a high risk of malnutrition. The IPA concluded: '*the care plans and risk assessments were up to date, and reflected change in resident need and advice from SLT[4] [speech and language therapist] and GP*'. However, the IPA advised that there was '*a discrepancy between the oral assessment vs the nutritional assessment*'. However, she advised that '*the nutrition care plan does contain adequate information to guide nutrition and feeding'*.

22. The IPA advised that the care plans and risk assessments met the relevant standards including the 'Home's Health Care Nutrition Policy and the '*[DoH Care Standards], Standard 12 – Nutrition, Meals and Mealtimes, and the [PHA] Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes (2014*)'. The IPA concluded *'… that the food and fluids provided were appropriate and followed recommendations from SLT and GP, and the resident care plan'*.

Feeding of the Resident on 27 June 2020: Feeding the resident

23. The IPA considered the account given by staff 'I tried to feed her with teaspoon, however she will not open her mouth…so, I stopped feeding her. She did not take anything. She coughed again and vomited some phlegm with fluids' and 'she was coughing not choking'. The IPA noted the complainant's account '*[the resident] did open her mouth and [nurse] gave her several spoonful of food. Mum clearly choked'*, as [the complainant's sister] '*was able to see her and hear the food gurgling at the back of Mum's throat*'. The IPA advised that resident *'…presented with choking risk on 27 June 2020 but that she was not*

[3] 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition.
[4] SLT - Speech and language therapists provide treatment, support and care for children and adults who have difficulties with communication, or with eating, drinking and swallowing.

positioned appropriately for feeding and that staff had not taken appropriate action'.

24. The IPA considered the implement used to feed the resident. She concluded from the statements from the complainant's sister and the staff interviews: '*that a spoon was used, which was appropriate, but that there is a dispute regarding whether it was clean or not'*.

Feeding of the Resident on 27 June 2020: Position in bed

25. The IPA advised that both the complainant and the Home agreed that the resident was not properly positioned in the bed when feeding began. '*From the documentation reviewed, I note that all parties agree that she was in the bed the wrong way round'*. The IPA advised that the Home upheld this element of the complaint and '*staff recognise that they should have checked the position of the bed before assisting the resident into the bed'.*

26. The IPA advised that '*the position of the [resident] in bed whilst being fed was not appropriate or in line with the care plan'.* The IPA advised that care plan three (prepared 9 August 2019) documents that the buzzer had to be within reach when the resident is in the bed. With the resident being in the bed the wrong way round, '*it is unlikely that the buzzer would have been within reach'*.

27. The IPA further advised that the position of the resident in the bed meant that the 'profiling function of the bed, which raises the head, could not be used. It would not be possible to achieve a satisfactory upright position without raising the head of the bed, because pillows alone would not give enough support'.

28. The IPA advised that the position of the bed meant that the staff were not following the Home's risk assessment or meeting DoH Care Standards. The IPA advised the resident '*was not correctly positioned to reduce the risk of choking. This did not follow the care plan or meet the [DoH Care Standards], 12 Nutrition, Meals and Mealtimes 24. Residents are positioned correctly and safely to avoid the risk of choking and to promote enhanced enjoyment of meals*".

Moving the Resident on 27 June 2020

29. The IPA described the care plans that were in place concerning how the resident should be moved. '*A Person in care Handling Profile' is included in the [resident's care records]. This details 'Movement in bed' as 'assistance of 2' and 'slide sheet''. Evaluation on 17th June states 'no changes to person in care handling profile*'. The IPA advised that the care plans were adequate and in line with appropriate standards. The IPA concluded '*the documentation is up to date and in line with [DoH, Care Standards]*'.

30. The IPA was asked about the way in which the resident was moved in the bed. She advised that the '*description provided by the complainant is very specific and plausible*'. She advised that prior to the introduction of regulations on manual handling, '*this type of patient handling was prevalent. It is possible that it was used as a 'lazy' way of quickly moving the patient*'. She concluded that '*in this case it is one person's word against another whether [the resident] was manually lifted'.*

31. The IPA advised, '*Manual lifting of the type described in the complaint is unacceptable practice due to risk of injury to both patient and staff therefore sliding sheets should have been used to adjust position in bed. The limits to manual handling are set by law in the Manual Handling Operations Regulations (Northern Ireland) 1992'*.

32. The IPA concluded '*Whether the nurses moved [the resident] up the bed or not, their overall practice was unsafe due to the bed being the wrong way round, pillows being used rather than the profiling bed and no attempt made to follow the care plan on correct moving and handling'*.

