Local Government
OMBUDSMAN

Parliamentary
and Health Service
Ombudsman

Care and treatment in a care home

A report by the Health Service Ombudsman and the Local Government Ombudsman on a joint investigation

Local Government
OMBUDSMAN

Parliamentary
and Health Service
Ombudsman

Care and treatment in a care home

A report by the Health Service Ombudsman and the Local Government Ombudsman on a joint investigation

Presented to Parliament pursuant to Section 14(4)
of the Health Service Commissioners Act 1993

Ordered by
the House of Commons
to be printed on 30 October 2013

HC 752

London: The Stationery Office

£16.00

Any enquiries regarding this publication should be sent to us at phso.enquiries@ombudsman.org.uk.

You can download this publication from our website at www.ombudsman.org.uk.

ISBN: 9780102987089

Printed in the UK for The Stationery Office Limited

on behalf of the Controller of Her Majesty's Stationery Office

ID 2597151 10/13

Printed on paper containing 75% recycled fibre content minimum

Contents

Foreword

We are laying before Parliament, under section 14(4) of the *Health Service Commissioners Act 1993*, this report on a joint investigation into a complaint made to us as Health Service Ombudsman for England and Local Government Ombudsman for England.

This report is being laid before Parliament to help others learn from the service failure it describes.

The complaint is about Reading Borough Council (the Council) and what was then Berkshire West Primary Care Trust (the PCT). The complaint was made by Mrs H about the care provided to her late uncle, Mr K, at a care home that provided intermediate care and long-term dementia care. The care home was run jointly by the Council and the PCT.

This report describes service failure in the care and treatment Mr K received at the care home. It illustrates the importance of getting it right in the care of elderly people, particularly in terms of nutrition and hydration, catheter care, the administration of medication, record keeping and communication with the family.

Dame Julie Mellor, DBE
Health Service Ombudsman

Dr Jane Martin
Local Government Ombudsman for England

October 2013

Summary

Mr K (aged 84) had a stroke in November 2008. In December he was transferred from hospital to the Care Home for rehabilitation to help him return home. The Care Home was funded jointly by Reading Borough Council (the Council) and what was then Berkshire West Primary Care Trust (the PCT). At the Care Home Mr K did not eat and drink adequately. He appeared to have diarrhoea but was given laxatives. He had a urinary catheter in place, which became blocked and there was delay refitting it. In January 2009 Mr K was readmitted to hospital. He died there from a pulmonary embolism due to deep vein thrombosis.

Mrs H (Mr K's niece) complained to the Council and the PCT about her uncle's care. Dissatisfied with their responses, she complained to the Local Government Ombudsman and the Health Service Ombudsman. She said staff kept giving Mr K the laxative, Movicol, which caused dehydration. She complained that there were no records of his food and drink intake, bowel actions and urine output. She said that poor care led to her uncle's early death and he suffered pain and distress. She said his family were distressed to see how he was treated, so much so that her mother stopped visiting. Mrs H wanted the Council and the PCT to apologise and to take action to prevent similar failings in future.

We found that the Council and the PCT did not act in line with recognised quality standards or established good practice in respect of nutrition and hydration, bowel and catheter care, record keeping and communication. Because of that, we decided that Mr K's care and treatment fell so far below the standards that it amounted to service failure. However, we did not find that the poor nutrition and hydration could be linked to Mr K's deterioration or his death from a pulmonary embolism.

We partly upheld Mrs H's complaint. The Council and the PCT agreed to:

- write to Mrs H to acknowledge the failings and apologise for their impact
- each pay £300 compensation to Mrs H for the distress she and her family suffered because of the failings we identified in Mr K's care; and
- prepare action plans to address the failings identified.

Introduction

1. This is the report on our joint investigation into Mrs H's complaint about Reading Borough Council (the Council) and Berkshire West Primary Care Trust (the PCT). It contains our findings, conclusions and recommendations with regard to Mrs H's complaint.

Background

2. Mrs H's uncle, Mr K, had a stroke in November 2008 and was admitted to hospital. He was transferred to an intermediate care[1] bed at the Care Home on 23 December, with the aim of aiding his rehabilitation following his stroke, and assessing his mobility requirements to help him to return home.

3. The Care Home was run jointly by the Council and the PCT, providing intermediate care and long-term dementia care. The Council's staff (unit managers, their deputies and assistants, duty officers and care staff) provided 24-hour care. Healthcare staff employed by the PCT (a nurse co-ordinator and staff nurse, both registered nurses, and physiotherapy and occupational therapy staff) were on duty from 9am to 5pm, Monday to Friday. Outside these hours, nursing services were provided by district nurses, who were employed by the PCT.

4. Mr K was readmitted to hospital on 29 January 2009 and died on 30 January, aged 84. The post mortem examination showed that he died from a pulmonary embolism[2] due to deep vein thrombosis.[3]

---

1 Intermediate care covers a wide range of services that facilitate early discharge from hospital or help prevent admission to hospital care or long-term residential care.

2 Blood clot in the lungs.

3 Blood clot in a deep vein of the body, usually in the lower leg.

The complaint

5. Mrs H complains about the care and treatment provided for her uncle during his time as a resident at the Care Home. She also complains about the level of communication Mr K's family received from the Care Home's staff, and about the poor standard of their record keeping. She says that the poor care Mr K received led to his early death and that he also suffered pain and distress, particularly in relation to catheter care. She also says that Mr K's family had the distress of watching the way he was treated and that her mother stopped going in to visit because she found it so distressing.

6. Mrs H would like the Council and the PCT to learn from their mistakes and to take appropriate action to avoid similar circumstances arising in the future. She would like to see evidence of systemic changes to the way that the Council and the PCT provide care for people like Mr K. She would also like an appropriate apology from both the Council and the PCT.

The matters investigated

7. The Local Government Ombudsman and the Health Service Ombudsman agreed to jointly investigate whether Mr K received appropriate care at the Care Home between December 2008 and January 2009 in relation to: nutrition and hydration; catheter care; administration of medication; record keeping; and communication with his family.

Our decision

8. We have reached a decision about Mrs H's complaint. We find that the care and treatment Mr K received from the Council and the PCT fell so far below the applicable standard that it amounted to service failure. We have concluded that this resulted in an injustice to Mr K and his family. However, we have not found that the failings we have identified led to Mr K's early death. We therefore partly uphold the complaint about the Council and the PCT.

The Ombudsmen's remit and powers

9. The Ombudsmen's remit and powers are set out in Annex A.

The basis for our determination of the complaint

10. A detailed explanation of how we determine complaints that injustice has been sustained in consequence of service failure and/or maladministration is set out in Annex B. This explanation includes full details of the general and specific standards that we apply, and the specific guidance and legislation relevant to the matters under investigation in this case.

The investigation

11. We telephoned Mrs H on 30 January 2012 to discuss the nature of her concerns and the way in which we would investigate her complaint. We confirmed our understanding of the complaint in a letter to her dated 31 January and on 6 March we wrote to confirm the issues we would investigate.

12. During the investigation we have examined all the relevant documentation. This includes the records held by the Care Home, and the papers relating to the attempted resolution of Mrs H's complaint by the Council and the PCT, including the joint investigation that took place. We have taken account of the comments received from Mrs H in her correspondence with us.

13. We also obtained advice from one of our clinical advisers, a senior nurse with particular expertise in the care of older people (the Nurse Adviser). The Ombudsmen's advisers are specialists in their field, and in their roles as advisers to the Ombudsmen they are independent of any NHS organisation.

14. In this report, we have not referred to all the information examined in the course of the investigation, but we are satisfied that nothing significant to the complaint or our findings has been omitted.

Key events

15. Mr K had a stroke on 28 November 2008 and was admitted to hospital. The clinical team considered that he would benefit from intermediate care to improve his mobility, confidence, and ability to manage daily activities, to help him to return home.

16. While in hospital he had persistent blood in his urine and a urinary catheter[4] was inserted. On the hospital discharge letter under the heading '*hospital aftercare*' it was noted that Mr K should attend as an outpatient for a '*trial without catheter*'. This was to ensure he could pass urine satisfactorily once the catheter was removed. A date for the clinic had not been arranged.

17. On 22 December 2008 Mr K was assessed by the nurse co-ordinator at the Care Home. She prepared the initial care plans for the Care Home. She noted that he needed a soft diet and normal fluids, and she planned that he should be weighed on admission and on the last Sunday of each month. She wrote a care plan regarding catheter care, which included giving a glass of fluid every hour, monitoring the colour of Mr K's urine, and connecting a single-use night drainage bag. She also signed a pre-printed care plan that said that, following admission, all medication should be given by the duty or designated carer, but that Mr K should be assessed by a nurse within five days of admission regarding suitability for self medication. Mr K was transferred to the Care Home on 23 December. On 24 December Mr K's weight was recorded as nine stone and six pounds.

18. Mr K spent Christmas Day at home with his family. At 8.15pm a care assistant at the Care Home recorded that he had returned from home and he was complaining that his catheter was making him sore.

19. On 28 December 2008 (the last Sunday in the month) Mr K's weight was nine stone and eleven pounds; a gain of five pounds in four days.

---

4 A tube placed into the bladder, held in place by a small inflatable balloon, which is connected via a larger tube to a drainage bag to continually drain urine from the bladder.

20. Mr K went home with his family on 1 January 2009. On arrival home, his family found that both his legs were through the same leg hole of his underpants. His family rang the Care Home about this and also asked the assistant unit manager to call a doctor, as there was blood in the urine bag. Mr K was seen by a doctor from WestCall (the out-of-hours care service for patients in West Berkshire used by the Care Home) that evening, at the Care Home, at about 8pm. The doctor found that there was some malodorous urine leaking around the catheter and used a sterile solution to flush the catheter. After this the catheter drained normally. The doctor also prescribed antibiotics. (There is no record of Mr K's family contacting the Care Home, or of a doctor's visit, although the drug charts show that Mr K started a course of antibiotics that evening.)

21. In the afternoon of 7 January 2009 staff noted that Mr K's catheter appeared to have a blockage. The care assistant noted that she informed the manager and the bag was changed, which seemed to relieve the problem. The care assistant also noted that Mr K had been encouraged to drink all day, as his urine had been very dark.

22. On 8 January a care assistant told the duty officer (who oversaw the care that was provided) that Mr K was constipated. Movicol (a laxative) was prescribed and started that evening.

23. On 11 January Mr K went out with his family, who reported that they found that his catheter tube was coiled up and on top of his thigh, therefore preventing it from draining.

24. In the early hours of 12 January 2009 Mr K rang his call bell and the care assistant saw that the catheter was blocked and the top of the tube was filled with blood. WestCall was contacted and at 3.31am a doctor arrived and changed the catheter bag. However, Mr K continued to pass blood-stained urine and he complained of discomfort and burning when passing urine. The catheter was removed and replaced by a district nurse at 9am, but shortly after it was blocked again. At 10.47am the staff nurse at the Care Home rang Mr K's GP to say that Mr K was in pain and not passing urine and needed a new catheter. The staff nurse was unable to change the catheter as she had not been trained to do male catheterisation. The GP said that a district nurse should change the catheter and at 11.20am the Care Home spoke to a district nurse to request someone to come and see Mr K. At 12.15pm Mr K was given some paracetamol to relieve his pain. A second district nurse arrived at 2.20pm and removed Mr K's catheter. He passed some blood clots but was still in pain. This district nurse decided not to insert another catheter as she thought this would cause him more pain. She spoke to the Care Home's staff nurse to say that she thought the GP should be informed so that Mr K could be admitted to the hospital, as he had an appointment for a cystoscopy[5] there the following day. (This was noted in the contact sheets completed by the carers but there is no evidence that the staff nurse recorded anything about this.) Observations were taken at 15 to 30-minute intervals to record if Mr K was passing urine. At 4pm a care assistant rang the GP to ask if Mr K could have some ibuprofen tablets as he was still in pain. In this conversation the GP found

5 A diagnostic procedure in which a thin camera with a light is inserted into the tube that drains urine from the bladder to examine the interior of the bladder.

out that the catheter had been taken out and not replaced and said he would come. However, as he was some distance away, he arranged for a district nurse, who could get there sooner, to visit. At 4.45pm a third district nurse arrived at the Care Home and recatheterised Mr K. The catheter drained about 400ml of blood-stained urine and eased Mr K's pain.

25. On 13 January Mr K attended hospital for a cystoscopy and when he returned, his catheter was draining. The next day it was noted that he had been encouraged to drink plenty as his urine was very dark. It was also noted that he refused to eat his lunch but had been provided with Ensure (a dietary supplement in a drink form).

26. Mr K was due to go for a home visit on 19 January to see how he would manage. In the early hours Mr K rang the bell and was attended three times (1.30am, 3.30am, 5.10am). At 5.45am he was found on his knees on the floor. He had suffered no apparent injury. At 7.30am a care assistant noted that Mr K had been worrying about the home visit and had not slept very much. His catheter was changed later that morning, by a district nurse. The home visit took place in the afternoon.

27. On 21 January food and drink intake charts were started.

28. Mr K should have been weighed on the last Sunday of the month (25 January 2009). As a result of a telephone conversation between his niece and the nurse co-ordinator, he was weighed on 26 January. He weighed nine stone, five pounds and eight ounces; a loss of five and a half pounds since 28 December 2008. The nurse co-ordinator changed the care plan so that he should be weighed weekly. The nurse co-ordinator also updated the catheter care plan, detailing all the actions to be taken with regard to Mr K's catheter. On the same day, one of Mr K's nieces contacted social services because she was concerned that Mr K was still being given Movicol, which she believed was why he was so weak; and the following day she had a telephone conversation with the nurse co-ordinator. The nurse co-ordinator recorded that she had discussed the Movicol with the duty officer, who had in turn explained the situation to Mrs H.

29. Mr K saw the GP in the morning of 27 January 2009. The GP noted that Mr K was not doing well generally, was drowsy and dozing off easily, and was intermittently breathless. He thought Mr K might have a chest infection or a pleural effusion[6] and arranged for a chest X-ray and blood tests to be performed. The chest X-ray took place the following morning. By this time, Mr K was hardly eating or drinking and was very drowsy.

