Northern Ireland
Public Services
Ombudsman

# Investigation Report

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

**NIPSO Reference: 18462**

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

## 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**

# SUMMARY

The complaint concerned the care and treatment provided to the complainant's late Aunt (the patient) by the Belfast Health & Social Care Trust (the Trust), when she was discharged from hospital into respite on 26 February and 10 November 2015. The complainant stated that the Trust discharged the patient into respite for lengthy stays against her will, and failed to appropriately discuss discharge procedures with her and her family. As a result, he complained that his Aunt was unaware she was free to return home at any time.

The investigation established that the Trust completed all of the required actions and processes prior to the discharge of the patient on 26 February 2015.

However, in relation to the discharge on 10 November 2015, the investigation established that the Trust failed to: make a record of the discharge processes followed and decisions made; and to communicate and consult with the patient's family prior to her discharge. In addition, the investigation identified that the Trust failed to invite the patient to the multi-disciplinary meeting on 11 November 2015.

I made a number of recommendations including an apology to for the failings identified and recommendations to improve the discharge process.

I am pleased to note the Trust accepted my findings and recommendations.

# THE COMPLAINT

1. The complaint concerns the care and treatment provided to the patient by the Trust on discharge from hospital in March and November 2015. The complainant stated that his Aunt was discharged *'into respite for lengthy stays against her will without relevant discharge procedures'* being followed. He complained that the Trust did not grant, invite, or notify the patient of discharge planning meetings to discuss her transfers.

2. In addition, the complainant stated that *'no one was given the opportunity to advocate or support [the patient].'* He stated that *'at no stage was the patient] or the family included in or informed that this was a temporary [placement], as [the patient] wanted it to be.'* The complainant advised that the family were unaware the patient was free to leave and return to her home at any time.

**Issues of complaint**

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

**Issue 1: Were appropriate discharge procedures observed when the patient was discharged from hospital into respite on the following occasions:**

- **26 February 2015**
- **10 November 2015**

# INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint.

**Independent Professional Advice**

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

- **CQSW** – Qualified Social Worker with over thirty years' experience (SW IPA).

6. The information and advice, which have informed my findings and conclusions, are included within the body of my report. The SW IPA has provided me with '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.

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

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsman's Principles for Remedy

9. The specific standards are those, which applied at the time the events occurred and which governed the exercise of the professional judgement of the Trust and staff whose actions, are the subject of this complaint.

10. The specific standards relevant to this complaint are:

- Northern Ireland Social Care Council's (NISCC) Codes of Practice for Social Care Workers and Employers of Social Care Workers, September 2002 (NISCC's Code of Practice)
- Belfast Health & Social Care Trust's Discharge from Inpatient Settings Policy 2015 (Discharge Policy)
- Department of Health, Social Services and Public Safety Circular, ECCU 1/2010, Care Management, Provision of Services and Charging Guidance

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

(Care Management Guidance)

- Department of Health, Social Services and Public Safety's Discharge from Hospital: pathway, process and practice (Discharge from Hospital Guidance), 28 January 2003

11. 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. In accordance with the NIPSO process, a draft copy of this report was shared with the Trust and the complainant for comments on factual accuracy and the reasonableness of the findings and recommendations.

# INVESTIGATION

**Issue 1: Were appropriate discharge procedures observed when the patient was discharged from hospital into respite on the following occasions:**

- **26 February 2015?**
- **10 November 2015?**

**Detail of Complaint**

12. The complaint concerns the care and treatment provided to the patient by the Trust. The patient was living intermittently between care homes and her own family home with the assistance of a care package. In March and November 2015, the patient was admitted to a residential care home for respite following discharge from hospital.

13. In these instances, the complainant stated that the patient was discharged from hospital *'into respite for lengthy stays against her will without relevant discharge procedures'* being followed. He complained that the Trust did not grant, invite, or notify the patient of discharge planning meetings to discuss her transfers to a residential care home. He believes that the patient was not *'involv[ed] in her future plans',* and was discharged to a residential care home *'against her wishes'.*

14. In addition, the complainant stated that *'no one was given the opportunity to advocate or support [the patient].'* He stated that *'at no stage was [the patient] or the family included in or informed that this was a temporary [placement], as [the patient] wanted it to be.'* The complainant explained that the family was unaware the patient was free to leave and return to her home at any time. He believes that these actions were *'indicative of the depersonalisation of care that followed [the patient] throughout her care, and the type of shortfall in care that left [the patient], in her latter years, sitting for up to two months at a time in [a residential care home].'*

15. As a result of the Trust's failure to provide an explanation *'of [the patient's] rights and options',* at the discharge meetings, the complainant believes that

she *'was robbed of months of time at her family home, [and] her right to private and family life was infringed upon.'*

**Evidence Considered**

16. I considered Standard 6 of NISCC's Code of Practice, which states that Social Workers must maintain *'clear and accurate records as required by procedures established for your work.'*

17. I also considered the Discharge Policy, specifically Section 3, Roles and Responsibilities:

*'**Allied Health Professionals and Social Workers***
*Make assessments, management plans and referrals appropriate to the patient's needs*
*Support and educate patients/ carers to prepare them for discharge*
*Provide contact names and numbers for patients/ carers to use in case of difficulties*
*Make records relating to discharge planning and decisions in the patient's file*
*Where necessary liaising with community-based counterparts.'*

18. In addition, I considered Section 4.1 of the Discharge Policy, which states:

*'**KEY POLICY PRINCIPLES**…*

- ***Ensuring the patient and, where applicable their carer, is central to the discharge process.** Communication and consultation with the patient, their family and carers are of prime importance in ensuring the patient experiences care as a coherent and coordinated pathway.*

*The process of assessment and decision-making should be patient-centred, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process… The assessment should include an assessment of the patient's mental capacity to make decisions about their personal welfare, which includes decisions relating to discharge planning, their ability to be involved in the process and what may be*

*needed to support them to be fully involved in the process…*

- ***Discharge planning is a multi-agency, multi-professional activity in which all professions including Community Staff have a contribution to make…*** *Community professionals need to be invited to attend pre discharge care meetings, for patients with complex needs****'.***