Record Keeping on 27 June 2020

33. The IPA advised that '*The Progress Sheet entry on 27 June 2020 refers to Care Plan 4 'Diet and fluids monitored and recorded' No coughing or choking episodes are reported on the progress sheet for that date.*' There is a retrospective entry regarding the incident was made on 28 June 2020 noting that the resident had vomited whilst being fed. The IPA concluded '*this is*

unacceptable because the records on the day do not accurately describe the incident, then are followed by the retrospective note. The events were therefore not adequately recorded'.

Complainant's Response to Draft Decision Report

34. I shared a draft copy of this report with the complainant and the Home for comment on factual accuracy and the reasonableness of the findings.

Feeding of the Resident on 27 June 2020: Feeding the resident

35. The complainant disagreed with the Home's response that the resident was coughing prior to the nurse feeding her lunch. She said 'this is not true; *Mum was not coughing and had not been coughing prior to the nurse coming to feed her'* and '*Mum was very settled prior to the Nurse coming into the room'*. The complainant was also concerned that nurse could not tell the difference between the resident '*coughing and clearing your throat*.'

Feeding of the Resident on 27 June 2020: Position in bed

36. The complainant also commented on the nurse's statement quoted by the IPA '*So I did not know that the bed was not in the proper position'*. She disagreed saying '*my sister told her that Mum was in the bed the wrong way round as soon as she came into the room but she choose to ignore this information'*.

37. The resident commented on the IPA's advice that care plan three (prepared 9 August 2019) documents that the buzzer had to be within reach when resident was in bed. She said '*we were not aware that this was documented in the Care Plan - we complained about this at least once a week. When we visited Mum the buzzer was regularly left hanging over the light fitting on the wall (towards the foot of the bed) or some other unreachable place'*.

Moving the Resident on 27 June 2020

38. The complainant also raised concerns about the Home's response about how they moved the resident as both she and her sister and '*witnessed this method [hooking hands under patient's arms and legs to lift] being used on many occasions but had no idea it was 'not permitted'*. The complainant said that her

sister had witnessed staff moving her mother in that way on 27 June 2020 and was able to describe it clearly, because she had seen it before.

General

39. The complainant made a general point that there was a '*total disregard for Care Plans and yet as long as they are in place it is accepted that the Home is acting correctly'*. She said that home staff lied about the implementation of care plans on six occasions including at meetings with representatives of the Trust. When she challenged the Home, they told her matters they would rectify matters, however, she said the Home continued to ignore care plans.

Analysis and Findings

Care Plan Four and Choking Risk Assessment

40. I note the IPA's advice and I accept this advice, I am satisfied that the Home had care plans in place that were adequate and in line with relevant standards. In addition, the Home had appropriate risk assessments in place to prevent choking. However, the IPA advised that there was a discrepancy between the oral assessment and the nutritional assessment. I consider this discrepancy in the records a service failure. However, I do not consider this failure to have affected the resident's care and treatment. I will refer to record keeping further below.

Feeding of the Resident on 27 June 2020

41. The Home and the complainant agree that the resident vomited. The Home staff say that this was a result of coughing. The complainant believed that her sister witnessed the resident choking and vomiting. Whilst I cannot be sure whether the resident coughed or choked, she did vomit.

42. When questioned by the Home manager, staff stated that resident did not eat anything at lunch. However, this contradicts the entry on the Daily Food and Fluid Intake Chart which states that a quarter of the resident's lunch was consumed. It also contradicts the statements made by the complainant's sister who witnessed the resident being fed.

43. The Home and the complainant agree that only one spoon was used when feeding the resident. However, there is a disagreement as to whether the spoon was clean or not. The nurse who fed the resident said when the Home Manager first interviewed her on 3 July 2020 stated '*I use the same spoon with her supplements, but I can assure that spoon was clean*'. This contradicts the complainant's account from her original complaint to the home '*Mum was fed her dinner, her pudding and her yoghurt using the same spoon, which was not washed in between each course'*. The Home's response of 29 July 2020 to the complainant has a different explanation '*she* [the nurse] *advises that the spoon that she used was not the same spoon used previously'*. The complainant responded in her letter of 14 August 2021 to the regional manager. She stated *'that there was only one spoon on the tray and it was definitely the same spoon that was used for each course, and it was not washed at any stage even though there was a sink in the room'*. The regional manager's response in her letter 7 October 2020 was to say '*She [the nurse] does admit that she tried to assist your Mum with desert using the same spoon and for this action she has apologised'*. The regional manager also stated that she was unclear as to why the Home manager had provided a different explanation.