30. At 7.45am on 29 January 2009 the assistant unit manager noted that a staff member was to remain with Mr K at all times. He was having difficulty swallowing drinks. At 9.30am the GP was called to see him and the GP then rang the hospital for the results of the X-ray. These showed a small pleural effusion at the base of the left lung and some hilar congestion.[7] He visited Mr K and thought he probably had congestive cardiac failure.[8] He arranged for Mr K to be taken to hospital.

---

6 A build up of fluid between the pleura – the membranes that line the lungs and chest cavity.

7 Fluid build up at the area where the blood vessels, nerves and main airways enter and leave the lungs.

8 Inability of the heart to efficiently pump blood around the body.

31. Mr K died the following day. A post mortem report said that Mr K:

> *'showed multiple significant natural disease processes, many of which are associated with age related degeneration. These include coronary heart disease with heart failure, a stroke and perhaps most importantly and acutely, pulmonary thromboembolism.'*

The report noted that Mr K was '*adequately nourished*'. The cause of death was recorded as: pulmonary thromboembolism, deep vein thrombosis, cerebral infarction,[9] and coronary heart disease.[10]

32. Mr K's family raised concerns about his death with the coroner, who published his review in October 2009. He was satisfied that Mr K had died from natural causes and that an inquest was not required.

The progress of the complaint

33. On 4 February 2009 Mrs H met the Council's adult social care complaints manager to discuss her complaint. She had concerns about a lack of medical care, personal care and monitoring, and concerns about staff conduct and the events leading up to Mr K's readmission to hospital. The Council decided to investigate her concerns under their safeguarding vulnerable adults procedures.[11]

34. Due to the serious concerns raised, the police were informed and a safeguarding vulnerable adults strategy meeting was held on 10 February 2009. On the same day, two senior managers from the PCT and the Council carried out a 'spot-check' at the Care Home to review residents and services. They decided that no urgent action needed to be taken. As part of this safeguarding investigation, in March a community consultant in elderly care, a dementia nurse and a social worker carried out medical and social reviews of all the residents at the Care Home. They concluded that there was no malpractice, although improvements to practice could be made. Concerns raised included confusing paperwork, poor record keeping, and nurses lacking knowledge of drugs. An action plan was developed that recommended that:

- all the records for each resident should be combined, so that there was one comprehensive record available to all, which all staff should be able to access at all times;
- staff should receive training in record keeping, including the importance of signing and dating records;
- the multidisciplinary team's effectiveness should be improved through better reporting and documentation of the meetings, and by having a GP involved;
- there should be a review of the storage of medicines, and qualified nursing staff should undertake refresher training regarding medicine management;

---

9 A blockage in a blood vessel supplying part of the brain.

10 Heart disease caused by abnormalities of the arteries supplying blood to the heart.

11 Safeguarding (protection) is a multidisciplinary approach to minimise and manage risk to adults who may be vulnerable. Safeguarding procedures are used to consider allegations or suspicions that a vulnerable adult is being abused or neglected.

- training needs for all the Care Home staff should be reviewed;
- there should be training in catheter management, pressure damage prevention, nutrition and communicating difficult messages; and
- all healthcare staff should participate in clinical supervision.[12]

35. Once the police confirmed that there would be no criminal proceedings, the social services complaint procedure started.

36. A joint investigation was arranged between the PCT and the Council and carried out by two people. An Independent Investigator and Independent Person were appointed by the Council, in agreement with the PCT. They met Mrs H on 18 May 2009 to agree the 49 issues of her complaint. As neither the Independent Investigator nor the Independent Person had medical qualifications, they requested that an independent, 'out-of-county' doctor read the Independent Investigator's report. A medical expert was commissioned, but Mrs H did not consider that he was impartial as he had worked for WestCall. Therefore, on 9 September, a new medical expert was appointed. He was a GP employed by the PCT.

37. The complaint investigation report was sent to the PCT and the Council on 6 October 2009. The Independent Investigator had interviewed a number of staff involved in Mr K's care. The Independent Investigator's report upheld or partly upheld 14 elements of the complaint and made a number of recommendations. In particular, it recommended that:
    - actions relating to record keeping detailed in the previous action plan (arising from the safeguarding investigation in March 2009) should be implemented immediately;
    - a statement of 'goals to be achieved' be prepared for each resident at the Care Home;
    - a catheter care protocol should be put in place;
    - clear guidelines on the subject of care assistants responding to medical questions should be put in place;
    - there should be training in pressure sore prevention; and
    - there should be scrutiny of the PCT's arrangements for out-of-hours cover provided by WestCall.

38. It was also recommended that a letter of apology should be sent to Mrs H.

39. The Independent Person's role was to comment on the conduct and conclusions of the investigation. He said that the investigation had been carried out in a professional manner and that he had '*fully agreed with and supported*' its conclusions.

40. On 20 November 2009 the Council and the PCT met Mrs H to go through the report's findings. They said that a number of actions had been implemented including:
    - one set of care records was now in place;

12 A formal process of professional support and learning to help clinical staff develop their knowledge and skills.

- all staff were being trained in record keeping;
- improved practice with regard to catheter care; and
- training for staff on nutrition and the importance of monitoring diet, fluid input and output, and weight.

41. Mrs H did not feel that the report was independent and she was also unhappy that the Council had not done anything about the people she believed had not provided the care they should have. However, she did name two members of staff who had provided a high level of care for Mr K. The Council and the PCT said that they accepted all the findings and recommendations in the Independent Investigator's report and would undertake a detailed review of the care provided for the Care Home residents and that the findings of the investigation would be incorporated with the recommendations to improve the service. An action plan was created in December 2009, outlining the action to be taken with regard to the recommendations. This plan showed that NHS staff had received refresher training in catheter care, a new catheter care folder had been developed and catheter training was included in induction for new staff. It was agreed that there would be a meeting with Mrs H in six months' time to update her on progress.

42. Mrs H remained dissatisfied. There was a meeting between her and the Council in June 2010 to try to resolve her remaining concerns. She challenged a number of the findings in the report and said that the reason why the investigation had failed to reach findings on a number of issues was because of the poor record keeping and staff saying that they could not remember what happened. She also disputed the evidence that Mr K was adequately nourished. In view of the fact that a number of Mrs H's outstanding concerns related to health care, it was agreed at the meeting that rather than progress to the next stage of the social service complaints process, the best way forward would be an early referral to the Local Government Ombudsman to allow for the opportunity of joint working.

43. There was a further meeting with Mrs H, the PCT and the Council on 28 September 2010 to provide an update on the progress against the action plan.

44. The complaint was received by the Local Government Ombudsman in November 2010 and was referred to the Parliamentary and Health Service Ombudsman in January 2011.

Inspection by the Care Quality Commission

45. While this joint investigation was being undertaken, the Care Quality Commission[13] carried out an unannounced nine-hour inspection visit at the Care Home on 15 July 2009. Extracts from their inspection report are included at Annex C.

The detail of Mrs H's complaint

46. The detail of Mrs H's complaint is set out in Annex D.

Evidence

47. During this investigation, we considered various documents. These included

13 The Care Quality Commission is the independent regulator of health and social care in England.

records from the Care Home. At the time of the events complained about, residents' records were kept in seven separate folders. (Care plans, daily contact sheets, and occupational therapy and physiotherapy information sheets were kept in each resident's room. Medical information sheets, prescriptions, and notes on GP visits were kept in the main office. Medication administration records were kept in the locked medication trolley. Records kept by the PCT's staff were held in the intermediate care office.) Extracts from Mr K's records are included at Annex E.

48. We have also considered the papers relating to the attempted resolution of Mrs H's complaint by the Council and the PCT, and the Care Quality Commission's inspection report. Given that the events complained about occurred well over three years ago, and relevant members of staff were interviewed by the Independent Investigator in June and July 2009, we decided not to interview these staff again. However, we have considered the interview evidence obtained in June and July 2009, extracts from which are included in Annex F.

Clinical advice

49. The clinical advice on which we have relied is attached as Annex G to this report.

Our findings

50. In determining whether there has been service failure, we refer to the *Ombudsman's Principles* (Annex B, paragraphs 6 and 7). In order to 'get it right' in relation to the care of Mr K, the Council and the PCT should have taken account of recognised quality standards and established good practice, as set out in this instance by the specific standards outlined in Annex B, paragraphs 8 to 11 and as described by the Nurse Adviser in Annex G.

51. In reaching our findings we have compared what happened with what should have happened.

52. We will address the elements of Mrs H's complaint in turn.

Nutrition and hydration

53. Mrs H complains that Mr K was not adequately supported to eat and drink; his food and drink intake were not recorded; and he was not weighed regularly. She said that he lost weight, and although his family brought food in, it was not given to him. She also complains that staff continued to give Mr K the laxative Movicol, even though he was incontinent with diarrhoea and staff did not listen to the family's concerns that the laxative was causing dehydration.

54. The National Minimum Standards and the NICE Guidance (Annex B, paragraphs 8 and 9) state that residents should be screened for risk of malnutrition on admission to care homes. In addition, the National Minimum Standards also state that service users should receive a diet suitable to individual assessed requirements. Prior to his admission to the Care Home, Mr K was assessed by the nurse co-ordinator, who did not carry out nutritional screening. However, she did identify his need for a soft diet and normal fluids.

55. Because there was no screening, it is not possible to be certain whether Mr K required support with his nutrition, or whether his food and drink intake should have been monitored when he moved to the Care Home. The nurse co-ordinator planned that Mr K should be weighed on admission and on the last Sunday of each month, which was routine for new residents. Later in his stay at the Care Home, when Mr K's weight apparently dropped by five pounds, the nurse co-ordinator took action and changed the plan to weekly weights. Given this, it appears that the nurse co-ordinator had no concerns about nutritional issues when Mr K moved to the Care Home, as she planned no specific action. The Nurse Adviser said that it is very important to ensure an adequate fluid intake when someone has a urinary catheter in place, but this does not mean that accurate fluid balance recording would be necessary. Taking everything into account, we are persuaded that, at the time of his admission to the Care Home, Mr K did not need strict monitoring of his food and drink intake.

56. Although Mrs H says that Mr K's food and drink intake was not recorded, staff recorded entries about his diet every day in the daily contact sheets (Annex E). These entries sometimes included information about his intake, for example:

> *'9 January – Tea served ... ate and drank all.*
>
> *'15 January – He ate nearly half of his lunch and all the pudding.'*

At other times it was recorded that he refused food or drink, for example:

'4 January – Declined cup of tea.

'19 January – Tea served, refused omelette but had yogurt jelly.'

The National Minimum Standards state that hot and cold drinks should be available at all times and offered regularly. The contact sheets demonstrate that this happened.

57. At interview (Annex F) the residential care officer said that food and drink intake charts were not completed if there were no concerns about weight or eating. The NICE Guidance states that people in care homes should be screened on admission and weekly if there is clinical concern, yet Mr K was not screened then, or at any time while in the Care Home. However, food and drink charts were started for Mr K on 21 January 2009, indicating that, by then, there were concerns. There is no rationale recorded for why the charts were started. Based on the evidence recorded in the food and drink charts, the Nurse Adviser said that it would have been reasonable to have discussed nutritional supplements with the GP.

58. In addition, one of the identified actions on the catheter care plan was to give frequent fluids, specifically one large glass of fluid every hour. The evidence shows that fluids were regularly offered to Mr K. However, the Nurse Adviser said that, even at an early stage following his admission to the Care Home, Mr K was not drinking the amount of fluid prescribed on his care plan. There is no indication that this fact was highlighted to the registered nurse, or that a specific care plan was drawn up concerning this problem.

59. With regard to Mr K's weight, four days after admission to the Care Home, staff recorded a five pound weight gain. The Nurse Adviser said that this could have been due to fluid retention, a feature of heart failure,[14] and should have been referred to the unit manager. However, she says that there was no indication at that time that Mr K was showing other signs of heart failure. The weight gain might also have been down to an error in the actual process of weighing Mr K. When he was weighed on 26 January 2009 there was a recorded loss of five pounds and eight ounces, which indicates that his overall weight loss since admission was only eight ounces. We cannot determine whether the weights were accurate.

60. In response to the identified apparent weight loss on 26 January 2009, the nurse co-ordinator did not carry out screening for nutritional risk, but only changed the care plan to record weekly weights. Although the nurse co-ordinator recorded that Mr K's family had brought in food in a cool box on that day, and that the residential care officer had been told to offer this food to support his diet, this was not identified on the care plan. There was also no record of it in the daily contact sheets. We have no reason to doubt Mrs H when she says that Mr K was not given the food that his family had brought in. However, the National Minimum Standards state that the home has to adhere to food hygiene standards. Food in a cool box may be perishable and therefore its safety cannot be guaranteed, and food brought in by relatives might not have a 'use by' date on it. If the food was not given to Mr K for

14 A condition when the heart cannot pump enough blood fast enough to meet the needs of the body.

these or other similar reasons, this should have been clearly explained to Mrs H.

61. The daily contact sheets clearly record that care staff were taking account of Mr K's food and drink. When interviewed by the Independent Investigator, the second assistant manager said that she could remember that his appetite became poorer as his health got worse, and he would be offered soup if he did not want the main meal. She said that Mr K ate what he wanted to, and said that staff tried to encourage him to eat as much as possible. However, both the Council and the PCT had a responsibility to ensure that nutritional screening took place, and this did not happen. There was therefore no system in place to make evidence-based decisions about Mr K's nutritional needs. Care staff did not escalate concerns in response to Mr K's apparent weight gain on 28 December 2008. In addition, there was a lack of person-centred care planning. We note that the Care Quality Commission's inspection report in July 2009 said that, to make sure residents' nutritional and health care needs were fully monitored and met, the Care Home needed to ensure that the residents' weight, food and fluid intake were monitored to identify any change that should be referred to health care professionals.