19. I also considered the patient's social work file, specifically entries by the Hospital Social Worker B, dated 4 and 11 November 2015:

*4 November 2015*
*"DN [District Nurses] have concerns about [the patient's] ability to manage her diabetes as they are calling regularly to check blood sugars and also 24 hour DN [District Nurse] service calling at night.'*

*11 November 2015*
*'TC [Telephone call] to [Trust's Social Care Coordinator] who confirmed level of POC [plan of care].*
*[Trust's Social Care Coordinator] advised that patient [the patient] may be willing to accept a period of respite prior to return home – to help in stabilising her blood sugars.*
*Capacity assessment documented by consultant – who felt she did not have capacity but would liaise with… [Consultant psycho-geriatrician] as patient had been attending Memory Clinic, although had missed some appointments there.*
*[Trust's Social Care Coordinator] reported that appointments are now sent to the day centre so that future appointments are not missed.*

*I spoke to [the patient] and she is agreeable to going into respite for a period of time. There is a bed available in Lansdowne [residential care home]. [The patient] will transfer there. [Trust's Social Care Coordinator] informed and will reassess during her stay.'*

20. In addition, I considered the Care Management referral form, dated 11 March 2015, which states the Trust *'advised [the patient's sister]… of [the patient's] agreement to remain in Care Home for a few weeks.'*

**The Trust's Response**

21. As part of investigation enquiries, the Trust was given an opportunity to respond to the complaint.

*Medically fit for discharge/ Step-down service*

22. The Trust stated that *'[the patient] had two short-term admissions to nursing home care in March 2015 and November 2015.'* It stated that the *'respite intervention was recommended by the Multi-disciplinary teams charged with her care in hospital, at the point of declaring [the patient] to be medically fit to leave hospital. The decision took into consideration consultation with community nursing and social work colleagues, in order to manage the risks identified at the time and to promote best recovery from episodes of poor health related to her unstable diabetes.'*

*The patient's capacity*

23. On discharge, the Trust stated that staff '*worked and engaged with [the patient] as a person with capacity to make decisions and it was always with her agreement that this arrangements proceeded.'* It stated that these respite placements were also discussed with the patient's *'wider family circle.'*

*Discharge planning meetings*

24. The Trust stated that *'due to the nature of acute hospital environments… [it does] not in all occasions undertake pre-discharge meetings, particularly where a person is already known to community services and there is no significant change in their care plan.'* At this time, the Trust stated that *'[the patient] had regular involvement with Community Social Work, District Nursing and also attended the Day Centre.'*

25. The Trust stated that *'the only circumstances where a discharge planning meeting may be required is where the needs of the person are of such*

*complexity, or that there are significant changes to an individual's care plan.'* It stated that *'this should be understood within the key principles inherent to supporting Older People, and as set out in the Care Management Circular (DHSSPS) 2010. This is that a hospital setting is not an appropriate place for decisions to be made regarding a person's long term care needs.'* However, the Trust state that *'it is important to note that whilst a pre-discharge meeting may not occur, it does not diminish responsibilities for Multi-disciplinary assessment and working, as well as the requirement for meaningful engagement and discussion with service users and families.'*

26. In addition, the Trust stated that it does *'not accept [the complainant's] claim that they did not engage with [the patient] or her family, furthermore that they did not support or advocate for [the patient].*' It stated that *'within the records… there is evidence of discussions with [the patient], her family and her legal representative.'*

**26 February 2015**

27. On 24 February 2015, the Trust stated that the Hospital Social Worker A *'spoke with [the patient] at her bedside in hospital and discussed step-down as an option. [The patient] agreed it was a good idea.'* The Trust stated that *'the financial implications of extending respite stay beyond two weeks was also discussed. [The patient] expressed no intention of staying after two weeks.'* It stated the Hospital Social Worker A recorded that *'I spoke with NOK [next of kin] [the patient's sister] and advised of plan. [The patient's sister] states she will pay any additional costs between two weeks in Lansdowne [Private Nursing Home]. They have done so in the past when she was in Lansdowne.'*

28. Subsequently, on 26 February 2015, the Trust stated that the patient transferred to Lansdowne Private Nursing Home. It stated that the Hospital Social Worker A recorded, *'I spoke with patient who is happy with same. I contacted sister… and advised of same. No issues.'*

**10 November 2015**

29. On 11 November 2015, the Trust stated that the multi-disciplinary meeting *'convened in Lansdowne Private Nursing Home (where [the patient] was residing at the time) details the heightened concerns of all the staff tasked with her care and protection.'* The Trust stated that *'there was a concern that [the patient] was requiring a lot of assistance from staff to attend to her care needs and it was becoming more obvious to the multi-disciplinary team that in her own home, despite a comprehensive care package, her physical condition was significantly less stable than when she was in the nursing home environment.'*

30. The Trust stated that '*while [the patient] was not invited to the multi-disciplinary meeting [on 11 November 2015], at all times decisions taken in the discharge planning were discussed with her by the Hospital Social Worker [B], as were the step-down arrangements and costs.'* The Trust stated that *'[the patient's] family were invited to and did attend this and further review meetings. Records do not convey why [the patient] was not at the meeting in November, but she was in attendance at the meeting in December.'*

31. The Trust stated that *'records accompanying this response indicate that [the patient] was consulted throughout and it was in discussion with her that this respite period was extended.'* Following admission to respite in November 2015, the Trust stated that the patient *'chose to remain in respite after her step-down arrangement had come to an end. She often talked to staff when she was at home about wishing to return to respite as she felt lonely.'*

32. Subsequently, on 7 December 2015, the Trust stated that a Consultant psycho-geriatrician, assessed the patient, and deemed that she was *'probably lacking the capacity to make decisions regarding her care needs.'*

33. On review, the Trust stated that its learning to date includes:
    - *'Information regarding the development and implementation of our Best Interest Toolkit.*
    - *Experiential learning from complex cases and court instruction*

- *The development of our Care Review and Support Team.'*

34. In addition, the Trust stated that it continues *'to work to improve our systems and process in relation to supporting people as they transition from hospital to the community or to alternative care facilities. As part of our Back to Basics project that we have recently commenced, we will be auditing, reviewing and developing best practice guidance to support people moving into temporary or permanent care placements.'*

**Relevant Independent Professional Advice**

35. As part of investigation enquiries, the SW IPA reviewed whether the Trust followed the appropriate discharge procedures when the patient was discharged from hospital into respite on 26 February and 10 November 2015.

