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

Report Reference: 202002176

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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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Listed Authority: Northern Health and Social Care Trust

SUMMARY

This complaint was about the actions of the Northern Health and Social Care Trust (the Trust). The complainant was dissatisfied with the Trust's decision to admit the patient to the Ladyhill Nursing Home (the Home), and the Social Work Team's communication with him during the time the patient was a resident within the Home.

The investigation established the Trust's decision to admit the patient to the care of the Home was appropriate. Therefore, I did not uphold this element of the complaint. However, the investigation found the Trust's communication with the complainant during the period 23 December 2021 to 12 February 2022 fell below the expected standard. The Trust did not inform the complainant that his Social Worker attempted to contact him at his home on two occasions. The investigation also established the Trust failed to maintain appropriate records of the two home visits which occurred on 29 December 2021 and 7 January 2022.

The report identified these failures as maladministration which caused the complainant to experience uncertainty, and a loss of opportunity to receive appropriate support from the Social Work Team.

Given the failures identified, I recommended the Trust apologise to the complainant and ensures learning from this example of poor communication.

THE COMPLAINT

1. This complaint was about care and treatment the Northern Health and Social Care Trust (the Trust) provided to the patient during the period 23 December 2021 to 12 February 2022. The complainant also raised concerns about the Trust's communication with him during this period. The complainant was the patient's brother and also her carer.

Background

2. The patient lived with Downs Syndrome and possible dementia. She had a severe learning disability and was non-verbal. Following a GP safeguarding referral and a suspected fracture to her pelvis, the Trust admitted the patient to the care of Ladyhill Nursing Home (the Home) on 23 December 2021. The patient remained in the Home until her discharge on 12 February 2022.

3. The complainant raised concerns to the Trust on 16 January 2022 about the patient's admission to the Home and the Social Work team's communication with him. The Trust issued its final response to the complaint on 12 August 2022.

Issue of complaint

4. I accepted the following issue of complaint for investigation:

   Whether the Trust acted appropriately and in accordance with relevant standards when it admitted the patient to the care home.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

6. After further consideration of the issues, I obtained independent professional advice from the following independent social worker advisor (ISWA):

- A Social Worker with 34 years' experience across all aspects of social services provision, including mental capacity and adult safeguarding.

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

Relevant Standards and Guidance

8. 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[1]:

   - The Principles of Good Administration

9. 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 and guidance relevant to this complaint are:

   - Northern Health and Social Care Trust's Adult Safeguarding Operational Guidance August 2021 (Adult Safeguarding Guidance); and
   - Northern Ireland Social Care Council Standards of Conduct and Practice for Social Workers November 2015 (NISCC Guidance).

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

10. 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.

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

THE INVESTIGATION

Whether the Trust acted appropriately and in accordance with relevant standards when it admitted the patient to the care home.

In particular this will consider:

- The decision to admit the patient; and
- Communication with the complainant.

The decision to admit the patient

Detail of Complaint

12. The complainant was unhappy with the Trust's decision to admit the patient to the Home. The complainant said Trust staff threatened to call the Police Service Northern Ireland (PSNI) if he did not agree to the patient's admission. The complainant also said he consented to the patient's admission *'under duress'*.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the following policies and guidance:
    - Adult Safeguarding Guidance; and
    - NISCC Guidance.

Trust's response to investigation enquiries

14. The Trust stated the patient's GP was concerned about a suspected fracture to the patient's pelvis and *'organised the X-ray & until the results were known correct manual handling was required to prevent further injury and/or pain'*. The GP's safeguarding referral, and the suspected fracture were factors in its decision to admit the patient to the care of the Home.

15. The Trust stated its primary duty is to the vulnerable person. The Trust also stated there would have been no threat of the PSNI had the complainant refused the patient's admission.

Relevant Trust records

16. The Trust provided this Office with the patient's medical records and Social Work records.

Relevant Independent Professional Advice

17. The ISWA advised the APP1 form[2] the district nurse completed on 21 December 2021 stated the complainant *'refused manual handling equipment and a plan of care and that the patient had pressure sores and was experiencing unexplained hip pain/extreme generalised pain during transfers and care'*. She also advised the GP's APP1 form dated 22 December documented the GP's safeguarding concerns. The ISWA advised these *'concerns met the threshold for consideration under the criteria of 'Adult at Risk of Harm'. This was appropriate according to the guidance'*.