62. We consider that the nurse co-ordinator did not provide care based on the best available evidence or practice in line with the Nursing and Midwifery Council (NMC) Code (Annex B, paragraph 12). Although we cannot conclude that Mr K experienced significant weight loss, taking everything into account, we find that, with regard to nutrition, the care provided by both the Council and the PCT fell below the applicable standards.

Movicol

63. We now turn to Mrs H's complaint that Mr K was given Movicol, which caused dehydration.

64. On 8 January a care assistant told the duty officer that Mr K was constipated. He was prescribed Movicol, one sachet to be taken twice a day, and took a dose that evening. He had it on 9 January and declined to take it on 10 and 11 January. He was given it twice on 12 January and once on 13, 14, 19 and 25 January. He refused it at all other times.

65. On 26 January one of Mr K's nieces contacted social services because she was concerned that Mr K was still being given Movicol, which she believed was why he was so weak. The following day she had a telephone conversation with the nurse co-ordinator, who had discussed the Movicol with the duty officer, who had in turn explained the situation to Mrs H the day before. There is no evidence of what was said in this discussion.

66. In her interview with the Independent Investigator, the nurse co-ordinator said that she would not give Movicol if someone had had their bowels open, even if it was prescribed, but that carers would need to monitor to check what the bowel action was like. She said she thought that Mr K did not have diarrhoea, but had constipation with overflow, when faecal liquid leakage passes around the constipated stool. She said that in these circumstances, it is appropriate to give Movicol to continue to soften the faeces and promote a bowel action. The deputy unit manager and the second assistant unit manager also mentioned the possibility that Mr K had faecal impaction[15] with overflow. The deputy unit manager also

15 Faecal impaction: a solid, immobile bulk of faeces that can develop in the rectum as result of chronic constipation.

said that if Mr K's family had concerns about the laxative, staff would have spoken to the nurse, who would have been in touch with the GP.

67. The Nurse Adviser confirmed that it was appropriate to prescribe Movicol, that the prescription had been in line with prescribing guidelines, and that there is no evidence to suggest that Movicol causes dehydration. However, she said that there was no examination of Mr K to determine whether he had faecal impaction, and no recording of his bowel movements, which would have monitored the effect of the Movicol.

68. We consider that, because it was reported that Mr K was constipated, it was appropriate to arrange for a laxative to be prescribed. We do not consider that he was overprescribed this and we do not agree with Mrs H that it would have caused him to become dehydrated. However, the National Minimum Standards state that service users should have care plans that detail the actions to be taken to ensure all aspects of their health needs are met. The nurse co-ordinator spoke of the need to monitor bowel movements. Both the Council and the PCT had a responsibility to ensure appropriate care plans were in place. Yet, despite being reported as constipated, Mr K did not have a care plan in relation to his bowel care, and there was no monitoring of his bowel movements. There also appears to have been no referral to the GP by the Council's or the PCT's staff to help address his family's concerns, or for examination to confirm if he was experiencing faecal impaction with overflow. In addition, although the records show that his family were concerned about this aspect of Mr K's care, there is no evidence that their concerns were adequately addressed by the Council's or the PCT's staff, or that the possible cause of his faecal soiling was explained to them. In line with the NMC Code, the nurse co-ordinator should have kept colleagues informed and recorded clear and accurate records of the discussions she had with regard to the family's concerns. This did not happen.

69. We do not conclude that the administration of Movicol caused Mr K ill effects. However, for the reasons outlined above, we find that, with regard to this aspect of the complaint, the care provided by the Council and the PCT fell below the applicable standards.

70. At the end of our investigation, on seeing the draft report, Mrs H raised further concerns about the administration of Movicol. She said it has side effects, all of which her uncle had: shortness of breath; excess body water, that is, swollen legs; malaise[16] and weakness; and low blood pressure. She said it should not be given to patients with heart conditions and should be stopped if the patient gets swollen ankles, or becomes fatigued or breathless. She questioned the dosage and the recording of the medication.

71. We asked our Nurse Adviser to comment again. She said '*All medications have potential side effects. The benefits/risks of medication administration are therefore carefully considered. It is important to note that constipation can cause serious discomfort/distress if left untreated*'. She said that the side effects that Mrs H listed are also symptoms that can be associated with other conditions, particularly when a person is acutely deteriorating. She

16 A feeling of general fatigue and unease.

concluded: '*I remain of the view that it was appropriate to prescribe Movicol. The prescription had been in line with prescribing guidelines, and I can confirm that there is no evidence to suggest that Movicol causes dehydration*'. In view of this, we conclude that there are no grounds to alter our findings (paragraph 69) about this aspect of Mrs H's complaint.

Catheter care

72. Mrs H said that catheter care was poor all the time, and Mr K was twice sent home with the catheter tube not positioned properly and unable to drain. She said that after an episode when Mr K was left on the bed, passing blood clots, after his catheter had been removed, he went rapidly downhill. She said that he had been left unable to pass urine and in agony.

73. The National Minimum Standards (Annex B, paragraph 8) state that residents should have care plans that set out in detail the actions which need to be taken by care staff, and that the plans should meet relevant clinical guidelines. Prior to his move to the Care Home, Mr K was assessed by the nurse co-ordinator, who wrote a care plan regarding catheter care that included giving a glass of fluid every hour, monitoring the colour of Mr K's urine, and connecting a single use night drainage bag to the leg bag. The Nurse Adviser has raised no concerns about the care planning on admission.

74. As we have said previously (paragraph 55), we are not persuaded that it was necessary for Mr K to have a strict fluid intake chart on admission, and the daily contact sheets record many instances of Mr K being given drinks. However, the Nurse Adviser said that the importance of ensuring an adequate fluid intake in patients with a urinary catheter cannot be underestimated. She also said that soon after his admission to the Care Home, Mr K's oral fluid intake was poor. There is evidence that care staff were aware of the importance of fluids. The deputy unit manager, in her interview with the Independent Investigator (Annex F), said that residents with catheters should be '*constantly drinking*', and on 7 January 2009 a carer noted '*I have been encouraging* [Mr K] *to drink all day as urine has been very dark*'. However, there is no evidence that this led to a reassessment of Mr K's needs by care staff or nurses to detail the actions that needed to be taken; and formal recording of how much he was drinking was not started until 21 January.

75. With regard to the two instances when Mr K visited his family without his catheter being properly positioned, the Nurse Adviser said that the urinary catheter and drainage bag should be below the level of the bladder. At interview, the deputy unit manager said that Mr K was trying to be independent, although he should have been helped to dress. We can understand that, because Mr K was in the Care Home to prepare him to be able to return home, and staff needed to encourage him to be independent. However, on balance, it would have been appropriate for staff to check that the catheter tube was positioned correctly, to ensure that he was managing in a way that would mean he would be safe on his return home.

76. With regard to the events on 12 January 2009, when Mr K's catheter became blocked, the nurse co-ordinator told the Independent Investigator that the staff nurse had given Mr K a bladder washout. There is no record of this. The catheter was replaced by a district nurse at 9am and it became blocked again, but the staff nurse at the Care Home was

not trained to catheterise men. It was entirely appropriate for her not to attempt to change the catheter, and she was working within the NMC Code (Annex B, paragraph 12). She contacted the GP, who arranged for a second district nurse to visit. The second district nurse removed, but did not replace, Mr K's catheter. The Catheter Care Guidance (Annex B, paragraph 10) states that nurses should undertake a risk assessment before a trial without catheter, which should be undertaken under controlled circumstances. This did not happen. In addition, the second district nurse made no record of her visit in the notes. Although she apparently told the Care Home's staff nurse that the GP should be informed about the situation (this was recorded in the daily contact sheet), the staff nurse made no record of this and the GP was not informed. The GP found out that Mr K was in pain and did not have a catheter later that afternoon, and as he was some distance away, he arranged for another district nurse to visit because she could be there sooner.

77. The second district nurse did not provide care based on best available evidence or practice, in line with the NMC Code. In addition, there was poor record keeping, and poor communication between the Care Home and the GP.

78. Taking account of the evidence set out in paragraphs 72 to 76, we find that with regard to Mr K's catheter care, the care provided by the Council and the PCT fell below the applicable standards.

Administration of medication

79. Mrs H said that medication was not administered properly and she saw Mr K taking medication meant for another resident that had been left on a table. She said that staff did not supervise residents when they took their medication. She said she knew that the Care Quality Commission had inspected the home and found failings with regard to medication.

80. The National Minimum Standards (Annex B, paragraph 8) state that records should be kept of all medicines administered, and medicines should be given by designated and appropriately trained staff.

81. The Nurse Adviser said that the registered nurses were not involved on a daily basis in the administration of Mr K's medication. She said that the medication administration records did record when medication was given and the times when Mr K declined to take medicines.

82. When interviewed by the Independent Investigator (Annex F), the deputy unit manager, first assistant unit manager and residential care officer all said that staff signed the administration sheets to say that they had given the resident their medication. They said that residents were watched while they took their medicine.

83. Although Mrs H believed that the Care Quality Commission had found failings with regard to medication, their inspection report contained no criticisms about this issue.

84. Although we have no reason to doubt Mrs H's recollection of events, we have to take an impartial view based on the available evidence. Given the time that has passed since these events, we consider that there is no feasible way of obtaining any further evidence about administration of medication to Mr K. Therefore, we cannot conclude that there were failings in the way medication was administered to him while he was at the Care Home.

Record keeping

85. Mrs H complains that staff did not complete records appropriately because they filled them in, in one go, at the end of the day. She complains that staff did not keep records to show Mr K's food and drink intake, bowel actions and urine output.

86. Confusing paperwork (each resident's records were kept in seven separate folders) and poor record keeping were identified in the review carried out as part of the safeguarding investigation in March 2009. The complaint investigation report of October 2009 also detailed concerns about record keeping, including a lack of information and information that was recorded incorrectly. The Nurse Adviser said that, having reviewed the records, she agreed with the findings of the Independent Investigator's report. The Care Quality Commission, in their report of July 2009, noted that the Care Home needed to improve its record keeping with regard to weight and nutrition, and also said that the residents' needs were not always fully outlined in their care plans.

87. Our investigation into Mr K's nutritional care has found that no malnutrition screening records were kept; communication with Mr K's family about extra diet was not recorded; there was no rationale recorded for starting food and drink charts; there was no care plan in relation to his bowel care or monitoring of his bowel movements; and there was no recorded evidence that his family's concerns about the administration of Movicol were adequately addressed. With regard to catheter care, although a member of staff noted concerns that Mr K's urine was very dark, no reassessment or actions to be taken to address this were recorded; and record keeping with regard to the events of 12 January 2009 was poor. A review of the records also shows that there is no record of the events of 1 January, when a doctor visited and prescribed antibiotics.

88. Although, when interviewed by the Independent Investigator (Annex F), the unit manager said that significant things such as medical visits or health issues should have been recorded in the daily contact sheets, we can see that this did not always happen. The unit manager told the Care Quality Commission at their inspection in July 2009 that he was aware that records needed to be improved.

89. The National Minimum Standards (Annex B, paragraph 8) state that care home records should be up-to-date and in good order. In addition, care plans should detail actions that staff need to take. The NMC Code (Annex B, paragraph 12) states that nurses must keep clear and accurate records of discussions, assessments, and treatment. The evidence of the timed records on the daily contact sheets does not suggest that these were completed in one go, at the end of the day, as Mrs H says. However, our investigation of several different aspects of Mr K's care and treatment has shown many instances when record keeping at the Care Home fell below the applicable standard.

Communication with Mr K's family

90. Mrs H said that the staff were rude and not respectful of Mr K's family's concerns and did not communicate effectively with them. Mrs H says that the family never saw the manager of the Care Home; the first assistant unit manager kept eating and drinking while they raised serious concerns; staff were abrupt when family members asked questions, failed to return calls when a family member called with concerns about Mr K's catheter and failed to involve his family in planning his care.

91. The care staff interviewed by the Independent Investigator during the joint investigation were asked about their communication with Mr K's family (Annex F).

92. The nurse co-ordinator said that she did not recall being angry and tried to find out further information if this was requested. She documented details of communications with Mr K's family on seven days. The unit manager said that more time was spent in discussion with Mr K's relatives than with other families. The first assistant unit manager said that staff tried to address any concerns that the family mentioned. She also provided an explanation of why she was eating when his family came to speak to her and said that she would put her food aside during these discussions.

93. Given the length of time that has passed, it is not possible to arrive at a conclusion about attitudes and events when those concerned have different accounts of what happened.

94. However, the Nurse Adviser said that it is established good practice that, in any care environment, family members are involved in care planning. She said that this is particularly important in rehabilitation settings where rehabilitation goals are being set, and discharge home is often dependent on input from family, as well as professional carers. In addition, *Putting People First: A shared vision and commitment to the transformation of Adult Social Care* (Annex B, paragraph 11) states that family members and carers should be treated as experts and care partners, and the National Minimum Standards (Annex B, paragraph 8) refer to fostering an atmosphere in which the family feel valued and that their opinions matter. The Nurse Adviser said that the records did not demonstrate involvement and engagement with Mr K's family or evidence that they were involved in care planning. Furthermore, we found that the Council's and the PCT's staff did not adequately address the concerns Mr K's family raised about Movicol, and there was no explanation of why food the family brought in was not given to him. On balance, we therefore conclude that the communication by the Council and the PCT fell below the applicable standard.

Conclusion with regard to care and treatment

95. We have been unable to reach a conclusion on Mrs H's complaint about medication administration. However, in a number of key respects, we find that the Council's and the PCT's staff at the Care Home did not 'get it right', in that they did not act in accordance with recognised quality standards and established good practice. We have found failings with regard to nutrition and fluids, issues in relation to constipation and the administration of Movicol, catheter care, record keeping and communication.

96. Therefore, taking everything into consideration, we find that the care provided for Mr K by the Council and the PCT fell so far below the applicable standard that it amounted to service failure.

Injustice

97. First, we assess whether an injustice to Mr K arose in consequence of the service failure we have identified.

98. Mrs H says that the poor care Mr K received led to his early death and that he also suffered pain and distress, particularly in relation to catheter care.