**26 February 2015**

36. The SW IPA advised that *'[the patient] was discharged from the Mater Hospital to Lansdowne Nursing Home on 26 February 2015. This was as a result of a decision to provide a 'step-down' service for [the patient].'*

*Medically fit for discharge/ Step-down service*

37. The SW IPA advised that a 'step-down' service *'reflects that the patient is medically fit to be discharged from hospital but may need or benefit from a residential or nursing service for a limited time to fully prepare them for integration into their own home.'* The SW IPA advised that *'discharge from hospital is always a medical decision and is based on the decision of the medical staff that there is no further treatment that needs to be carried out within that particular care setting... [it] reflects that there is no longer a need to keep the patient in a ward bed… This reflects best practice and allows for a bed to be freed up.'*

38. Once deemed medically fit for discharge, the SW IPA advised that *'Social Workers and other allied health professionals, where appropriate, become involved. This is to ensure that the proper supports are in place to facilitate the process of movement from hospital to community.'* In this instance, the

SW IPA advised that *'[the patient] was assessed as being supported by an interim/step-down respite placement.'*

*Discharge procedures/ Consideration of the patient's needs*

39. The SW IPA advised that *'the discharge process is the responsibility of a multi-disciplinary team which have specific roles in ensuring best practice in caring for and supporting those leaving the hospital setting.'* The SW IPA advised that *'the Social Worker is at the core of the discharge process and provides the key link with the patient and with their family/ carers.'*

40. As part of investigation enquiries, the SW IPA was asked if the Trust's Discharge Policy was adequately followed in this instance. The SW IPA advised that the Discharge Policy reflects *'the Trust's commitment to the "safe and prompt discharge of patients from acute care"'.* The SW IPA referred to Section 1.2 of the policy, which details *'the role and responsibilities of Social Workers (and other Allied Health Professionals) in the discharge process.'*

41. On review of the patient's social work notes, the SW IPA advised that there was *'a consideration of [her] needs and circumstances'* The SW IPA advised that *'there is evidence from the files that all four elements of the [Hospital Social Worker's] role were undertaken and completed in adherence to the policy:*

    - *Assessment was carried out which resulted in the decision for [the patient] to enter respite'.* The Hospital Social Worker A spoke with the Trust Social Care Coordinator who stated *'she felt "The lady would benefit from period of respite following discharge to manage blood sugar levels"';*
    - *[The patient] and her next of kin, [the patient's sister], were involved in decision-making process and informed of developments.'* The patient '*is noted as agreeing that 'respite was a good option' and that [the Hospital Social Worker A] should look for possible beds in the North Belfast area'.* In addition, the SW IPA advised that the conversation between the Hospital Social Worker A and the patient's sister *'was by*

*telephone as [the patient's sister] was unwell at this particular time.'* The patient's sister *'agreed with the step-down procedure';*

- *'Records of the process are contained in [the patient's] file; and*
- *Both Trust staff and Nursing home personnel were engaged in the discharge process.'*

42. In addition, the SW IPA advised that the Discharge Policy contains a *'Carers and Discharge – A Practical Guide for Staff'* section, which *'refers to Social Workers and Allied Health Professionals'.* The SW IPA advised that this guide *'is largely an aide-memoir for staff to ensure that they have undertaken all necessary actions to ensure a comprehensive discharge which has all necessary support in place to address all aspects of the patient's physical and emotional needs. This includes links to the Trusts Community support where necessary and liaison with carers.'*

43. The SW IPA advised that the guide contains a discharge checklist, which *'is designed to ensure that multiple, complex needs are identified and met. [The patient] did not have multiple needs and the files indicate that her key needs were met and key contacts engaged and involved as appropriate.'* The SW IPA advised that *'In the circumstances engaging the discharge list would have been unnecessary and a duplication of existing actions and subsequent recording.'*

44. In relation to a discharge meeting, the SW IPA advised that *'there is no note of [one taking place] in [the patient's] case file. However this was not a complex transfer involving a number of different Trust staff rather a straightforward process which was coordinated by the Social Worker [1].'* In the circumstances, the SW IPA advised that *'all coordination and information sharing was carried out without the necessity to call such a meeting.'*

*The patient's capacity*

45. In relation to the patient's capacity to make decisions regarding her care, the SW IPA advised that *'there is no indication that [the patient] lacked capacity… This is not reflected in any of her medical or social care notes.'* The SW IPA

advised that *'it should be noted that [the patient's] next of kin [the patient's sister] was also involved in this process and no concerns are noted regarding [the patient's] ability to make this decision.'* The SW IPA advised that *'[The patient's sister] is noted as agreeing that this step-down process was acceptable and that she would take responsibility for any costs incurred.'*

*Overall*

46. The SW IPA advised that *'the Social Worker [A] undertook all of the key actions needing to be undertaken when an individual is deemed by medical staff to be ready for discharge. In [the patient's] case this included:*
    - *Identifying the benefit of a Step-Down arrangement as being of benefit for her, in particular regarding the management of her blood sugar levels;*
    - *Discussing this with [the patient];*
    - *Discussing this with [the patient's sister], her next of kin; and*
    - *Liaising with other appropriate Trust staff both in the hospital and the community.'*

47. In addition, the SW IPA advised that *'all of the processes and relevant considerations are noted in the file, as are relevant e-mail correspondence concerning [the patient's] health and wellbeing, as is the information pertaining to the consideration of respite as a step-down process for [the patient's] returning to the community.'*

48. While in respite, the SW IPA advised that it is recorded that the patient *'raised the idea of staying in the [nursing] home herself. The fact she herself felt she needed a further period in respite indicates that she did not feel fully ready to return home. In the circumstances it was appropriate for her to remain in respite for this further period of time.'*

**10 November 2015**

49. The SW IPA advised that the patient entered respite on 10 November 2015 *'as a result of her continued general ill health.'* On review, the SW IPA advised

that '*there are no notes… which appear to cover this period of time [and] the file does not contain a Discharge Planning meeting for this period of hospitalisation.'* However, the SW IPA advised that *'it is possible to extract this information from the general information contained in email correspondence and other earlier discharge minutes*.'