18. The ISWA advised the Trust's decision to admit the patient to the Home on 23 December 2021 *'was appropriate'*. This is because the patient needed to be cared for *'safely and in view of her physical condition'* which was not appropriate to continue to be undertaken at home. She advised, as the documents record the complainant refused equipment necessary for safe manual handling *'further assessment was also necessary so that future care arrangements would be considered and agreed with the complainant'.* The ISWA advised the records contain an email from the Home summarising the care the patient received during her placement *'that would not have been able to be carried out at home'*.

19. The ISWA advised *'taking all of the above into account, I think that the admission to a nursing home was in the patient's best interests and was therefore the correct decision'*. In relation to the issue of duress and pressure of PSNI involvement, the ISWA advised *'I could not find anything to suggest that this was the case'*. She advised the Trust made its decision on the *'basis of the patient's best interests and I could not identify that there would have been any role for police'*.

Analysis and Findings

[2] An Adult Safeguarding Referral/Screening and Information Form.

20. The nursing records contain the district nurse's APP1 form (completed on 21 December 2021) documenting her concerns with the patient's mobility. The nursing records also document the patient was suffering from pressure sores in December 2021, which were deteriorating and required treatment. The Social Work records document in December 2021, the patient's GP had concerns regarding her welfare.

21. Following both referrals, the Social Work records document on 23 December 2021, Social Worker A (SW A) attended the patient's home. The records document SW A's main focus during this visit was the patient's physical condition and risk of deterioration. I note the Social Work records also document the complainant did not have appropriate manual handling equipment available in his home. In consideration of these factors, along with the APP1 forms, the Social Work records document SW A considered the patient met the threshold for consideration under the 'Adults at Risk of Harm[3]'. She made the decision (on the same day) to admit the patient to either a hospital or a care home for care and treatment. The records document the Trust made the decision along with the complainant to admit the patient to the care of the Home. The ISWA advised this *'decision was the correct one'*.

22. I note the ISWA advised the Social Work records document the care the patient received during her placement within the Home. She advised *'this was a level of skilled care, particularly in terms of continuous cleansing and dressing of wounds, frequently checking of wounds, and repositioning every three to four hours, that would not have been able to be carried out at home'*.

23. The complainant said he consented to the patient's admittance to the Home under duress. The ISWA advised the Trust's decision making was *'on the basis of the patient's best interests and I could not identify that there would have been any role for the police'*. Whilst I have no reason to doubt the complainant, the records do not document a threat of PSNI involvement had he not consented to the patient's admittance. The ISWA advised the patient's admittance to the Home was agreed between the parties, *'with some*

[3] The Adult Safeguarding guidance defines an 'Adult at Risk of Harm' as 'a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances'.

persuasion and that agreement still being rather reluctantly given on the part of the complainant'.

24. I acknowledge this was a very difficult situation for both the patient and the complainant. In response to the draft Investigation Report the complainant said if he thought the patient was in any pain, he would have taken her to hospital *'straight away'*. I wish to reassure the complainant that his commitment to his sister's care is not in doubt. The ISWA advised SW A's actions on 23 December 2021, and the decision to admit the patient to the care of the Home *'was appropriate according to the guidance'*. She advised this is because the patient needed to be cared for safely and in view of her physical condition after a period of being at home without a plan of care. I accept this advice. I accept the ISWA's advice *'it was in her best interests to be admitted to the home for the provision of skilled care, for physical tests, and for a period of review as to make plans for her safe care at home'*. Based on the records available and the advice received, I do not uphold this element of complainant.

Communication with Complainant

Detail of Complaint

25. The complainant was unhappy with the Social Work Team's communication with him during the period the patient resided at the Home (23 December 2021 to 12 February 2022). In response to the complaint the Trust stated its Team were in contact with the complainant during the period the patient was a resident at the Home. The complainant disagrees with this statement.