99. We have concluded that there were failings in care with regard to Mr K's nutrition. However, we have been unable to establish that this caused significant weight loss. The Nurse Adviser said there was no indication that the failings identified in relation to nutrition led to his deterioration and we consider that they cannot be linked to his later death from a pulmonary embolism. We also note that the coroner reported that Mr K was adequately nourished, although we know that Mrs H disputes this. Furthermore, we do not conclude that Mr K suffered distress because of failings with regard to the administration of Movicol; nor do we conclude that record keeping that fell below the applicable standard would have been a source of distress for him.

100. However, we have identified a significant failing in the delay in recatheterising Mr K on 12 January 2009, in part due to the actions of a district nurse and in part due to poor communication by the Care Home staff with the GP. We have no doubt that these failings meant that Mr K, who was already in pain and was left unable to pass urine for over two hours, would have suffered further unnecessary pain and distress. This was the injustice that Mr K suffered in consequence of the service failure we have identified.

101. We now assess whether Mr K's family experienced injustice in consequence of the service failure we have identified. Mrs H says that her family had the distress of watching the way her uncle was treated and that her mother stopped visiting him because she found it so distressing.

102. Clearly, Mrs H was distressed that food she took in for Mr K was not given to him. We also acknowledge that finding out that he had suffered pain and distress due to the delay in recatheterisation would also have caused distress to his family. In addition, the safeguarding investigation and the joint investigation identified poor record keeping and I can understand how this would have caused Mr K's family concern when they found out about it. Finally, although in regard to communication we cannot be certain about events that took place some years ago, we have found that there was a lack of involvement of the family in Mr K's care planning. It is understandable that they would have found this distressing. We therefore conclude that the family suffered the injustice of distress in consequence of the service failure we have identified.

The Ombudsmen's conclusions

103. Having studied the available evidence and taken account of the advice provided by the Nurse Adviser, we find the care provided for Mr K by the Council and the PCT while he was at the Care Home fell significantly below the applicable standard. This was service failure. We have assessed whether injustice to Mr K and his family arose in consequence of the service failure we have identified and concluded that it did. However, we have not found that the failings we identified led to Mr K's early death, as Mrs H believes.

104. We therefore partly uphold Mrs H's complaint about the Council and the PCT.

Recommendations

105. In making our recommendations, we have taken account of the Ombudsman's Principles for Remedy, in particular:

    - '*Putting things right*' – which includes considering fully and seriously all forms of remedy (such as an apology, an explanation, remedial action, or financial compensation).

106. We recommend that, within one month of the date of this final report, the Council and the PCT should jointly provide Mrs H with an open and honest acknowledgment of the failings identified in this report and an apology for the impact that these failures had upon Mr K and his family.

107. We recommend that the Council and the PCT should, within one month of the date of this final report, each pay financial compensation to Mrs H of £300 in tangible recognition of the injustice of distress suffered by her and her family.

108. A copy of the apology and notification that payment has been made should be sent to both Ombudsmen.

109. We note that action has already been taken with regard to some of the failings identified in this report. However, Mrs H was last told about these actions many months ago and she has told us that she considers that the action taken since the complaint has not properly been explained to her. A response to this report gives the Council and the PCT the opportunity to give an up-to-date report on their actions.

110. Therefore, we recommend that, within three months of the date of this final report, the PCT and the Council should formulate a joint action plan in relation to all the failings identified in this report (nutrition and hydration, issues in relation to constipation and the administration of Movicol, catheter care, record keeping and communication).

111. The joint action plan should:

    - describe action taken in relation to the Care Quality Commission's recommendations of July 2009;
    - describe what has been done to ensure that the organisations have learnt lessons from the failings identified by this upheld complaint; and
    - detail further plans, including timescales, to avoid a recurrence of the failings we have identified.

112. In addition, the PCT should formulate an action plan to address the identified failing in catheter care by the community nursing service, as set out in paragraph 76, which should:

    - describe how they have taken action to ensure that the organisations have learnt lessons from the failings identified by this upheld complaint; and
    - detail what they plan to do, including timescales, to avoid a recurrence of the failings we have identified.

113. The action plan should be sent to Mrs H, with copies to both Ombudsmen, Berkshire West Clinical Commissioning Group, Monitor and the Care Quality Commission. The PCT should ensure that Mrs H, Berkshire West Clinical Commissioning Group and the Care Quality Commission are kept informed of progress against the action plan.

114. On 31 March 2013 the PCT was abolished in accordance with the NHS reforms. From 1 April 2011 responsibility for provision of the services complained about transferred to Berkshire Healthcare Foundation

Trust (the Trust). The Trust has agreed to implement the recommendations of the apology and the action plan that we made, and the (former) PCT will implement the financial recommendation we made.

Final remarks

115. In this report we have set out our joint investigation, findings, conclusions and decision with regard to Mrs H's complaint about the care and treatment Mr K received from the Council and the PCT while he was at the Care Home. We can assure Mrs H that her complaint has been thoroughly and impartially investigated and that our conclusions have been drawn from careful consideration of detailed evidence, including the advice of an independent clinical adviser. We hope that this report will give Mrs H some reassurance that the identified failings will be addressed. We also hope that this report will draw what has been a long and complex complaints process to a satisfactory close.

Dame Julie Mellor, DBE
Health Service Ombudsman for England

Dr Jane Martin
Local Government Ombudsman

August 2013

Annex A

The Ombudsmen's remit and powers

The Health Service Ombudsman's jurisdiction and role

1. By virtue of the *Health Service Commissioners Act 1993*, the Health Service Ombudsman is empowered to investigate complaints about the NHS in England. In the exercise of her wide discretion she may investigate complaints about NHS organisations such as trusts, family health service providers such as GPs, and independent persons (individuals or organisations) providing a service on behalf of the NHS.

2. In doing so, she considers whether a complainant has suffered injustice or hardship in consequence of a failure in a service provided by the organisation, a failure by the organisation to provide a service it was empowered to provide, or maladministration in respect of any other action by or on behalf of the organisation. Service failure or maladministration may arise from action of the organisation itself, a person employed by or acting on behalf of the organisation, or a person to whom the organisation has delegated any functions. If the Health Service Ombudsman finds that service failure or maladministration has resulted in an injustice, she will uphold the complaint. If the resulting injustice is unremedied, in line with her Principles for Remedy, she may recommend redress to remedy any injustice she has found.

The Local Government Ombudsman's remit

3. Under Part 3 of the *Local Government Act 1974,* the Local Government Ombudsman has wide discretion to investigate complaints of injustice arising from service failure or maladministration by local authorities (councils) and certain other public organisations. She may investigate complaints about most council matters, including social services and the provision of social care. If the Local Government Ombudsman finds that maladministration or service failure has resulted in an unremedied injustice, she may recommend redress to remedy any injustice she has found.

Powers to investigate and report jointly

4. *The Regulatory Reform (Collaboration etc. between Ombudsmen) Order 2007* clarified the powers of the Health Service Ombudsman and the Local Government Ombudsman, with the consent of the complainant, to share information, carry out joint investigations and produce joint reports in respect of complaints that fall within the remit of both Ombudsmen.

5. In this case, we agreed to work together because the health and social care issues in Mrs H's complaint were so closely linked. A co-ordinated response consisting of a joint investigation leading to a joint conclusion and proposed remedy in one report, seemed the most appropriate way forward.

Annex B

The basis for the Ombudsmen's determination of the complaint

1. In general terms, when determining complaints that injustice or hardship has been sustained in consequence of service failure and/or maladministration, we generally begin by comparing what actually happened with what should have happened.

2. So, in addition to establishing the facts that are relevant to the complaint, we also need to establish a clear understanding of the standards, both of general application and those that are specific to the circumstances of the case, which applied at the time the events complained about occurred, and which governed the exercise of the administrative and clinical functions of those organisations and individuals whose actions are the subject of the complaint. We call this establishing the overall standard.

3. The overall standard has two components: the general standard, which is derived from general principles of good administration and, where applicable, of public law; and the specific standards, which are derived from the legal, policy and administrative framework and the professional standards relevant to the events in question.

4. Having established the overall standard we then assess the facts in accordance with the standard. Specifically, we assess whether or not an act or omission on the part of the organisation or individual complained about constitutes a departure from the applicable standard. If so, we then assess whether, in all the circumstances, that act or omission falls so far short of the applicable standard that it constitutes service failure or maladministration.

5. The overall standard which we have applied to this investigation is set out below.

The general standard: the *Ombudsman's Principles*

6. The Principles of Good Administration, Principles of Good Complaint Handling and Principles for Remedy[17] are broad statements of what public organisations should do to deliver good administration and customer service, and how to respond when things go wrong. The same six key Principles apply to each of the three documents. These six Principles are:

   - Getting it right
   - Being customer focused
   - Being open and accountable
   - Acting fairly and proportionately
   - Putting things right, and
   - Seeking continuous improvement.

7. The Principle of Good Administration relevant to this complaint is '*Getting it right*'. This includes that '*Public organisations must act in accordance with recognised quality standards, established good practice or both, for example about clinical care*'.

The specific standards

Care Homes for Older People: National Minimum Standards, Care Home Regulations

8. The *Care Standards Act 2000* was introduced in April 2002 and ended

17 The *Ombudsman's Principles* is available at: www.ombudsman.org.uk.

the distinction between nursing and residential homes. From April 2004 the Commission for Social Care Inspection and the Commission for Healthcare Audit and Inspection were responsible for the inspection, monitoring and regulation of health and social care in England. This role was taken over in April 2009 by the Care Quality Commission. *Care Homes for Older People: National Minimum Standards, Care Home Regulation*s (the National Minimum Standards) was published, in accordance with section 23(1) of the *Care Standards Act*, in February 2003.[18] The standards are core standards that apply to all care homes providing accommodation and personal or nursing care for older people. The main piece of legislation overseeing all care homes in England is *The Care Homes Regulations 2001*. In assessing whether a care home conforms to *The Care Home Regulations 2001*, the regulator must take the National Minimum Standards into account. Standard 7 includes:

> *'7.2 The service user's care plan sets out in detail the action which needs to be taken by care staff to ensure that all aspects of the health, personal and service needs of the user ... are met.*
>
> *'7.3 The service user's plan meets relevant clinical guidelines produced by the relevant professional bodies concerned with the care of older people ... .'*

Standard 8 includes:

> *'8.9 Nutritional screening is undertaken on admission and subsequently on a periodic basis, a record maintained of nutrition, including weight gain or loss, and appropriate action taken.'*

Standard 9 includes:

> *'9.3 Records are kept of all medicines received, administered and leaving the home ...*
>
> *'9.7 In residential care homes, all medicines ... are administered by designated and appropriately trained staff ... .'*

Standard 15 includes:

> *'15.1 ... service users receive a varied, appealing, wholesome and nutritious diet, which is suited to individual assessed and recorded requirements ...*
>
> *'15.3 Hot and cold drinks and snacks are available at all times and offered regularly ... .'*

The introduction to Standards 31 to 38 states that a skilled care home manager will foster '*an atmosphere of openness and respect, in which residents, family, friends and staff all feel valued and that their opinions matter*'.

Standard 37 includes:

> *'37.3 Individual records and home records are secure, up to date and in good order ... .'*

Standard 38 includes:

> *'38.2 The registered manager ensures safe working practices including ... food hygiene: correct storage and preparation of food to avoid food poisoning, including labelling and dating of stored food ... .'*

---

18 These have been superseded by regulations set out in *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.*

National guidance

9. The National Institute for Health and Care Excellence (NICE)[19] clinical guideline 32 *Nutrition Support in Adults: Oral Nutrition Support, enteral tube feeding and parenteral nutrition* (the NICE Guidance – February 2006) offers best practice advice on the care of adults who are malnourished or at risk of malnutrition. It states that people in care homes should be screened on admission and screened weekly if there is clinical concern. The NICE Guidance states that nutrition support should be provided for those who are at risk of malnourishment, defined as those who have eaten little or nothing for more than five days and/or who are likely to eat little or nothing for the next five days or longer.

10. In 2008 the Royal College of Nursing published *Catheter care: guidance for nurses* (the Catheter Care Guidance), written and endorsed by a group of expert practitioners. This states that nurses should:

    'undertake a risk assessment and use the outcomes to determine a suitable method for trial without catheter ...

    'provide appropriate care for individuals where the trial without catheter is not effective.'

    It says that a trial without catheter should be undertaken in controlled circumstances and not on an ad hoc basis.

11. *Putting People First: A shared vision and commitment to the transformation of Adult Social Care* was published by the Department of Health in December 2007. This committed a number of central and local government organisations, as well as the NHS and third-sector organisations, to work together to bring adult services in England much more within the control of service users, to give them choice and control over the services they received. It said that an objective of a personalised adult social care system was that family members and carers should be treated as experts and care partners.

Professional guidance

12. The Nursing and Midwifery Council (NMC – the organisation responsible for professional regulation of nurses) published *The code: Standards of conduct, performance and ethics for nurses and midwives* (the NMC Code) in May 2008. This contained general and specific guidance on how nurses should approach their work. It represents the standards that the NMC expects nurses to meet. The NMC Code states that nurses must:

    'keep [their] *colleagues informed when* [they] *are sharing the care of others ...*

    'deliver care based on the best available evidence or best practice ...

    'have the knowledge and skills for safe and effective practice when working without direct supervision ...

    'recognise and work within the limits of [their] *competence ...*

    'keep clear and accurate records of the discussions [they] *have, the assessments* [they] *make, the treatment and medicines* [they] *give, and how effective these have been.'*

---

19 NICE is the independent organisation responsible for providing guidance on promoting good health and preventing and treating ill health.