50. The SW IPA advised that '*it would appear that the main focus of concern remains health issues relating to [the patient's] diabetes. In particular concerns regarding her blood sugar levels are consistently noted.'* The SW IPA advised that *'this is coupled with concerns regarding her memory and cognitive ability which raises concerns regarding her ability to manage medication and control her diet to help alleviate these issues.'*

51. The SW IPA advised that *'there is evidence'* in the patient's notes that on discharge to respite, her *'health and well-being [was] considered and that, as far as possible, [her] wishes and preferences [were] taken into consideration.'*

*The patient's capacity*

52. In relation to the patient's capacity at this time, the SW IPA advised that she *'had become somewhat confused… but was still capable of voicing her wishes to return to her own home.'* The SW IPA advised that *'[the patient] had no concerns regarding going into respite in the past and it is not unreasonable to assume that if this were a step in eventually returning to her own home that this would not be an issue.'*

53. However, the SW IPA advised that *'[the patient's] capacity at this juncture was limited and it would not have been in her best interests to make this decision on her own. While there might be an indication from her previous agreement to enter respite this should have been informed by support from her next of kin/ carers.'* The SW IPA advised that *'I have been unable to identify from the files if [the patient's] was contacted regarding [the patient's] proposed entry into respite. If this occurred it should have been clearly documented.'*

54. On 7 December 2015, the SW IPA advised that the patient's *'limited capacity is noted in a report prepared by Consultant Psycho-Geriatrician… which*

*states that on balance she felt that "[the patient] does not have sufficient mental capacity to decide on her placement and needs".'* The SW IPA advised that *'while this assessment occurred post [the patient's] move to respite… it is within a sufficiently short time frame to reflect an accurate picture of her capacity prior to discharge.'*

*Discharge Meeting*

55. As part of investigation enquiries, the SW IPA was asked if the Discharge Policy was adequately followed in this instance. The SW IPA advised that *'I have been unable to find any information regarding the processes followed regarding [the patient's] discharge from hospital.'* The SW IPA advised that *'there is a 'Core Assessment' [Northern Ireland Single Assessment Tool (NISAT)] document dated [27 November 2015] prepared by… the Social Worker [B]. However, this lacks detail. In particular there is no Assessor Analysis and Summary in the document.'*

56. The SW IPA advised that *'I was unable to identify a note of a discharge meeting in [the patient's] case files. However this was not a complex transfer involving a number of different Trust staff rather a straightforward process which was coordinated by the Social Worker [B]. In the circumstances all coordination and information sharing was carried out without the necessity to call such a meeting.'*

*Multi-disciplinary meeting*

57. The SW IPA advised that a *'multi-disciplinary meeting had to take place in order to plan for [the patient's] return'* home following respite. The SW IPA advised that *'as the multi-disciplinary meeting was to look beyond immediate circumstances and to assess [the patient's] longer term needs, assess alternatives and subsequent planning relating to these decisions it was appropriate for this to take place'* on 11 November 2015. The SW IPA advised that *'there was no necessity to have this meeting take place before [the patient's] discharge to respite.'* The SW IPA advised that at this meeting a decision was made that the patient *'remain in respite nursing home care for a further period of time.'*

58. The SW IPA advised that *'a further review was carried out on 25 November [2015]. This was followed up by a comprehensive Best Interest Meeting on 21 December 2015. This was attended by a range of representatives from the Trust including the Consultant Pychogeriatrician, [the patient's] GP, Nursing staff and Social Care Staff. It was also attended by family members and their representatives. The purpose of the meeting was described in the minutes as ''to discuss staff concerns and safety issues regarding [the patient] and her wish to return to her own home".'*

59. Following discussion, the SW IPA advised that '*it was concluded that [the patient] should remain in respite at this time. This was to ensure that her health and well-being needs were fully addressed before she returned home. It was agreed that [the patient] would return home on 4 January 2016. The minutes note that this would allow for a period of liaison between the family and Trust staff and ensure that all practical arrangements to facilitate the move were in place. This included ensuring that the Social Worker 'had all safety systems in place' and was following up on further potential supports.'*

60. The SW IPA advised that '*In the circumstances, the decisions taken by Social Services were reasonable. There was close liaison with medical and health care staff which helped to assess [the patient's] physical, emotional and psychological health and her ability to return to her own home. The decision to extend the respite was taken in [the patient's] best interest. While this may not have reflected [the patient] or her family's immediate wishes it did allow for a measured return to home for [the patient]. Social Services also supported [the patient] to maintain her day centre placement which kept her linked into her local community. This was an important part of maintaining her independence and supporting her to return to her own home… Social Services remained supportive of [the patient] and provided a timely and appropriately measured response to her wishes considering her particular health and well-being circumstances.'*

*Record keeping*

61. On the patient's move to respite, the SW IPA advised that *'record keeping was limited with no recording noted regarding conversations with [the patient] or her carers regarding her move to respite on this occasion.'*

**Trust's response to IPA**

**10 November 2015**

62. The Trust stated that it acknowledges that the lack of detail in Social Care Records for this period *'would not reflect best practice'.* It said that it *'has been working to support an improvement in standards of recording and in particular, addressing the issue of staff recording information where it is not easily recognised or accessed. A new IT Mobility project currently being developed with community Social Work is also currently seeking to support contemporaneous recording to ensure a higher quality in key records.'*

63. In addition, the Trust stated that it is *'currently reviewing'* written procedures for discharge from hospital *'to improve the quality of Hospital Social Work operating standards.'*

64. In relation to the Social Worker B's assessment on 27 November 2015, the Trust stated that '*it is regrettable that the quality of assessment which would be expected is not in evidence.'* Since 2015, the Trust stated that *'staff completing a NISAT assessment have… been issued with an Aide Memoire to provide further guidance regarding the detail expected in a core assessment. Staff are asked to pay particular attention to the professional task inherent in the analysis and summary sections.'*