44. Having examined the evidence, I accept the complainant's sister's description of the event which remained consistent in contrast to the account of care home staff. I am satisfied that the resident vomited and on the balance of probabilities this was because she was choking on food. I accept the Daily Food and Drinks Intake Chart records and the sister's account that the resident had eaten some food. I am also satisfied that the spoon was not cleaned between courses. I also considered my finding in relation to the resident's positioning for feeding which I considered contributed to the risk of choking. Therefore I uphold this element of the complaint. I refer to standard 12 of the DoH Care Standards and I consider that the feeding of the resident on the day did not meet this standard.

45. I consider this a failure in her care and treatment. I am satisfied that the failure identified increased risk to the resident, caused the resident to experience the stress of vomiting and the loss of opportunity to be fed appropriately, with clean

utensils. I am also satisfied that the failure would have caused the complainant's sister the injustice of witnessing the event and the complainant the injustice of hearing about the event.

Feeding of the Resident on 27 June 2020: Position in bed

46. I note both the Home and the complainant agree that staff placed the resident in the wrong position in the bed for feeding. The Home stated that this was acceptable because staff propped her up with pillows and thus she was upright enough for feeding. However, I note that the IPA advised the resident '*was not correctly positioned to reduce the risk of choking. This did not follow the care plan or meet the [DoH Care Standards], Standard 12 Nutrition, Meals and Mealtimes 24. Residents are positioned correctly and safely to avoid the risk of choking and to promote enhanced enjoyment of meals'.*

47. The IPA concluded that the resident 'had presented with choking risk on 27 June 2020 but that she was not positioned appropriately for feeding and that staff had not taken appropriate action'. I accept the IPA's advice. I consider that the position of the resident in the bed was not appropriate for feeding and that the staff had not followed the care plans. I consider this a failing in the resident's care and treatment.

48. I acknowledge that the complainant's sister experienced upset as she watched her mother being fed in an inappropriate position. I also acknowledge that the complainant experienced upset when her sister informed her of the Home's actions. I understand that staff were busy from the statements they provided to the Home manager as part of her initial investigation into the complaint. However, I am critical that they did not follow care plans and mitigation measures outlined in the risk assessments. Being busy should not be seen as an acceptable reason for failing to provide appropriate care standards. This is an issue for the care home to resolve by ensuring that appropriate numbers of trained staff are working to ensure residents are properly cared for and safe. Therefore, I uphold this element of the complaint. I am satisfied that the failure identified also caused the resident to experience the loss of opportunity to be fed in an appropriate manner and increased the resident's risk of choking. It may also have contributed to the resident vomiting.

Moving the Resident on 27 June 2020

49. I note the comments of the complainant about how staff moved the resident. The care plans related to moving the resident were considered by the IPA to be '*adequate and there is also extensive supporting documentation in the file relating to use of slings and manual handling which provides adequate detail relating to how she should be moved*'.

50. The IPA advised that 'a 'Person in care Handling Profile' is included in the documentation [provided by the Home]. This details '*Movement in bed' as 'assistance of 2" and "slide sheet*". The IPA advises that the complainant's sister who witnessed events said '*they then proceeded to hook their hands under Mum's arms and also under her legs and lifted her up the bed'*. She contrasts this with the accounts of the staff on that day, *'[Care Assistant] 'We put [the resident] in more upright position by putting more pillows. Home Manager 'Why didn't you feel the need of sliding sheet?' Care Assistant, 'No, since she was already very centred on the bed*'. The Home stated in its response to the complainant, *'[the staff] said they would never use this type of technique. This would not be a technique that any of our staff would be taught or one that is permitted'*.

51. The IPA advised that '*The description provided by the [complainant's sister] is very specific and plausible. Prior to regulation of manual handling, this type of patient handling was prevalent. It is possible that it was used as a 'lazy' way of quickly moving the patient, but in this case it is one person's word against another whether [the resident] was manually lifted'*. The IPA concluded that on 27 June '*Whether the nurses moved [the resident] up the bed or not, their overall practice was unsafe due to the bed being the wrong way round, pillows being used rather than the profiling bed and no attempt made to follow the care plan on correct moving and handling'*.