Annex C

Extracts from the Care Quality Commission key inspection report, 15 July 2009

1. On 15 July 2009 the Care Quality Commission gave the Care Home a two star good service rating.

2. *'What the care home does well: the* [Care Home] *creates a comfortable, fresh, clean and homely environment for the people who live there, and for those people who require further support midway between hospital discharge and returning home. The home has a staff team who are committed to meeting the needs of the residents and keeping those residents safe. Staff treat residents with dignity and respect at all times ...*

3. *'What they could do better: The service must ensure documents that monitor a resident's weight, food and fluid intake are monitored to identify any change that should be referred to health care professionals, and/or to update the person's care plan. This is to make sure the person's nutritional and health care needs are fully monitored and met.*

4. *'The service should where appropriate use information received from health care professionals to inform and update the person's care plan ...*

5. *'Clients who receive intermediate care have their needs fully assessed prior to admission with continual review throughout their period of rehabilitation.*

6. *'People who use the service have their health and personal care needs met by a caring and respectful staff team, but those needs are not always fully outlined within their plan of care.*

7. *'The intermediate service is currently reviewing the format of residents care plans and records as recommended from a recent medical and safeguarding review.*

8. *'Medication policies and procedures are in place and only trained staff administer residents' medication. Medication was observed to be stored securely. On the day of this key inspection we observed staff attend in-house medication training as delivered by a pharmacist on the monitored dosage system used by the home ...*

9. *'The assistant manager showed the inspector hand written minutes of a senior staff meeting held the day before this inspection that detailed areas that the senior team recognise as requiring improvement within record keeping and monitoring.*

10. *'The manager stated that he is aware that records need to improve, and said he is committed and confident that improvements will be take place to safeguard and fully detail the needs of the people who use the service now that the service has a full complement of permanent staff ... .'*

Annex D

The detail of Mrs H's complaint

1. Mrs H said that initially Mr K was doing very well in the Care Home and his family were told he might be discharged early. However, he developed a cough and the home did not call out the GP at the weekend. She said that he started to cough up green phlegm and deteriorated, becoming '*not with it*'. She said that when Mr K did go to hospital, staff complained about the state he was in, but when they were told where he came from, staff '*clammed up*'.

2. Mrs H said that catheter care was poor all the time, and Mr K was twice sent home with the catheter tube coiled up and unable to drain properly. She said that after an episode when Mr K was left on the bed, passing blood clots, after his catheter had been removed, he went rapidly downhill. She said that he had been left unable to pass urine and in agony, and the GP had refused to come.

3. With regard to food and fluid, Mrs H said that staff did not complete records to show his food and drink intake, bowel actions and urine output. She said that Mr K was not adequately supported to eat and drink, nor was he weighed regularly. She said that he lost weight. His family brought him food in a cool box, but it was not given to him. She also said that staff continued to give him a laxative, even though he was incontinent with diarrhoea; and staff did not listen to the family's concerns that the laxative was causing dehydration. At the end of our investigation, Mrs H added that the records for 23 December 2008 stated that Mr K liked a soft diet. However, his teeth went missing and were never found. His family arranged for a dentist to visit and fit a new set of teeth. Mrs H said that if they had not done this, Mr K would not have been able to eat some of the meals provided.

4. Mrs H said that medication was not administered properly and she saw Mr K taking medication meant for another resident that had been left on a table. She said that staff did not supervise residents when they took their medication.

5. With regard to the records, Mrs H said that staff did not complete them appropriately, as they were completed in one go, at the end of the day. At the end of our investigation Mrs H said that many issues about her uncle's health and wellbeing were not recorded or were ignored. She said '*Either the staff were unable/incapable to deal with* [Mr K's] *needs, were negligent or had a total disregard for his health or wellbeing*'. She added: '*somebody needs to be accountable for the pain and suffering that* [Mr K] *endured*'.

6. Mrs H said that the staff were rude and not respectful of Mr K's family's concerns and did not communicate effectively with them. Mrs H says that her family never saw the manager of the Care Home, one member of staff kept eating and drinking while her family raised serious concerns, staff were abrupt when the family asked questions, failed to return calls when a family member called with concerns about Mr K's catheter, and failed to involve the family in planning his care. She said that she would not treat an animal the way they treated her uncle. At the end of our investigation Mrs H added: '*I believe that the lack of care led to* [Mr K's] *death and wish that we had taken him home*

instead of letting him go to rehab as I am convinced that he would have lived longer'. She further added:

> '*We were preparing for* [Mr K's] *return and in fact the stairlift was due to be fitted the day he died. If* [he] *was such a "Poorly man" as stated why were we told to prepare for his return and why was equipment delivered home ready for him to use.*'

7. Mrs H said that after the independent investigation she was told that they were going to put a '*dummy*' in the home, to see how they were treated, but was then told that they could not do this. She said that the action taken since the complaint had not really been explained to her. She said she knew that the Care Quality Commission had inspected the home and found failings with regard to record keeping and medication.

Annex E

The Care Home's records

Extracts from the daily contact sheets

23 December 2008

12.00 Arrived at 12 o'clock ... drink given ...

12.45 Teeth don't fit likes to have soft diet drink given.

13.00 Sat at table for lunch leek & ham pie mash, veg, juice.

19.15 ... In bed – cup of tea given.

24 December 2008

08.10 Breakfast served.

11.45 Cup of tea given.

17.00 Served sandwiches and tea.

20.00 Cup of tea given.

25 December 2008

07.00 Drink offered.

20.15 Returned from home. Beaker of blackcurrant given. Complaining that catheter is making him sore.

26 December 2008

07.00 Catheter disconnected, cup of tea offered.

10.15 Breakfast served.

11.30 Hot drink served.

13.00 Lunch served corn beef hash & veg & trifle.

15.20 Served a cup of tea.

17.00 Buffet served.

20.00 Cup of ovaltine given, sitting in room with visitors.

27 December 2008

07.00 Tea offered.

13.00 Lunch served steak kidney, potato and veg. Trifle.

17.00 Served chips and egg, tea and cake.

21.45 Horlicks and biscuits given.

28 December 2008

07.00 Tea offered.

09.30 ... came to the lounge for breakfast.

11.10 Having a cup of tea in his bedroom.

13.00 ... Lunch served turkey dinner. Rice pudding.

16.10 Still with family, tea served.

17.10 Tea served with sandwiches and cake.

20.15 Hot drink served.

21.00 Put on bed, catheter bag did not connect with night bag because carer did not find a night bag.

29 December 2008

07.00 Cup of tea served.

11.00 Cup of tea and biscuits offered.

12.30 [Mr K] *has a tummy bug and he has to just drink. He will be staying in his room.*

15.30 Cup of tea. No complaints of his tummy.

17.15 Had beans on toast & mince pie, cup of tea.

20.05 Hot drink offered – Horlicks.

30 December 2008

Untimed Please can the night bag be single use only and never used repeatedly. Leg bag change on Sun. As per care plan.

09.05 Breakfast served.

13.00 Wheeled to the main lounge for lunch. Soup served with bread.

15.20 Coffee and biscuits given.

17.00 Cup of tea served and cake.

20.20 No hot drink given.

31 December 2008

07.00 Tea offered.

09.45 ... Gave tea and toast.

11.30 Had a cuppa tea and biscuits.

13.00 Came to dinner table had chicken supreme, jelly and cream.

15.00 Cup of tea served.

17.00 Tea served having ham sandwiches, cup of tea and cake.

19.00 Having cold drink sitting in his room.

1 January 2009

07.00 Drink offered.

08.00 Walked along to breakfast had toast and tea.

2 January 2009

06.15 ... drank two beakers of water during the night.

07.00 Coffee offered.

08.30 Breakfast given.

11.00 Jug of water given.

11.45 Emptied bag, still drinking water.

12.30 Called for lunch. Fish and chips & fruit flan cream. Water given.

15.00 Cup of tea and biscuits given.

17.15 Sausage rolls and tomatoes and scones served for tea.

19.30 Has visitors and hot drink given.

3 January 2009

07.00 Drink offered.

10.00 Jug of water served.

11.30 Tea served with biscuits.

13.05 Lunch served – hotpot and veg, water, tapioca and jam.

15.45 Hot drink served.

16.30 Jug of water given with drop of cranberry given. Family informed that [Mr K] *suffers from diarrhoea when he drinks too much cranberry juice.*

17.00 Egg, ham, chips and yoghurt with water served for dinner.

20.25 Catheter emptied and beaker of Horlicks given with two biscuits.

21.35 ... fresh jug of water given.

4 January 2009

07.00 Drink offered.

09.35 Breakfast served – cereal and toast.

11.00 Cup of tea served.

13.00 Dinner served – roast chicken.

15.00 Declined a cup of tea, has visitors.

15.30 Refused an offer of a cup of tea.

17.10 Served soup & a slice of bread.

20.00 Served Horlicks and biscuits.

5 January 2009

07.00 Drink offered, catheter bag emptied.

10.00 Breakfast served – cereal and toast.

10.50 Cold drink given.

11.30 Cup of tea served in room.

12.00 Dinner served & soup.

15.30 Cup of tea and biscuit given.

17.00 Fish fingers, chips, Arctic roll and cup of tea for dinner.

20.00 Cup of Ovaltine given.

22.30 ... Put into bed night bag put on.

6 January 2009

07.00 Tea offered. Supervised with taking night bag off.

Untimed – Please only use single use night bags at night – connect bag to white connector on leg bag – dispose of bag am.

09.15 ... now going to lounge for breakfast.

11.30 Cup of tea offered.

13.30 [Mr K] *had pasta and veg, stewed apple and custard.*

16.00 Cup of tea served.

17.00 Tea served – sandwiches.

20.00 Hot drink served.

7 January 2009

07.00 Drink offered, night bag taken off.

09.20 Eating breakfast.

11.20 Offered drink (declined).

14.20 [Mr K's] *catheter seemed to have a blockage. I bought it to the attention of the manager. The bag was changed and this seemed to sort the problem out. I have been encouraging* [Mr K] *to drink all day as urine has been very dark.*

15.15 Prune juice given.

17.00 Waffle and spagetti, tinned fruit & water for dinner.

20.00 Horlicks given.

8 January 2009

07.00 Tea offered.

11.00 Tea biscuits served.

11.15 Quite constipated ... did tell duty officer.

13.00 Lunch served. Roast chicken, potatoes & veg, angel delight.

16.00 Declined a cup of tea, contented with water.

17.00 Tea served, sandwiches etc.

18.00 Sat in lounge, juice/water served.

19.00 Small glass of prune juice given.

20.00 Sitting in bedroom with visitor. Cup of Ovaltine given.

21.00 Glass of water drank.

9 January 2009

07.00 Drink offered.

08.10 ... taken to breakfast.

10.30 Cup of tea and biscuit given.

12.00 Juice given.

15.15 offered [Mr K] *and his visitors a hot drink. They declined,* [Mr K] *is drinking water.*

17.45 Tea served – jacket potato, cheese and beans. 1 cup of tea and yoghurt. [Mr K] *ate and drank all.*

21.25 Given Horlicks and biscuits.

10 January 2009

07.00 Drink offered.

12.00 Sat in lounge, hot drink offered.

14.50 Came back to lounge for lunch ... [Mr K] *had cottage pie and veg, fruit salad, one glass of water.*

15.30 He was in his room with his niece. Tea served.

17.00 Tea served in lounge with cheese on toast & cake.

20.35 Hot drink served.

11 January 2009

07.00 Tea offered.

09.10 He was having his breakfast.

20.15 Hot drink offered – Horlicks and two biscuits.

12 January 2009

01.15 [Mr K] *rang bell. Carer attended noticed* [Mr K's] *catheter was blocked & the top of the tube was filled with blood. Carer rang Westcall, Doctor to be arriving shortly. Carer supervised* [Mr K] *to armchair, cup of tea served.*

03.31 Doctor arrived. Changed catheter bag.

07.22 [Mr K] *rang to tell carer catheter still draining blood, not blocked.*

07.15 [Nurse co-ordinator and assistant unit manager] *checked* [Mr K's] *catheter.*

07.55 Awake. [Mr K] *is in a lot of pain. Urine in catheter bag is red.*

09.00 [The district nurse] *has removed the catheter and replaced it. It is still blocked.*

11.30 Still in pain. Catheter still emptying blood.

12.30 Chemist delivered paracetamol. Given x2 tablets to [Mr K] *... catheter is still draining blood. Refused hot drink, just wants to drink water.*

13.30 He is still in pain. Waiting for the district nurse.

14.20 District Nurse came. Removed catheter. There is leaking blood and [Mr K] *has passed some clots again. The District Nurse did not want to insert another catheter as this would cause more pain. The District Nurse has gone to the portakabin to speak to the Community Nurse. She also thinks the GP should be informed and that* [Mr K] *could be admitted to the Royal Berks* [hospital] *as he has an appointment there tomorrow morning.*

22.30 Awake, night bag connected, drink given.

13 January 2009

00.30 Awake drink given.

05.52 Called said he had indigestion after drinking a glass of orange.

07.00 Drink offered night bag disconnected.

08.45 Walked a little way to the dining area then needed wheelchair, looking pale but a lot brighter than yesterday.

12.50 Back at table. Mince and veg served, had stewed apple for dessert.

16.00 Refused cup of tea. Had ½ glass of water since 14.00hrs.

17.00 Cheese on toast, tea, jelly and ice cream for dinner.

20.15 ... resting in chair. Had half a glass of water. Checked urine bag. Still emptying well, less blood that yesterday. Refused hot drink.

21.00 Still in chair ... sips of water given. Refilled water jug.

21.30 Catheter emptied. Dark urine.

14 January 2009

07.00 Drink offered.

10.00 Served him porridge and a glass of water for breakfast.

10.45. Wheeled back to his room, encouraged to drink plenty, urine very dark.

13.00 Lunch served – macaroni cheese & veg.

13.45 Ensure given – refused to eat lunch.

15.15 ... Declined a hot drink.

17.45 ... Taken to the lounge in a wheelchair. Had two sandwiches, cake and a cup of tea.

19.00 Taking in a hot drink.

15 January 2009

07.00 Drink offered.

09.50 [Mr K] *had a bowl of porridge, but ate very little and did not drink the milk. Has had ½ cup of tea and ½ glass of water.*

11.10 Asked to go back to his room. Declined hot drink. Poured some water out for him. Checked catheter bag, draining well, drained 500mls since 08.00am, no blood present.

11.50 ... has declined to come to lounge for lunch. He wants to lie down and we will save his lunch for him and he can have it when he wakes up.