65. The Trust also accepted the SW IPA's advice that *'as [the patient] capacity was limited at this juncture, her ability to make decisions independently should have been scrutinised further.'* It stated that '*it regrets that staff did not fully explore at the time, [the patient's] ability to make a capacious decision regarding her placement, even if it was intended only to be a temporary arrangement.'*

66. In addition, the Trust acknowledged the SW IPA's view/advice/opinion *'that record keeping was limited and in particular, evidence of [the patient's] carers being consulted was not evident.'* It stated that *'this does not reflect the standard which the Trust would wish to see. The Trust is commencing an audit cycle for Social Work, which will include consideration of the quality of records and the involvement of families. This audit cycle is due to commence in January 2020.'*

**Responses to draft report**

67. The complainant said that the patient's *'one consistent wish was to return to her family home from respite, [she] often discussed her indifference for [the nursing home] and felt it lacked any stimulus for her mentally and was bored. [She] felt she was deteriorating in this environment; she however appreciated the staff's efforts…. [The patient] often discussed about her social need was met with the company she met at day care centre at the grove. The familiarity and the memories in the home that [she] lived in for 66 years was of particular importance to her.'*

*10 November 2015*

68. At this time, the complainant stated that the patient's next of kin, '*was continuously pressurised by [the] district nurse… via numerous phone calls to assist [in] the process of committing [her] into a Nursing home long term, despite [the patient's sister] making it clear that [the patient] did not want or like this setting even on a short term basis.'*

69. In addition, the complainant stated that '*during a visit from [the Social Worker 2], [the patient] with two witnesses [the complainant and the patient's sister] asked [the Social Worker B]… if there was any sign that [the patient] was getting out because she felt she was deteriorating in [the] nursing home.'* The complainant said that the Social Worker B *'did not make it abundantly clear to [the patient] that it was indeed her right to leave respite care at any stage. [The Social Worker B] went on to try to convince [her] to stay in [the] nursing home and [the patient] showed reluctance and frustration with this .'*

70. Following discharge in late December 2015, [the complainant] stated that the patient *'lived successfully at home… for a period of six months with the provision of an amended care package.'* He stated that revised care package required *'nursing staff to remain slightly longer in the mornings for the patient's] blood glucose levels to stabilise, when previously this had not been written into her care package… which necessitated ambulance call outs and hospital stays.'*

71. The complainant advised that '*an account of [the patient's] intentions are made clear in the best interest meeting in December 2015 where her advocate, who built a relationship with [the patient] over a series of weeks, categorically stated that [she] desperately wanted to return to home. This evidence paved the way for [the patient] to be repatriated to her family home where she yearned to be. [The patient's] family made the case time and time again and her legal representative… represented this desire.'*

72. In response to the draft report, the Trust stated that it accepted the recommendations set out, and had no further comment or evidence to submit. I note the Hospital Social Worker B stated that *'this was a particularly difficult case for all involved from the Grove Integrated Care Team. I was very proud to be part of a team that provided outstanding commitment to the care and safeguarding of this lady.' S*he stated that *'I received positive feedback from management in relation to my work on the case. At this time, NISAT was a fairly new assessment tool. I understand the Trust have since provided further guidance to professionals to aid in the completion of this assessment.'*

73. With regard to record keeping, the Hospital Social Worker B said that *'there were numerous case recordings on Paris[2] and in the case files of attempts from all disciplines to liaise with the family in relation to discharge planning. However, the majority of these attempts to contact the family were unsuccessful.'*

[2] Record management system

**Analysis and Findings**

**26 February 2015**

*Assessment of the patient's needs*

74. The patient was discharged from the Mater Hospital to Lansdowne Private Nursing Home on 26 February 2015. I note the complainant stated that the patient was discharged *'into respite for lengthy stays against her will without relevant discharge procedures'* being followed. I also note he complained that the patient was not *'involv[ed] in her future plans',* and that *'at no stage was [she] or the family included in or informed that this was a temporary [placement], as [the patient] wanted it to be.'*

75. In this instance, I note the SW IPA advised that there was *'a consideration of [the patient's] needs and circumstances'* by the Trust, and a decision to *'provide a 'step down' service'* on discharge was made. I refer to the Discharge Policy, which states that, as part of the discharge process, Hospital Social Workers must *'make assessments, management plans and referrals appropriate to the patient's needs.'* I note the SW IPA advised that the Hospital Social Worker A had discussions with the Trust's Social Care Coordinator at the Grove Integrated Care Team, who expressed she believed the patient would benefit from respite *'to manage [her] blood sugar levels.'*

76. In addition, I note the SW IPA advised that the Hospital Social Worker A spoke with the patient, and her next of kin, who both agreed with the step-down procedure. I note the Trust recorded that it had *'advised [the patient's sister]… of [the patient's] agreement to remain in Care Home for a few weeks.'* I note the Trust stated that *'the financial implications of extending respite stay beyond two weeks was also discussed. [The patient] expressed no intention of staying after two weeks.'* However, I note the SW IPA advised that the patient's sister stated that '*she would take responsibility for any costs incurred*.' I also note the SW IPA advised that the patient specifically requested placement in a residential care home in North Belfast.

77. I refer to the Trust's Discharge Policy, which states that there must be '*communication and consultation with the patient [and] their family',* during the

discharge process. It states that 't*he process of assessment and decision making should be patient-centred, placing the individual, their perception of their support needs and their preferred type of support at the heart of the process.'* I also note the SW IPA advised that the Hospital Social Worker A spoke with hospital and residential care home nursing staff, when considering the patient's needs. I refer to the Trust's Discharge Policy, which states that *'where necessary'* Social Workers should liaise *'with community-based counterparts.'*

78. I also note the Discharge Policy states that Social Workers must *'make records relating to discharge planning and decisions in the patient's file.'* I note the SW IPA advised that *'all of the processes and relevant considerations are noted in [the patient's] file, as are relevant e-mail correspondence concerning [the patient's] health and wellbeing, as is the information pertaining to the consideration of respite as a step-down process for [the patient] returning to the community.'*

79. In addition, I note the SW IPA referred to a *'Carers and Discharge – A Practical Guide for Staff',* within the Discharge Policy. The SW IPA advised that this guide contains a checklist which *'is designed to ensure that multiple, complex needs are identified and met.'* However, I note the SW IPA advised that the patient '*did not have multiple needs and the [clinical] files indicate that her key needs were met and key contacts engaged and involved as appropriate.'* Therefore, I note the SW IPA advised that it '*would have been unnecessary and a duplication of existing actions and subsequent recording'* to complete the checklist. On review, I accept the SW IPA's advice that the it was not necessary to complete this documentation due to the particular circumstances of this discharge.