52. Based on the IPA's advice, the account of the complainant's sister and the lack of plausibility in the account of care home staff, I accept that the overall practice was unsafe and I uphold this issue of complaint. I accept that complainant and

her sister and the resident suffered an injustice as a result of the unsafe overall practice on 27 June 2020. The complainant and her sister suffered distress as did the resident.

Record Keeping on 27 June 2020

53. I accept the IPA advice that the record keeping on 27 June 2020 was '*unacceptable because the records on the day do not accurately describe the incident, then are followed by the retrospective note. The events were therefore not adequately record*ed'.

54. I refer to the NMC Code, Standard 10, which provides that nurses are required to '*complete all records at the time or as soon as possible after an event' and 'complete all records accurately and without any falsification'*. I consider that maintaining accurate and appropriate records are essential if relatives and families are to have faith in the standard of care provided to their loved ones. This has been particularly important when the ability of families to visit their loved ones has been considerably curtailed during the response to the COVID 19 pandemic. I see no reason why an accurate record of the events of 27 June could not have been recorded at the time.

55. I conclude that the Home did not create and maintain proper records of the events of 27 June 2020, which I consider is a service failure. I refer to the DoH Care Standards standard eight, in particular which states: '*Records are maintained for each resident detailing the following: - Incidents, accidents or near misses occurring and action taken*'. The Frist Principle of Good Administration *'Getting it right*' requires bodies to act *'in accordance with the public body's policy and guidance (published or internal)*'. The Third Principle of Good Administration, '*being open and accountable'*, requires bodies to keep proper and appropriate records. I consider that by failing to satisfactorily record the events of 27 June 2020, the Home failed to meet these principles. I am satisfied that this failure constitutes maladministration and I uphold this element of the complaint.

56. This service failure caused the complainant the injustice of frustration and annoyance.

57. While not an issue raised by the complainant, I am concerned about the rigour of the investigation conducted by the care home. I consider the contradiction between the accounts of staff and the residents family could have been resolved by a proper consideration of the records. I consider there is a need for a change in culture around how complaints are managed. Thorough and timely investigation of complaints provide an opportunity for resolution the building of trust and the opportunity to learn and improve. I do not consider these objectives were achieved in this case.

58. I refer to the human rights principles of fairness, respect, equality, dignity and autonomy (FREDA). I consider that the Home failed to meet these principles in its care of the resident while she was being fed and moved in the bed. I consider the Home did not give sufficient consideration to the patient's human rights and did not adhere to the FREDA principles of respect and dignity. I consider this failing maladministration. As referred to above in paragraphs 45, 48 and 52, the resident and complainant suffered distress as a result.

CONCLUSION

59. This complaint is about care and treatment Home staff provided to the resident on 27 June 2020. The investigation established that the care and treatment of the resident was not appropriate. I am satisfied that the resident was not positioned correctly whilst being fed and that this may have contributed to her vomiting. I am satisfied that when the resident was fed, one spoon was used and that it was not washed in between her meal and supplements. I am satisfied that when moving the resident in the bed, the overall practice of staff was unsafe. I found maladministration in relation to record keeping about the incident. I am satisfied the failures identified caused the complainant, her sister and the resident distress and increased risk to the complainant. I also found maladministration in consideration of the resident's human rights. I am satisfied that the complainant and her sister experienced the injustice of upset caused by their mother not receiving appropriate care and treatment.

Recommendations

60. I recommend the Home within one month of the date of this report:

    i. Provides the complainant and her sister with a written apology in accordance with NIPSO ‘Guidance on issuing an apology’ (June 2016), for the injustice caused to her as a result of the failures identified;

    ii. Provides evidence it shared and discussed this report with staff involved in the resident’s care;

61. I further recommend the Home provides refresher training to relevant staff to incorporate the following:

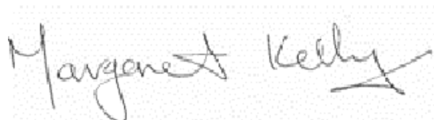
    i. The importance of following care plans and risk assessments when feeding residents;

    ii. The importance of using appropriate manual handling techniques when moving residents; and

    iii. The importance of accurate record keeping.

It should provide me with evidence of this training within three months of the date of my final report.

62. I wish to offer my condolences to the complainant and her family on the loss of their mother. It is clear the complainant was keen to ensure her mother received the highest level of care and treatment available. I hope the information contained in this report answers some of the remaining questions she had in relation to the care provided to her mother.



Margaret Kelly, Ombudsman **May 2022**

Appendix 1

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.