Evidence Considered

Legislation/Policies/Guidance

26. I considered the following guidance:
    - NISCC Guidance.

Trust's response to investigation enquiries

27. The Trust stated it *'maintained regular contact via telephone, home visits and text with [the complainant]'*. Its records document SW A attended the complainant's *'home on 29 December 2021, but he was not in'*. SW A tried to

visit the complainant a second time on 7 January 2022 and the complainant did not answer. The complainant *'would not usually have wished for planned appointments to be made therefore it was deemed less stressful for him for SW to call in when passing his house'*. The Trust acknowledged it should have issued a follow up via letter to the complainant to arrange a visit, or to advise him SW A called to the home. There is an omission of records for the contact made on both 29 December 2021 and 7 January 2022. It is usual practice that the Social Worker completes a record as soon as possible after the visit, and a brief note of the home visit if the carer is not in.

28. The Trust stated SW A made telephone contact with the complainant on 14 January 2022 and sent a text message to him on 17 January 2022. Within the text message, SW A asked the complainant if he would like SW A to visit. The complainant declined this invitation.

29. Following the complainant's request for a different Social Worker on 1 February 2022, the Trust stated it allocated Social Worker B (SW B) to provide support to the complainant. SW B contacted the complainant on 3 February 2022 and on 9 February, 10 February, and 16 February 2022.

Relevant Trust records

30. The Trust provided this Office with the patient's Social Work records for the period 1 December 2021 to 12 February 2022.

Relevant Independent Professional Advice

31. The ISWA advised the Social Work records document SW A visited the complainant at his home on 29 December 2021 and 7 January 2022. The records document the complainant was not at home on both occasions to receive the visit. The ISWA advised SW A ought to have arranged these visits in advance so the complainant could have made himself available. She further advised she is not clear if SW A left a calling card following the unsuccessful visits. This would have let him know she was trying to get in touch.

32. The ISWA advised she would have expected SW A to contact the complainant following her unsuccessful visits. In particular, she would have expected SW A to contact the complainant following the attempted visit on 7 January *'as by then there had been no contact with him for some time and it would be reasonable to attempt to make that contact'*. In relation to records, the ISWA advised SW A did not record the attempted visits *'immediately following them having taken place*'. SW A should have recorded attempts to communicate with the complainant *'at the time or soon after'*.

33. Following the visits, the ISWA advised there was *'a gap in contact until the complainant made contact with the social worker on 14 January'*. However, once SW A established contact on 14 and 17 January, the complainant *'appears to have been reluctant to engage in conversation with the social worker'*. There was nothing further SW A could do at this point other than offer to meet with him, *'which she clearly did'*. SW A's opportunity to communicate with the complainant was *'minimal due to the complainant's reluctance to engage'*.

34. The records document the complainant submitted a request to SW A for allocation of a new Social Worker following his ongoing complaint. The Trust allocated SW B to provide support to the complainant. There was a gap between the complainant's request and SW B's contact with the complainant in early February. This may have been due to service pressures and may have been unavoidable. She advised *'it was not an unreasonable gap as reallocation can take a little time due to the logistics involved'*. However, the ISWA did not see anything in the records to indicate how the Trust communicated with the complainant in the meantime or that it informed him about the reallocation's progress. She advised the *'complainant ought to have been informed by the team manager of her response to his request for a change of social worker and should have been advised and updated with regard to the likely timescale for this'*.

35. The ISWA advised she could not identify any particular Social Work Standards relevant to the shortcomings in communications identified. However, *'as a*

matter of general courtesy and good communications, I think actions should have been taken'.

Analysis and Findings

36. The Social Work records document SW A attempted to conduct an unannounced visit to the complainant at his home on 29 December 2021 and 7 January 2022. The complainant was unavailable on both occasions. I note the records do not contain a contemporaneous record of SW A's attempt to visit the complainant at home on these dates.

37. I refer to the NISCC guidance which requires Social Workers to maintain *'clear and accurate records'*. The ISWA advised SW A should have recorded attempts to communicate with the complainant *'at the time or soon after'* her visits on 29 December and 7 January. I accept this advice. The Trust stated the Head of Service and Professional Social Work Lead reviewed the records and agreed with the ISWA's advice that there *'appears to be an omission'* in the records for the two dates. I consider the Trust's records failed to meet the NISCC standard.