13.20. [Mr K] *had beef stroganoff, mashed potato and veg. 1½ glasses of squash and 1 slice of cheesecake. He ate nearly half of his lunch and all the pudding.*

15.10 Horlicks given.

17.15 Tea served – marmite on toast and a cup of tea, no pudding.

16 January 2009

09.55 ... had 1 bowl of porridge, 1 glass of water and 1 cup of tea.

11.15 Cup of tea served.

13.45 Lunch given. Served fish, chips and peas. Mashed potato given instead of chips because [Mr K] *has lost his teeth.* [Mr K] *had half his lunch ... 1 glass of water.*

15.30 Cup of tea offered.

17.00 Catheter emptied. Urine very dark.

20.00 Horlicks and biscuits given, sitting with visitors.

17 January 2009

07.00 Tea offered, night bag disconnected.

08.40 Assisted to dining room for breakfast. Requested wheelchair half way down corridor due to breathlessness.

13.00 Served cauliflower cheese, treacle sponge and water for lunch.

17.00 At table, quiche and salad served, fruit flan for afters.

20.50 Horlicks given, has visitors.

18 January 2009

04.30 Has been coughing. Drinks given.

07.00 Drink offered.

09.30 Honey, lemon, hot water given.

11.00 Lying on bed, hot drink offered.

13.00 Taken to dining area, lunch served, lamb, roast potatoes and veg, fruit crumble and custard for afters.

17.00 Came to dining room for supper. Sandwiches and ice cream. Cup of tea.

19 January 2009

01.30 Rang, Cup of tea given.

05.45 Was found on the floor on his knees. Assisted back onto bed, no apparent injury. Accident form completed.

07.00 Tea offered. Has been very anxious, not slept much, worrying about assessment this morning.

10.20 Catheter checked and changed by district nurse.

10.30 Eating breakfast.

11.50 Tea/coffee offered – declined.

13.00 Lunch served with chicken casserole & rice pudding.

16.15 Returned from home visit.

17.30 Tea served, refused omelette but had yogurt jelly.

20.00 Had a mug of horlicks.

20 January 2009

07.00 Drink offered.

09.45 Having breakfast.

11.00 Tea and biscuits given.

13.00 Lunch – corn beef hash, jam sponge and custard.

15.00 Lay on bed, with visitors, mug of coffee given.

17.05 Tea served, cheese on toast, angel delight & tea.

20.00 Hot drink given.

21 January 2009

07.00 Drink offered.

08.30 Porridge given.

13.00 Lunch served – beef stew, veg and mash.

16.00 Coffee, did not want a biscuit.

17.00 Tea served, chicken soup & bread & tea.

20.00 Had a cup of tea.

22 January 2009

07.00 Night bag disconnected and tea offered.

09.00 Gave breakfast.

11.25 Tea served and biscuits.

13.00 Lunch served. Savoury mince, mash and veg, squash, apple pie and custard.

15.20 Cup of tea, visitors in bedroom.

17.00 Tea served soup & roll & ice cream.

19.00 Tea and biscuits.

20.00 Asked for cup of Horlicks.

00.00 Awake ... drink given.

23 January 2009

08.00 Came to breakfast, shredded wheat, toast, tea.

11.00 Tea offered said no would like a glass of squash orange.

11.10 Fresh water put in room.

13.00 Lunch served, fish and chips.

15.05 Refused tea. Drinking orange squash.

17.00 Tea served – soup and bread butter and cake.

20.30 Horlicks served.

24 January 2009

00.30 Awake in bed – drink given.

04.30 Glass of juice given.

08.00 Had breakfast.

11.30 Had cup of tea.

14.00 Catheter changed, blocked again.

14.10 Having a bit of dinner.

15.35 Cup of tea offered.

17.15 Tea served – didn't eat much.

00.00 ... drink given ...

25 January 2009

09.10 Brought down to breakfast in a wheelchair as still feeling breathless. Cereals given.

10.45 Cup of tea refused.

13.00 Roast pork, roast potatoes & veg & rice pudding & jam served for lunch. Ate fairly well.

15.30 Tea refused – visit from family.

16.30 Nieces with him. They fed him banana and custard.

17.05 Tea served – tomato soup, bread & butter & yoghurt and cup of tea.

26 January 2009

01.00 Rang, asked for cup of tea.

07.00 Tea offered, has been very breathless, but has no pain.

11.00 Had cup of tea, refused biscuit.

13.00 Sat at table for dinner. Ate very little.

15.30 Asleep when drinks offered.

17.00 Tea served – soup & bread and butter, squash.

20.45 Ovaltine 1 cup.

27 January 2009

07.00 Tea offered.

09.45 Breakfast served.

10.15 Gone back to room to see doctor.

13.00 Lunch served, spaghetti Bolognese & cake.

15.30 Dentist came.

17.00 ... came to dining room. Refused soup had ice cream.

20.00 Encouraged to drink more water, beaker filled up.

28 January 2009

03.20 Asked to sit in his chair, urine dark.

07.00 Sat in lounge eating breakfast.

08.00 [Mr K] *has an appointment at hospital for X-ray 9am.*

13.15 In dining room at table for dinner. Had soup, jelly, cream juice.

15.30 In his room, served a cup of tea and biscuit.

17.00 Served tea, mashed potatoes and toast, but he had nothing.

20.00 Refused an offer of a hot drink.

22.30 Sat in armchair in room. Assisted to bed by carer, night bag attached, was very, very tired.

29 January 2009

07.45 All care given to [Mr K] *while in bed. Staff member to remain with* [Mr K] *at all times.*

08.00 [Mr K] *was laying sideways in bed, propped up, help with 2nd carer.* [Mr K] *wanted some porridge and tea, some mouthfuls take, although unable to swallow, also difficulty in drinking, he also felt sick. The Nurse suggested he stay in bed till the Dr came, supervised while in bed.*

10.30 With [Mr K] *Giving juice a few sips at a time.*

11.30 Dr came checked him out and is sending him to hospital for checks and to have a drip.

Extracts from the Care Home's professional communication sheets – entries by nurse co-ordinator

7 January 2009

T/C [telephone conversation] *to* [niece] *re ?hospital admission in 2/52* [two weeks].

19 January 2009

T/C from [Mrs H] *... who is very concerned why recatheterisation took so long to happen on 12.1.09. Advised of the pain control ... Discussed communication between Duty office ... and* [GP] *... Complaints procedure discussed ...*

T/C from [niece] *to confirm that DN's first visit on the 12.1.09 was prior to 14.30 as per nursing notes.*

Both nieces aware that [Mr K] *had a fall overnight ...*

Telephone call to [niece] *... Discussed plan HV* [home visit] *to be revised ...*

20 January 2009

T/C from niece unable to visit ... discussed that personal call bell not working ...

22 January 2009

T/C to niece re day bed ...

26 January 2009

T/C from niece re ?appropriate for discharge. We discussed plans for discharge to go ahead ...

[Niece] *wanted to know if* [Mr K] *had been weighed & ? losing weight ...*

Family have brought in foods in a cool box [residential care officer] *advised & to give to support diet.*

27 January 2009

T/C to [niece] *1) re Movicol ... I advised* [her] *that I had had a conversation with* [the duty officer] *who in turn had spoken with* [Mrs H] *26.1.09 and explained procedure re Movicol. 2) I advised* [niece] *that the DN is to order a pressure mattress ... 3)* [Mr K] *had reported that ...*

29 January 2009

Discussed with ... Duty Officer re her conversation with [Mrs H] *...*

T/C to [niece] *...*

T/C from [niece] *re ...* [list of eight points] *...*

... I have advised [niece] *that she is welcome as is her sister ... to come to the* [Care Home] *to see the GP ...*

... conversation with [Mrs H] *... remains concerned re the care ...*

Annex F

The evidence from interviews that took place in June and July 2009 as part of the joint investigation conducted by the Independent Investigator and the Independent Person

1. The following are the most relevant points from the interviews in relation to the matters under investigation.

The nurse co-ordinator

2. '[The nurse co-ordinator] *said that ... her role is to work jointly with Health and Social Services. Part of her role was to assess patients that were referred to the Care Home from* [the hospital] *... Families and the patient are advised that the Care Home is a "home like environment" and not a hospital with care being administered by social service carers. The health team, consisting of physiotherapists, occupational therapists and nurses input is "hosted in" ...* [the nurse co-ordinator's] *role is not a clinical one. Her role includes assessing, obtaining agreement from the social service manager that his team is able to care for the patient and setting up the initial care plan ... The medication care plan is updated by the staff nurse or herself. Social Services require a care plan has to be in place prior to admission ...*

3. '[The nurse co-ordinator] *said that she came on duty at 7.15am on 12/1* [12 January 2009] *and was advised that the GP had visited* [Mr K] *at 3.20am that day due to difficulties with his catheter. She said that his catheter was draining, albeit slowly. She said that the documentation showed that the carer had emptied the commode, and they decided they would monitor him and review him again. The Staff Nurse and* [the nurse co-ordinator] *reviewed* [Mr K's] *status. It was decided that the staff nurse would arrange for the catheter to be changed. The staff nurse administered a bladder wash out and contacted* [Mr K's] *own DN* [district nurse] *surgery to arrange for a nurse to change the catheter. The staff nurse says that she did monitor* [Mr K]. *There is no record on the contact sheet completed by the staff nurse of what was done. It was agreed that this was poor reporting.*

4. '[The nurse co-ordinator] *said that when she got back from the hospital at lunch-time, she was asked to see* [Mr K] *by a member of the social service team.* [Mr K] *was distressed and in pain. The catheter was still in situ, and there was blood clots in the catheter bag. She rang* [the GP], *and asked if they could take the catheter out to rest the bladder. She said that while she was talking to* [the GP], *she was told that the DN had arrived and was going to change the catheter.* [The nurse co-ordinator] *said that the district nurse who removed the catheter, did not recatheterise* [Mr K] *as she felt the bladder needed to rest, she advised* [the nurse co-ordinator] *of her decision, she did not leave any notes*. [The nurse co-ordinator] *said that before leaving the building, she went to see* [Mr K] *with* [the duty officer] *and at that stage he was peaceful and not in pain also one of his nieces was with him.* [The nurse co-ordinator] *discussed with* [the duty officer] *that if* [Mr K] *developed pain or did not pass urine within the two hour period to contact the GP*. [The assistant manager] *had left instructions in the Senior Message Book for the carers to check* [Mr K] *every 15 minutes and to call the GP if required.* [The duty officer]

contacted [the GP], *at 16.30* [the GP] *made arrangements for the district nurse to visit to re-catheterise. (the GP notes were used to confirm this)* [Mr K] *was attending the hospital the next day – for cystoscopy.*

5. *'*[The nurse co-ordinator] *said that at the time, neither she nor the staff nurse were trained in male catheterisation (since this event both the staff nurse and* [the nurse co-ordinator] *have been trained ... .*

6. *'Movacol* [Movicol] *is used to promote a bowel action, and is often the drug of choice. She said that in the contact sheets it says he was constipated, and the medication was commenced. It was prescribed one sachet to be taken twice a day. He started it at 20.00 hrs on 8/1, had it on 9/1. She said that he refused it in the evening, and on the 10th and 11th. He had two doses on 12th, one on 13th and 14th, the 19th and the 25th ...* [the nurse co-ordinator] *said that she would not give Movacol if someone had had their bowels open, even if it was prescribed, but you would need to monitor to check what the bowel action was like.*

7. '[The nurse co-ordinator] *said that she was of the view that* [Mr K] *did not have diarrhoea, but had constipation with overflow. The faecal liquid leakage passed per rectum is as diarrhoea. She said that in these circumstances it is appropriate to take Movacol to continue to soften the faeces and promote a bowel action.*

8. '[The nurse co-ordinator] *said that she had several phone calls from* [Mr K's niece], *who would be very tearful following her conversations with her sister*. [The nurse co-ordinator] *said that she was firm in her response to progress the conversation forward. She said she did not recall being angry with either niece. She said that at the end of the phone call she would find out further information and if this was requested, she would get back to them, she also asked them if they were happy with outcome. Two of the telephone calls are documented in the investigation notes.* [The nurse co-ordinator] *also received telephone calls from* [Mrs H] *... .'*

The unit manager

9. *'... I asked if the contact sheets are supposed to record everything that happens to a person, and he said that they are supposed to record significant things, such as medical visits, or health issues.*

10. *'I asked* [the unit manager] *if he had any records of the family being told about* [Mr K's] *situation, and he said that he talked to* [Mr K's niece], *who visited very regularly and he would have a chat with her. He said that he never felt that she was having great concerns, but these were just conversations he might have with any relative. They were just a passing conversation.*

11. *'When asked to describe the relationship with the family and the Care Home*, [the unit manager] *said that it differed from other families in that it was very time-consuming, talking to them at their visits or on the phone, on a regular basis. Much more time was spent talking to them, and staff were saying that they were forever ringing up, and this was a lot more than most other residents.'*

The deputy unit manager

12. *'... We asked her whose responsibility it was to oversee giving out drugs, she said that there is a Monitered Doseage* [sic] *System, and those are in line with the MAR* [medication administration record] *sheet, people arrive from hospital with*

two weeks worth of medication, and they are put into an ice cream box in the medication cabinet. Medication is given out by hand, and then given to the service user, usually at meal time. [The deputy unit manager] *said that the member of staff signs to say that they have given the medication to the service user. She said that it should not happen that someone can take someone else's medication.*

13. '[The deputy unit manager] *said that giving out the medication can be a long process.* [The deputy unit manager] *said that* [Mr K] *managed paracetamol broken in half, but found it difficult to swallow a whole tablet, so they would cut them in half for him.* [The deputy unit manager] *explained that sometimes people would bring their own medication in, having taken it with them to hospital. She said that staff would go through the discharge letter from the hospital, and see what medication they were currently on. She said that the hospital medication would be taken as being what they were to have, and the rest would be put in one of their cabinets which gets sent off to Boots because it is no longer needed.*

14. *'I asked* [the deputy unit manager] *whose responsibility it was to keep food and fluid charts, she said that these are only kept if people need to have their food and fluid intake monitored. She said that most food or fluid was also recorded on the contact chart. She thought that* [Mr K] *was put on a food and fluid chart because there were concerns that he was losing weight. She said that it was the care staff's responsibility to fill in the contact sheet, the fluid and food chart, and the continence chart. These are kept in folders, and go wherever the service user goes ... .*

15. *'We explained that the family was concerned that Mr K was receiving Movacol as medication for his constipation, although it also causes dehydration, and that the family say that when they questioned her about this, she said that she would not listen to their views, and he could refuse to take it if he wanted to. They also explained that as it was to prevent constipation, it was not a suitable drug for him to take when he had diarrhoea. We asked* [the deputy unit manager] *for her comments on this.* [The deputy unit manager] *said that Movacol was prescribed because people are constipated, and at one stage the family said that he had diarrhoea. But at that time,* [Mr K] *was still constipated, and liquid was by-passing the stool, and because he was not always that mobile, then he was likely to get constipated. She explained that the Movacol was prescribed twice a day, so he should have been taking it twice a day. She said that if the family were concerned that this was causing dehydration, staff would have spoken to* [the nurse co-ordinator]*, and she would have been in touch with the GP.*

16. '[The deputy unit manager] *said that fluids are always pushed, and if they drink a lot, they have to go to the toilet a lot. She had not heard that Movacol caused dehydration, and she does not recall a conversation with the family when they said that he was becoming dehydrated, and if she had had such a conversation she would have gone to* [the nurses].