80. Overall, I accept the SW IPA's advice that there is evidence that the Hospital Social Worker A undertook and completed *'all four elements'* of their role in relation to the discharge process, as per the Discharge Policy. As detailed above, I note that an assessment was performed, which resulted in the decision for the patient to enter respite; the patient, and her next of kin were involved in the decision making; records of the process were retained; and

both Trust and nursing home staff were engaged in the discharge process. In addition, I note that the Trust appears to have discussed the length of stay in respite with both the patient and her next of kin. Therefore, I do not uphold this element of the complaint.

*The patient's capacity*

81. I note the complainant believes that '*no one was given the opportunity to advocate or support [the patient].'* At this time, I note the SW IPA advised that the patient's medical and social care records do not indicate that she *'lacked capacity'.* I refer to the Trust's discharge Policy, which states that the process of assessment '*should include an assessment of the patient's mental capacity to make decisions about their personal welfare which includes decisions relating to discharge planning, their ability to be involved in the process and what may be needed to support them.'*

82. As noted above, I also note the SW IPA advised that the patient's sister was involved in step-down discussions. I note the SW IPA advised that the patient's sister did not raise *'concerns… regarding [the patient's] ability to make a decision.'* In addition, I note the Trust stated that it at this time it *'worked and engaged with [the patient] as a person with capacity to make decisions.'*

83. Having noted the view of the Trust alongside the relevant records and SW IPA advice, I have not identified evidence, which indicates that the patient did not have capacity in February 2015. I consider the Trust therefore appropriately involved the patient and her family in discussions regarding discharge. Therefore, I do not uphold this element of the complaint.

*Discharge Meeting*

84. I note the complainant stated that the Trust did not grant, invite, or notify the patient of discharge planning meetings to discuss her transfers to a residential care home. In addition, I note the SW IPA advised that there is no record of a discharge meeting taking place at this time.

85. However, I note the Trust stated that, as per its Discharge Policy, *'the only circumstances where a discharge planning meeting may be required is where the needs of the person are of such complexity, or that there are significant changes to an individual's care plan.'* I also note the Trust stated that *'[the patient] had regular involvement with Community Social Work, District Nursing and also attended the Day Centre'*. On review, I note the SW IPA advised that '*this was not a complex transfer involving a number of different Trust staff rather a straightforward process which was coordinated by the Social Worker.'*

86. In addition, I note the Trust stated that '*it is important to note that whilst a pre-discharge meeting may not occur, it does not diminish responsibilities for Multi-disciplinary assessment and working, as well as the requirement for meaningful engagement and discussion with service users and families.'* As detailed above, I note that there is evidence of multi-disciplinary working and discussions between the Trust, the patient and her family. I also note the SW IPA advised that *'all coordination and information sharing was carried out without the necessity to call'* a discharge meeting.

87. On review, as per the Trust's discharge policy, I accept the SW IPA's advice that a discharge meeting was not required at this time. Therefore, I do not uphold this element of the complaint.

*Stay in respite*

88. I note the SW IPA advised that the patient agreed to stay in respite for a couple of weeks, and the patient's sister agreed to pay any costs after the two weeks. On 10 March 2015, I note the SW IPA advised that Social Worker A visited the patient in the nursing home, and her respite was extended with the patient's consent. I note the patient's sister was advised of the extension. Subsequently, on 19 March 2015, I note Social Worker A visited the patient again. The SW IPA advised that it is recorded that the patient *'raised the idea of staying in the [nursing] home herself [for a further week]. The fact she herself felt she needed a further period in respite indicates that she did not feel fully ready to return home. In the circumstances it was appropriate for her to remain in respite for this further period of time.'*

89. On review of the available information, I note that there is evidence of the patient and her family's desire to return home. However, I note that there is evidence of Social Worker A's encouragement and advice, to both the patient and her family, that it would be best for the patient to remain in respite for a further period to help manage her condition. On reflection, I accept the SW IPA's advice that it was appropriate for the patient to remain in respite at this time.

**10 November 2015**

*Assessment of the patient's needs*

90. I note the complainant believes that the patient was discharged from hospital *'without relevant discharge procedures'* being followed. Therefore, I considered the patient's discharge on 10 November 2015. I note the SW IPA advised that '*there are no notes… which appear to cover this period of time.'* However, I note the SW IPA advised that '*it is possible to extract… from the general information contained in email correspondence and other earlier discharge minutes',* that the Trust considered the patient's health and well-being.

91. On 10 November 2015, I note the SW IPA advised that the patient entered respite *'as a result of her continued general ill health.'* The SW IPA advised that '*the main focus of concern remains health issues relating to [the patient's] diabetes. In particular concerns regarding her blood sugar levels are consistently noted.'* I refer to the Hospital Social Worker B's file note on 4 November 2015, which stated that *'DN [District Nurses] have concerns about [the patient's] ability to manage her diabetes as they are calling regularly to check blood sugars and also 24 hour DN [District Nurse] service calling at night.'*

92. In addition, I note the SW IPA advised that there were additional concerns in relation to the patient's '*memory and cognitive ability'.* On 11 November 2015, I note the Hospital Social Worker B recorded that the patient had missed appointments at the Memory Clinic, therefore '*appointments are now sent to the day centre [attended by the patient] so that future appointments are not*

*missed.'* As a result of these issues, I note the SW IPA advised that there were concerns that the patient could not adequately manage her medication and diet to control her diabetes.