38. I note the Social Work records document the complainant's reluctance to engage with the Social Work Team and the complainant said he does not answer their telephone calls as it appears as a 'private number' on his telephone. The Trust stated due to this, it considered unannounced house visits less stressful for the complainant. However, following the attempted visits, I would have expected SW A to have contacted the complainant in some way to advise him of her attempts. I note the Social Work records do not contain a record that SW A contacted the complainant to advise him as such. The ISWA advised *'this was a gap in contact'* given that SW A called at his home twice and was unable to see him. She advised, in particular, she would have expected SW A to contact the complainant following her attempted visit on 7 January *'as by then there had been no contact with him for some time and it would be reasonable to attempt to make that contact'*.

39. The Trust stated it does not use calling cards, and telephone contact from SW A to the complainant *'historically had not been responded to by him'*.

Nevertheless, it acknowledged it should have issued a follow up letter to the complainant to arrange a future visit and/or to advise him SW A attempted to visit.

40. The ISWA advised she could not identify any particular social work standards in relation to this issue of complaint and communication with families is *'dependent upon the situation'*. However, I refer to the NISCC Guidance which requires Social Workers to communicate *'in an appropriate, open, accurate and straightforward way'*. I also refer to the Second Principle of Good Administration which requires public bodies to communicate effectively. The ISWA advised *'as a matter of general courtesy and good communication, I think […] actions should have been taken'*. I accept this advice.

41. The records document on 1 February 2022, the complainant requested appointment of a new Social Worker following his ongoing complaint. The Trust stated it appointed SW B to provide support to the complainant. The records document SW B contacted the complainant on 3 February 2022.

42. Following the complainant's request, I note the ISWA identified the Trust should have kept the complainant informed of the progress of his request during these two days. I welcome the Trust's acceptance that it should have sent a letter to the complainant to update him on the status of his request to reallocate a Social Worker. However, as the Trust took just two days to reallocate a different Social Worker, I do not consider the complainant waited an excessive amount of time. Therefore, I have not identified any maladministration in relation to this aspect of the complaint.

43. I am concerned about the quality of communication the Trust provided the complainant during the period 23 December 2021 to 12 February 2022. I am also concerned about the lack of records documenting SW A's attempted visits on 29 December and 7 January. I acknowledge the Trust stated the complainant was reluctant to engage with the Trust. Nevertheless, I have identified a number of failings in communication. I refer to the Third Principle of Good Administration which requires public bodies to give people information

that is clear, accurate, complete, relevant, and timely. I consider these failings maladministration and I uphold this element of the complaint.

44. I consider the maladministration identified caused the complainant to sustain the injustice of uncertainty. This is because the complainant was unaware SW A was attempting to contact him. I also consider the identified maladministration caused the complainant to sustain the injustice of a loss of opportunity to avail of the Social Work Team's support during what was a very difficult time for him.

CONCLUSION

45. I received a complaint about the Trust's decision to admit the patient to the care of a Home on 23 December 2021. The investigation established it was appropriate for the Trust to admit the patient to the care of the Home on 23 December 2021. Therefore, I did not uphold this element of the complaint.

46. I also received a complaint about the Trust's communication with the patient during the period the patient was a resident within the Home (23 December 2021 to 12 February 2022). The investigation established the Trust's communication to the complainant during the period 23 December 2021 to 12 February 2022 fell below the expected standards. I consider this constitutes maladministration. I uphold this element of the complaint for the reasons outlined in this report.

47. I appreciate how difficult this time has been for the complainant. I hope the ISWA's advice and the findings, and recommendations of this report provide him an element of closure. I understand since the complainant raised this complaint with my Office, the patient has passed away. I wish to share my sincerest condolences to the complainant for the loss of his sister.

Recommendations

48. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the maladministration identified (within **one month** of the date of this report).

49. I further recommend within **one month** of the date of this report the Trust:

i. Discusses the findings of this report with relevant staff and asks them to reflect on the failures identified and discuss it as part of their next appraisal;

ii. The Trust reminds relevant staff of the importance of keeping proper and appropriate records in accordance with the Standards for Social Workers[4] and Records Matter[5] (January 2020); and

iii. The Trust implements a procedure to issue a letter to a carer following any Social Worker's unsuccessful attempt to visit.

Margaret Kelly
Ombudsman **2023**

[4] Standards-for-Social-Workers.pdf (niscc.info)
[5] Records Matter January 2020 is a joint publication by NI Public Service Ombudsman, NI Audit Office, and Information Commissioner's Office.

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

Being open and accountable

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.
- Publishing service standards for handling complaints.

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants.

Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.