17. *'We asked her how she found the family, as it seemed clear to us that they were asking a lot of questions about his medical care. She said that at the time, they were very friendly, but at times they would visit and all would be fine, then they would go home and ring about something they weren't happy with ... .*

18. *'*[The Independent Person] *asked if this was the same as with other residents, and she said she remembered having a conversation with* [Mrs H]*, who came in and asked what* [Mr K] *had had for dinner.* [The deputy unit manager] *told her that he had meatballs, and she said that he didn't like them. He had eaten them, and she asked why he had been given them.* [The deputy unit manager] *said that she told* [Mrs H] *that it was his choice to have meatballs, and you would not know that he didn't like them as he had eaten them. She said that he was always given choice.*

19. *'*[The deputy unit manager] *said that one day she was going to give* [Mr K] *his tablets in bed, and* [Mrs H] *said that she would give them to him, but* [the deputy unit manager] *said that it was her job, so insisted on giving them to him ... .*

20. *'*[The deputy unit manager] *said that they had someone who had no teeth, but could eat adequately. She said that staff would mince up his food if he had wanted it. She said that as a soft diet was on his file, the kitchen was aware that he was on soft diets, but sometimes people would not want liquidised food. She said that in the area where* [Mr K] *would be eating there would be 11 at the most, and there would be 2 staff on duty to assist clients with eating, so someone would have noticed if he was having difficulty eating his food and would have done something about it.*

21. *'We asked her about* [Mr K's] *catheter care, and she said that she has not dealt with his catheter. She is aware of what has gone on, because messages have been passed on, and with catheter, everyone has to be constantly drinking ... .'*

The first assistant unit manager

22. *'... She explained that as a duty officer role, she would oversee the care that was being provided, and through the communications book, they would see if there was any cause for concern for anyone. Through the handovers, they would follow things through.*

23. *'*[The first assistant unit manager] *said that* [Mr K] *was a lovely gentleman, and had a lovely sense of humour. He was a bit different when his family came in, in that for instance, there was a specific reason why he was on a soft food diet, and he would be offered warm milk for his cornflakes, and he was once offered bread and butter and marmalade, but he wanted toast and jam. When he was given the toast and jam, the family said that staff had not specifically catered for his needs. But* [the first assistant unit manager] *said that their job was to promote his independence, and not to take away what he wanted.*

24. *'She said that while the family were there, they used to be quite positive, and then sometimes, when they went home, they would phone up and say that they weren't happy with something. She said that staff tried to address any concerns that the family mentioned.*

25. *'I asked* [the first assistant unit manager] *about the two legs being put through one leg of his pants, and that the family had rung up about this. She said that they asked her if she was able to call the doctor as there was blood in his catheter bag. She said that if they wanted to bring him back earlier, she would call the doctor to come and look at him. Apparently they said that they did not want to bring him back early, but they told her that they were not happy about the two legs*

through one leg of his pants. [The first assistant unit manager] *said that* [Mr K] *was trying to be independent, and she told the nieces she would try to find out about it. She said that she couldn't find out anything about it, but thought that he should have been helped to dress, and she was told that he was all right when he left. I asked if* [Mr K] *was dressing himself, and she said someone should have helped him, but it looked, from the description in the day sheet, as though he had done his bottom half himself.*

26. *'*[The first assistant unit manager] *said that she did not get back to* [Mr K's niece] *about the two legs going into the one pant hole, because she couldn't find out anything. There is a catheter information leaflet which is in the care plan. I asked her about training for staff, and she said that staff are trained when they start, by other members of staff telling them what should be done.*

27. *'We asked about catheter care, and she said that it should not have been strapped to the leg while he was sleeping. At night it is attached to a night bag which is near the bed. So before getting someone out of bed, the night bag would be taken off. It looks as though no one does anything with the catheter that morning. Usually it is the night staff who would disconnect it, and it just goes straight into the leg bag. There is no record of anyone doing anything.*

28. *'I asked* [the first assistant unit manager] *about the catheter being coiled up and put on the top of* [Mr K's] *thigh, and she said that anyone with common sense shouldn't have done that, but it could have happened. Perhaps the tubing was too long, and it got kinked up ... .*

29. '[The first assistant unit manager] *said that drugs are given out as required, within the allocated amount. She said that* [Mr K] *struggled with paracetemol, and they got him soluble eventually.* [The first assistant unit manager] *said that they are taken to, the individual when they are given out. She said that they are watched while taking their medication. The domestic staff are also watching. She said that staff sign to say that they have given the individual some medication, and they make sure that this happens. She said that they are supposed to supervise that individual has actually taken the medication ... .*

30. *'We explained that the family said that when they went to visit, she was frequently eating, and asked her to tell us about this. She said that staff were there for the individuals they were to care for ...* [The first assistant unit manager] *said that she didn't have a break as such, but would sit and do her work while having her food. She said that she would do paper work whenever she got an opportunity. She said she would then do the pills, and usually between 6.30 and 7.30 was a quiet time. She said that she didn't use the staff room. She said that she did have her lunch when she was on duty, but if she was speaking to anyone, she would put her lunch to one side ... .'*

The second assistant unit manager

31. *'We asked* [the second assistant unit manager] *how patients were cared for at the Care Home, what was their routine, and she explained that independence is a great part of the Care Home's culture. She said that* [Mr K] *was being encouraged to be as independent as possible, as the aim was to get him home. She said that he would assist with his personal care, but*

there would be always someone to help if necessary.

32. *'...* [The second assistant unit manager] *said that when she arrived in on the morning of 12th* [a night carer] *said that* [Mr K] *had been passing blood through his catheter. She said that the assistant had called WestCall out, and a doctor had come. She said that the doctor did not prescribe pain relief, and she can remember saying to* [the night carer] *that if anyone came out and someone was in pain, she was within her right to ask for pain relief for the patient. Paracetomol was delivered on 11th, and* [the second assistant unit manager] *says that the day the catheter was removed,* [Mr K] *had no pain relief.* [The second assistant unit manager] *said that she asked the nurse to get him some pain relief. Apparently* [Mr K] *only said to* [the second assistant unit manager] *that he had only got discomfort. This was on the 12th.*

33. *'... She could remember that* [Mr K] *had lost his teeth, and said that his appetite became poorer as his health got worse. She said that he could be offered soup if he did not want the main meal. She said that* [Mr K] *ate what he wanted to, and said that they tried to encourage him to eat as much as possible.*

34. *'We asked about weighing* [Mr K], *and she said that people were weighed when they arrived, and then on a monthly basis, unless there were weight issues, when they would be weighed more often. She said that if they were not eating enough, they would be weighed more regularly. She said that* [Mr K] *seemed to be an unwell man right from the word go. He did not seem to want to be rehabilitated from the beginning, but seemed to try and keep a certain amount of independence, although he wouldn't want to walk from the bedroom to the lounge. She said that he needed a lot of encouragement to do those things ... .*

35. *'*[Mr K] *was prescribed Movicol, and declined to take it sometimes.* [The second assistant unit manager] *said that initially they were trying to get* [Mr K] *to take it, as he was constipated. She said that it would appear that he had it 4 times in 8 days. She said that it does not cause diarrhoea, and as it had been prescribed, it would be good for him, as it would have kept him regular.* [The second assistant unit manager] *said that when you have constipation, the fluid from the top of the constipation can seep out and flow out as diarrhoea.'*

The residential care officer

36. *'... he is the residential care officer, he runs the shift ... .*

37. *'We said to* [the residential care officer] *that the family had explained to us that* [Mr K] *went home for a visit on 11 January this year, and when he arrived there, his catheter was coiled up, and placed on the top of his thigh, so it could not drain properly. We asked* [the residential care officer] *if he could explain to us how this had happened?* [The residential care officer] *said he started working at 2.30 pm, so was not present when the incident must have happened, but he was present when the family got back with* [Mr K]. *He said that* [Mr K's niece] *came to him and told him that the catheter was coiled up and put on* [Mr K's] *thigh, he said that he went and apologised to* [Mr K and his niece], *and spoke to all the staff and reminded them that when catheters are being used, the tube has to be straight.*

38. *'*[The residential care officer] *told us that if there are no concerns about weight or eating,* [a fluid and food intake chart] *is not filled in. He said that people are weighed when they arrive, and then once a month, unless there are problems with their weight, when they are weighed every week.*

39. *'I asked* [the residential care officer] *how they could see whether someone needed weighing more regularly, and he said that if they could see they were not eating or drinking, they would then start weighing them more regularly.*

40. *'*[The Independent Person] *asked how you would know, if they weren't recording on a food intake and fluid sheet, that there was an issue.* [The residential care officer] *said that food and fluid intake would be recorded on the daily contact sheet. It is the responsibility of the care assistants to complete the daily contact sheets. I asked him what sort of training was given with regard to filling in daily contact sheets, and he said that an induction was provided initially, and care assistants were told that every time someone was checked on, a note should be made. He said that if people were in the lounge, nothing would be noted if they were just sitting there, unless something unusual happened ...*

41. *'We asked* [the residential care officer] *to talk us through the procedure he followed when giving out drugs – is there any way of ensuring that patients are given their own drugs, and cannot possibly reach out and get drugs intended for someone else? He said that staff giving out the drugs hand them to individuals, and then watch to see that they take them before signing the drug sheet ... .*

42. *'*[The Independent Person] *asked who did the record keeping, and he said that the contact sheets would be filled in by the care assistant. He said that they did not keep checks on how the contact sheets were being completed.* [The Independent Person] *said that during this time* [Mr K] *was having problems with his catheter, was shaking, in pain, up all night, but nothing in record ... .*

43. *'*[The Independent Person] *asked what was the process for handing out drugs, and he said that if someone was on medication, they would give them the tablet, see them take it, and sign to say you had seen them take it. He said he would give it to them, and see that it had been taken. He said that it was not possible for someone to take the medication for someone else. Everyone's medication is in an ice cream box on the trolley. They have never had medication in their rooms, unless they are in assessed for self-medicating.'*

The GP

44. *'... On 12 January 2009* [the GP] *said that he was rung, and asked if* a [district nurse] *could come, as it was their responsibility, and finally one arrived, and took* [the catheter] *out. There was some blood, and she decided not to put another one in, and to do trial without catheter (TWC).* [The GP] *said that this was not what he expected. Apparently the* [district nurse] *also told staff to push the fluids.*

45. *'*[The GP] *said that he got a call asking if* [Mr K] *could have pain relief.* [The GP] *asked if the catheter was passing OK, and they said that he had no catheter.* [The GP] asked if he was passing urine, *and they said no, so* [the GP] *thought no wonder he was in pain, as his bladder was obviously filling up with the fluids he was*

drinking, but they were not passing out. He rang a [district nurse], *who went over and catheterised him.* [The GP] *said that this was not a question about pain relief, but about why it had happened. The answer was that he had an acute urinary obstruction, that he should not have had.*

46. *'I asked* [the GP] *about the pain of re-catheterising him, which was what the* [district nurse] *had given as her reason for not doing so, and he said that anaesthetic jelly should have been used, and it would not have caused him much pain. What you can't do is nothing. We asked what if it had been to allow the bladder to rest, and* [the GP] *said that you can only do that formally. You can do a TWC, to see if he could have managed without catheter, but you must make sure that everyone knows precisely what is going on. He said that no one thought to ask why he was getting so uncomfortable ... .*

47. *'I asked whether* [the GP] *thought that* [Mr K] *was rapidly losing weight, and he said that he relied on the staff at the Care Home, and when staff were worried about him because he was losing a bit of weight, and wasn't eating or drinking much he thought this was a good form of management* [sic].'

Annex G

Clinical advice

The Nurse Adviser

Nutrition and hydration

What should have happened

1. The NICE Guidance (Annex B, paragraph 9) covers the care of patients with malnutrition or at risk of malnutrition, whether they are in hospital or at home. The accompanying quick reference guide states that screening for malnutrition, or risk of malnutrition, should be undertaken on all patients in care homes on admission and that it should be repeated when there is clinical concern. Clinical concern would include factors such as loss of appetite, apathy, weight loss and fragile skin.

2. Standard 8 of the National Minimum Standards (Annex B, paragraph 8) states: '*nutritional screening is undertaken on admission and subsequently on a periodic basis, a record maintained of nutrition including weight gain or loss and appropriate action taken*'.

3. Hydration is a basic human need and a fundamental aspect of care. There is no agreed recommended daily intake for water; a conservative estimate for older adults is that a daily intake of fluid should not be less than 1.6 litres per day.[20] Individuals at risk of dehydration, or those that require assistance with drinking, should be identified and their fluid intake should be monitored and recorded. The National Minimum Standards state that hot and cold drinks should be available at all times.