93. However, I note the SW IPA advised that '*I have been unable to find any information regarding the processes followed regarding [the patient's] discharge from hospital.'* I note the SW IPA advised that *'there is a 'Core Assessment' document dated [27 November 2015] prepared by… [Social Worker B]. However, this lacks detail. In particular there is no Assessor Analysis and Summary in the document.'*

94. I refer to the Discharge Policy, which states that Social Workers must *'make assessments, management plans and referrals appropriate to the patient's needs',* including liaising *'with community-based counterparts.'* I also note the Discharge Policy states that Social Workers must *'make records relating to discharge planning and decisions in the patient's file.'* In addition, I refer to Standard 6 of NISCC's Code of Practice, which states that Social Workers must maintain *'clear and accurate records as required by procedures established for your work.'*

95. On review of emails, I note the SW IPA advised that there is evidence of the Trust's assessment of the patient's needs prior to discharge. However, as per the Discharge Policy, I am critical that there are no '*records relating to discharge planning and decisions in the patient's file'*. In addition, I note that there is no evidence of Trust staff '*liaising with community-based counterparts'* prior to discharge. As detailed in paragraph 115, I note that there was a subsequent discussion of the patient's needs on 11 November 2015, between the Trust and the patient's family. I have addressed the Trust's communication with the patient and her family in relation to the discharge process in paragraph 102.

96. I consider the Trust's failure to make a record of the discharge processes followed and decisions made, is a failure in the social care provided to the patient. As a result of this failure, I consider that the complainant suffered the

injustice of uncertainty, as to whether the Trust considered and performed all of the relevant actions prior to discharging the patient into respite. I will address injustice in the conclusion of the report. I uphold this element of the complaint.

97. In response, I am pleased to note the Trust acknowledged that the lack of detail in the social care records for this period *'would not reflect best practice'.* It said that it *'has been working to support an improvement in standards of recording... A new IT Mobility project currently being developed with community Social Work is also currently seeking to support contemporaneous recording to ensure a higher quality in key records.'* In addition, I note the Trust stated that it is *'currently reviewing'* written procedures for discharge from hospital *'to improve the quality of Hospital Social Work operating standards.'*

98. In addition, I note the Trust accepted that Social Work assessment on 27 November 2015 was not as should be expected. I note the Trust stated that since 2015, *'staff completing a NISAT assessment have… been issued with an Aide Memoire to provide further guidance regarding the detail expected in a core assessment. Staff are asked to pay particular attention to the professional task inherent in the analysis and summary sections.'*

*Discussion with the patient's family*

99. I note the complainant believes the patient was not *'involv[ed] in her future plans',* and was discharged to a residential care home *'against her wishes'.* I note he also complained that *'no one was given the opportunity to advocate or support [the patient].'* In addition, [the complainant] stated that *'at no stage was [the patient] or the family included in or informed that this was a temporary [placement], as [the patient] wanted it to be.'*

100. I note the SW IPA advised that '*as far as possible',* the Trust considered the patient's *'wishes and preferences'.* I note the SW IPA advised that the patient was *'somewhat confused… but was still capable of voicing her wishes to return to her own home.'* On review, I note the Hospital Social Worker B,

recorded on 11 November 2015 that *'I spoke to [the patient] and she is agreeable to going into respite for a period of time', 'to help in stabilising her blood sugars.'* I note this entry indicates that the patient agreed to go into respite on a temporary basis. In addition, I note the Trust stated that the patient *'chose to remain in respite after her step-down arrangement had come to an end. She often talked to staff when she was at home about wishing to return to respite as she felt lonely.'*

101. However, I note the SW IPA advised that '*[the patient's] capacity at this juncture was limited and it would not have been in her best interests to make this decision on her own.'* I note the Hospital Social Worker B recorded on 11 November 2015, that a *'capacity assessment [was] documented by consultant – who felt [the patient] did not have capacity but would liaise with [Consultant psycho-geriatrician].*' Subsequently, on 7 December 2015, I note the SW IPA advised that a Consultant Psycho-Geriatrician assessed that *'[the patient] did not have sufficient mental capacity to decide on her placement and needs'*. I note the SW IPA advised that although this assessment occurred post the patient's move to respite, '*it is within a sufficiently short time frame to reflect an accurate picture of her capacity prior to discharge.'* [3]

102. As such, I note the SW IPA advised that the Trust should have sought '*support from [the patient's] next of kin/ carers.'* I refer to the Discharge Policy, which states that during the discharge process there must be '*communication and consultation with the patient [and] their family'.* On review, I note the SW IPA advised that *'I have been unable to identify from the files if [the patient's sister] was contacted regarding [the patient's] proposed entry into respite. If this occurred it should have been clearly documented.'*

103. On review, I accept the SW IPA's advice. I note the Trust took the patient's wishes and preferences into account prior to her entry into respite. However, I note the Discharge Policy states that there should be communication and consultation with a patient's family during the discharge process, regardless of

[3] I note the Trust stated that *'when it became evident that [the patient] was no longer able to fully engage in decision making an advocate from the Alzheimer's Society was appointed on 4 December 2015… [The patient] also had legal representation at best interest meetings.'*

capacity. Therefore, I consider that the Trust should have contacted the patient's sister to discuss options in relation to her discharge from hospital.

104. I consider that the Trust's failure to communicate and consult with the patient's family prior to her discharge is a failure in the patient's social care. As a result of this failure, I consider that the complainant suffered the injustice of uncertainty as to whether the patient had the opportunity to be adequately supported by her family, when deciding on options for future care following her discharge from hospital. I will address remedy for this failure in the conclusion of the report. As a result, I partially uphold this element of the complaint.

105. I am pleased to note the Trust accepted the SW IPA's finding that *'as [the patient's] capacity was limited at this juncture, her ability to make decisions independently should have been scrutinised further.'* I note it stated that '*it regrets that staff did not fully explore at the time, [the patient's] ability to make a capacious decision regarding her placement, even if it was intended only to be a temporary arrangement.'*

*Discharge Meeting*

106. In addition, I note the complainant stated that the Trust did not grant, invite, or notify the patient of discharge planning meetings to discuss her transfers to a residential care home. I note the SW IPA advised that there was no evidence '*of a discharge meeting in [the patient's] case files.'* However, I note the SW IPA advised that '*this was not a complex transfer involving a number of different Trust staff rather a straightforward process which was coordinated by the Social Worker. In the circumstances all coordination and information sharing was carried out without the necessity to call such a meeting.'*

107. I refer to the Care Management Guidance, which states that Trusts *'should have arrangements in place for the safe and effective discharge of people from hospital and their transfer between care settings. Discharge and transfer procedures should be agreed between hospital and community settings and should be communicated proactively to all staff/ service users or their organised representatives as appropriate.'* I also note the Discharge from

Hospital Guidance, which notes that '*patients, who have both health and social care needs, must only be discharged when they are clinically fit. This is a decision made by the multidisciplinary team when considering all the factors, which will include the relative safety of remaining in hospital or being elsewhere and the patient's and carer's view of these risks.'*

108. I am critical of the lack of documentation evidencing that the Trust followed the appropriate procedures prior to the patient's discharge to respite. In addition, as the patient's family were not involved in discussions, I cannot conclude that '*all coordination and information sharing was carried out'* prior to discharge. Further, I note that on 11 November 2015, it was agreed in a multi-disciplinary meeting that the patient's '*needs would require 24 hour care'.* I also note the Trust stated that *'there was a concern that [the patient] was requiring a lot of assistance from staff to attend to her care needs and it was becoming more obvious to the multi-disciplinary team that in her own home, despite a comprehensive care package, her physical condition was significantly less stable than when she was in the nursing home environment.'*

109. Therefore, I consider that there is evidence that the patient's care needs had changed at this time. However, I consider that it was appropriate for the Trust to discharge the patient to the care home, as the care home was able to meet her needs. In addition, I note there was a consideration and plan for the patient's return to her own home, as a multi-disciplinary meeting was held on 11 November 2015. I note the Trust stated that the patient was not invited to this meeting. However, I note the Trust stated that '*decisions taken in the discharge planning were discussed with [the patient] by the Hospital Social Worker [B], as were the step-down arrangements and costs.'* In addition, the Trust stated that *'[the patient's] family were invited to and did attend this and further review meetings.'* I note the SW IPA advised that '*[the patient's] longer term needs… and subsequent planning relating to these decisions'* were discussed at this meeting.

110. As the MDT meeting took place the day following the patient's transfer to

respite, I consider that the complainant did not suffer any injustice as a result of the discharge meeting not taking place. I partially uphold this element of the complaint. However, I consider that the Trust should have sought the patient's views as to whether she wanted to attend the multi-disciplinary meeting. I consider the Trust's failure to do so was a failure in the patient's social care. However, I note that the patient's family were present at this meeting and there is evidence that the Trust discussed the entry into respite with the patient. Therefore, I consider that the complainant did not suffer any injustice as a result of this failure.

*Stay in respite*

111. I note the complainant stated that the patient's sister, '*was continuously pressurised by [the] district nurse… via numerous phone calls to assist [in] the process of committing [the patient] into a Nursing home long term, despite [the patient's sister] making it clear that [the patient] did not want or like this setting even on a short term basis.'* I note the complainant also advised that the patient *'showed reluctance and frustration'* at the prospect of remaining in the nursing home. He believes that the Social Worker B did not make it clear that she had the right to leave respite at any time.

112. At the MDT meeting on 11 November 2015, I note the SW IPA advised that the decision was made for the patient to remain in respite for a further period. I note this decision was reviewed on 25 November 2015, and a Best Interest Meeting was subsequently held on 21 December 2015. I note the patient's family were present at this meeting, and the SW IPA advised that the purpose of the meeting was to '*discuss staff concerns and safety issues regarding [the patient's] and her wish to return to her own home.'*

113. I note the SW IPA advised that '*there was close liaison with medical and health care staff which helped to assess [the patient's] physical, emotional and psychological health and her ability to return to her own home.'* I also note the complainant advised that the patient's advocate *'categorically stated that [she] desperately wanted to return home.'* However, I note the SW IPA advised that '*it was concluded that [the patient] should remain in respite at this*

*time. This was to ensure that her health and well-being needs were fully addressed before she returned home. It was agreed that [the patient] would return home on 4 January 2016.'*

114. On review, I accept the SW IPA's advice that the decisions taken by the Social Work Team were *'reasonable',* as *'the decision to extend the respite was taken in [the patient's] best interest'.* Therefore, I do not uphold this element of the complaint.

## CONCLUSION

115. The complaint concerned the care and treatment provided to the patient by the Trust, when she was discharged from hospital into respite on 26 February and 10 November 2015. On investigation of the complaint, I conclude that the Trust completed all the required actions and processes prior to the discharge of the patient on 26 February 2015.

116. However, I have found the following failures in social care, in relation to the Trust's actions on 10 November 2015:

- Failure to make a record of the discharge processes followed and decisions made; and
- Failure to communicate and consult with the patient's family prior to her discharge.

117. I am satisfied that the failures in social care I identified caused the complainant to experience the injustice of uncertainty.

118. In addition, I identified the following failures in care and treatment by the Trust:

- Failure to invite the patient to the multi-disciplinary meeting on 11 November 2015.

119. However, I am satisfied that the patient and the complainant did not suffer any injustice as a result of these failings.

**Recommendations**

120. I recommend that the Trust issues the complainant with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified, and should be issued **within one month** of the date of my final report.

121. I consider there were a number of lessons to be learned which provide the Trust with an opportunity to improve its services, so that complex cases like the patient's are managed appropriately and to improve the experience of older people and their families. I note the Trust stated that as part of its Back to Basics project, it will be auditing, reviewing and developing best practice guidance to support people moving into temporary or permanent care placements, '*which will include consideration of the quality of records and the involvement of families. This audit cycle is due to commence in January 2020.*' I recommend that the Trust provides me with the results of the audit accompanied by any actions, which result from the audit. The results of the audit should be forwarded to my office within three months of the date of my final report.

122. I also note the Trust has stated that it developed a Care Review and Support Team in September 2017 to ensure clear oversight of care plans for older people resident in nursing and residential care homes. In addition, I note the Trust developed and launched its Best Interest Toolkit, to ensure staff have a clear framework for best interest decisions.

123. The Trust should consider bringing the Social Work IPA in relation to the social care on 10 November 2015 to the attention of Social Worker B, to reflect on the completion of the NISAT assessment.

124. I am pleased to note the Trust accepted my findings and recommendations.

**PAUL MCFADDEN**
**Acting Ombudsman** **May 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.