What did happen

4. An assessment undertaken by the intermediate care co-ordinating nurse on 22 December 2008 identified that Mr K was taking a soft diet and normal fluids. On the client's 'special request form' it is noted that Mr K required a purée diet, that he disliked soft food and pork, and that pork did not agree with him.

5. A care plan was drawn up on 22 December 2008 in response to the assessment. This identified the fact that Mr K was on a soft diet and that the kitchen was aware. Significant factors such as his dislike of pork were not recorded. Further, there was no indication of planned actions to address problems with ill-fitting dentures (the main reason for the requirement for a soft diet).

6. Mr K was not assessed for his risk of malnutrition at any stage during his stay on the unit. There was clear evidence that he did eat and drink during this time but it is not possible to comment on whether his food intake was sufficient to meet his nutritional needs because accurate food monitoring was not consistently maintained. However, without an initial nutritional risk assessment, it is not possible to identify if this level of monitoring was required.

7. Mr K was given an Ensure (nutritional sip feed) drink on 14 January 2009. There is no indication that he was given Ensure at any other time or that his family requested this. Most importantly, due to the fact that a nutritional risk assessment had not been undertaken, it is not clear if nutritional supplements were required. Food charts were started on 21 January, but

---

20 *Water for Health: Hydration Best Practice Toolkit for Hospitals and Healthcare*, Royal College of Nursing and National Patient Safety Agency, August 2007.

the rationale for starting the charts was not documented. There is no indication in the daily contact sheets to suggest that Mr K's pattern of eating or dietary intake had deteriorated significantly in the days leading up to 21 January. It is apparent that he continued to eat some of his meals between 21 and 29 January. However, his food intake was variable at this time. There were some occasions when he only ate a quarter of his meal. It would have been reasonable for staff to have asked the GP for a prescription of nutritional supplements to have been considered. However, we do not know whether he would have taken these even if prescribed.

8. A weight care plan was generated on 23 December 2008, indicating that Mr K needed to be weighed on admission and that his weight should be recorded. He was initially weighed on 24 December and his weight was recorded as nine stone, six pounds. Four days later his weight had increased to nine stone, eleven pounds. This is a considerable weight gain over a four-day period, and should have prompted care staff to escalate this to the unit manager or a registered nurse. Mr K had a known history of heart disease, and fluid retention (a feature of heart failure) could have resulted in an increase in weight. However, there is no indication that, on that day, Mr K was presenting with other significant changes indicative of increasing heart failure, for example increased breathlessness and ankle swelling. I am concerned that the scales may not have been correctly calibrated and/or there was an error in their use. Clearly, the weight gain should have been reported. On 26 January 2009 Mr K's weight was recorded as nine stone, five pounds and eight ounces. According to this measurement it would appear that he had lost five pounds since 28 December 2008. However, when compared with the recorded weight on 24 December his weight loss would have only been eight ounces. There is no way of knowing which of the weights was accurate.

9. In response to the identified apparent weight loss on 26 January 2009 the care plan was amended. The plan was to record weekly weights. Other actions, including the fact that the family had brought in food in a cool box on that day and that staff needed to offer Mr K this food as an alternative, were not identified on the care plan. Mr K was seen by a dentist on 27 January; the rationale for this is not recorded but it would appear that it was in response to the fact that his dentures were lost on 16 January.

10. With regard to fluid intake, an assessment undertaken by the intermediate care co-ordinating nurse on 22 December 2008 noted that Mr K was taking a soft diet and normal fluids and that he had an indwelling urinary catheter in place. (An indwelling catheter is a catheter that is inserted into the bladder and is allowed to remain there.) It is very important to ensure the adequacy of fluid intake when patients have a urinary catheter in place. It is, however, important to note that the presence of a long-term urinary catheter would not in itself mean that accurate fluid balance recording would be required. Care staff should, nevertheless, be alert to possible indicators of potential dehydration, for example, concentrated (dark) urine and poor oral intake. It is in response to these indicators that accurate fluid input and output monitoring should start. One of the identified actions in the catheter care plan was to give frequent fluids, specifically one large glass of fluid every hour. It is evident that fluids were regularly offered to Mr K

but even from an early stage he was not meeting the fluid intake requirement set out on his care plan. This should have been drawn to the attention of the registered nurse, in order for the care plan to have been reviewed in discussion with the GP.

The impact on Mr K

11. The lack of screening for the risk of malnutrition was a failing in the care of Mr K. Additional shortcomings include a lack of person-centred care planning and failure to escalate concerns in response to Mr K's apparent weight gain on 28 December 2008. The impact of these failings is not possible to quantify. Clearly, they caused distress to Mr K's family. However, there is no indication that they contributed to the deterioration in his condition. I note that, at post mortem, the pathologist found that Mr K was well nourished.

12. With regard to fluid intake, in the absence of any objective, factual data, I am not able to identify the impact of the gap between what should have happened and what did happen. It is not possible to accurately identify whether a person is dehydrated or not without a review of blood biochemistry results.

Is there any indication that Mr K was given too much Movicol?

13. In terms of the administration of Movicol, it is clear that this was prescribed in response to concerns that Mr K was constipated on 8 January 2009. Movicol sachets contain macrogol, which is a type of medicine known as an osmotic laxative. The contents of the sachet are mixed with water to make a drink. It relieves constipation because it causes the water it is dissolved in to be retained in the bowel instead of being absorbed in the body, and this softens the stool. Each sachet of Movicol also contains sodium bicarbonate, sodium chloride and potassium chloride (electrolytes).[21] These are included to help ensure that the laxative works without causing the body to gain or lose significant amounts of sodium, potassium or water. Known side effects are abdominal distension, pain and nausea. The dose for the treatment of constipation is usually one to three sachets a day, depending on the severity of the constipation (*British National Formulary*[22] March 2006: page 62). Mr K was prescribed one sachet of Movicol twice a day, which was within the prescribing guidelines for the medication.

14. Chronic constipation can increase the risk of faecal impaction, where dried, hard stools collect in the rectum and anus. Faecal impaction worsens constipation because it makes it harder for stools to pass out of the anus as the path is obstructed. 'Overflow' can occur when watery stools leak around the obstruction, appearing like diarrhoea and causing soiling. There is no evidence of any action taken to identify whether Mr K actually had faecal impaction; for example, a rectal examination. This should be undertaken by a doctor, or a nurse who is competent to undertake the examination. The Royal College of Nursing has produced guidance for nurses on bowel care, including rectal examinations.

---

21 The level of electrolytes in the body, and their balance, affects the amount of water in the body, the acidity of the blood, and other important processes.

22 A publication of the British Medical Association and the Royal Pharmaceutical Society that provides healthcare professionals with authoritative information on the use of medicines.

15. The failings in this aspect of medicine administration are the fact that a stool chart was not maintained to monitor the impact of the administration of the Movicol and the possible reason for faecal soiling and incontinence was not explained to Mr K and his family. Further, when his niece raised concerns about the possibility that the administration of Movicol was causing dehydration, these should have been escalated to a senior member of staff or a registered nurse.

16. There is no evidence to suggest that Movicol causes dehydration.

Catheter care

What should have happened

17. Urinary catheters are invasive devices used to drain urine from the bladder. Using any form of catheter has a number of associated risks. Common risks include bypassing (urine passed outside catheter), discomfort, blockage, infection and bleeding. The Royal College of Nursing has published guidance for nurses on catheter care (Annex B, paragraph 10). A trial without catheter should be undertaken in controlled circumstances and not on an ad hoc basis. When a trial without a catheter fails, the bladder should be drained as soon as possible to prevent anxiety, pain and bladder damage associated with acute retention (inability to pass urine).

18. The NMC Code (Annex B, paragraph 12) states that nurses must keep clear and accurate records of assessments and treatments. I would, therefore, expect to see evidence of a care plan with identified actions for the care and management of Mr K's catheter.

19. In order to promote the free drainage of urine, it is established good practice to ensure that the urinary catheter and drainage bags are below the level of the bladder, and leg bags should be securely fastened to minimise the risk of the catheter being pulled, which would result in unnecessary trauma.

20. In regard to clinical competence, the NMC Code says that nurses must have the knowledge and skills for safe and effective practice and must recognise and work within the limits of their competence. Not all registered nurses have the necessary training, knowledge and skills to undertake male catheterisation and as a result they must call upon other professional colleagues, for example, district nurses, who have the necessary competencies to undertake the procedure.

What did happen

21. There is clear evidence of assessment, care planning, evaluation and updating of Mr K's catheter care plan; for example, the need for the 'night bag' to be single-use only. One of the identified actions on the care plan is to give frequent fluids, specifically one large glass of fluid every hour. There are no fluid charts, therefore it is not possible to identify if this planned action was followed. The importance of ensuring an adequate fluid intake in patients with a urinary catheter cannot be underestimated. The amount of fluid intake increases the urine output from the kidneys, thus irrigating the bladder and washing away any particles down the catheter that may have formed in the bladder.

22. According to Mrs H there were two occasions, 1 and 11 January 2009, when Mr K arrived home and his catheter had not been correctly positioned, resulting in the obstruction of the flow of urine. The incorrect position of the catheter and leg bag would be failings, however,

in the absence of any objective, factual data it is not possible to provide a fully informed view on this issue and it would be inappropriate for me to speculate in regard to this.

23. On 12 January 2009 at 1.15am Mr K rang his bell; the carer attended and noted that the catheter was blocked and the top tube was filled with blood. The carer appropriately called WestCall at 1.27am and the doctor attended at 3.31am. This was a reasonable response time. He changed the catheter bag but did not prescribe any analgesia. At 9am a district nurse attended, removed the catheter and replaced it. At 10.47am a staff nurse contacted the doctor, informing him that the catheter was draining blood and was blocked. The staff nurse explained that she was not trained to undertake male catheterisation. It was entirely appropriate for her not to attempt to change the catheter and she was working within the NMC Code. The doctor did not attend Mr K but asked for the district nursing team to change the catheter. A district nurse attended, removed the catheter and according to an entry in the contact sheet did not reinsert it as she did not want to cause Mr K any additional trauma. The doctor was not informed by either the Care Home's staff or the district nurse of this change of plan. A trial without catheter should occur under controlled circumstances, with staff available to reinsert it quickly if the patient becomes distressed. It is evident that there was poor communication between the district nurse, care home staff and the doctor. The district nurse should not have undertaken the trial without catheter on this ad hoc basis.

24. Mr K was still not passing urine and was still in pain. At 4.30pm the doctor was informed of the situation. The doctor organised for another district nurse to attend. Mr K was recatheterised at 4.50pm.

The impact on Mr K

25. The rationale for not reinserting a catheter when the second district nurse attended was reasonable. However, given the fact that Mr K had a previous history of urinary retention, he was likely to experience similar problems. The lack of appropriate communication of the decision made by the district nurse to the doctor was a serious failing. The delay in the reinsertion of the catheter led to Mr K suffering unnecessary pain and distress.

26. I note that NHS staff have now received refresher training in catheter care, including male catheterisation, and that a new catheter care folder has been developed by the Care Home as recommended in the joint investigation report. It also appears that an overview of catheter care is included in the induction of new staff at the Care Home. There is no indication, however, of evidence of ongoing training or of how competencies are monitored and maintained.

Administration of medication

What should have happened

27. It does not appear that registered nurses were involved, on a daily basis, in the administration of Mr K's medication.

28. Standard 9 of the National Minimum Standards (Annex B, paragraph 8) says that records are kept of all medicines administered and should be given by designated and appropriately trained staff.

What happened

29. Concerning the complaints that Mr K was not supervised when taking his medication and that on one occasion he took another

patient's medication, in the absence of any objective, factual data it would not be possible to provide an informed opinion and it would be inappropriate to speculate in regard to these issues. The medicine administration records do record when medication was administered and the occasions when Mr K declined to take medicines that were offered to him. The Independent Investigation interviews record the explanation provided by staff on the practices that were usually followed. There is no way of telling if these actions were actually followed when Mr K's medications were administered. It would not be possible to establish if an inhaler, previously used by another patient, had been given to Mr K to use.

Record keeping

What should have happened

30. The NMC Code (Annex B, paragraph 12) states that nurses must keep clear and accurate records of discussions, assessments, treatment and medicines given and their effectiveness.

31. Standard 3 of the National Minimum Standards (Annex B, paragraph 8) says that each service user should have a plan of care for daily living and Standards 7 and 37 say that records should be maintained, accurate and up to date.

What did happen

32. The poor standard of record keeping has been clearly highlighted in the joint investigation report. This said:

> *'We were concerned by the quality of the record keeping at* [the Care Home]. *The report has highlighted how, on several occasions, the contact sheets did not record important information, and sometimes recorded information incorrectly. The quality of recording has already been noted in the report prepared* [by the community consultant in elderly care as part of the review following the safeguarding investigation] *and I completely endorse the recommendation she made with regard to record keeping and the training of staff in the best way to keep records.'*

33. I have reviewed the care home records and agree with the findings of the report. I have no additional comments to make.

The impact on Mr K

34. The lack of assessment and poor record keeping is of particular concern because it provides little evidence of comprehensive assessment, adequate care planning, and monitoring with regard to specific aspects of care; for example, bowel action and nutritional risk, or of appropriate evaluation of care delivery. Recommendations made in the joint investigation report, flowing from the identified failings, are sound. [The Care Home's] *Care Home Action Plan 2009* reasonably addresses the recommendations made. However, it is unclear if these have all been fully implemented and there is no indication of actions taken to measure and monitor the standard of record keeping in the future.

Communication with Mr K's family

What should have happened

35. There are no specific guidelines on communication with family members. However, it is established good practice that in any care environment (subject to the patient's consent) family members are involved in care planning. This is particularly important in rehabilitation settings where

rehabilitation goals are being set and discharge home is often dependent on the care contribution of the family as well as professional care givers. Keeping family members informed of changes in a patient's condition is also established good practice.

What did happen

36. There is evidence of a lack of involvement and engagement with Mr K's family. They were not involved in care planning and there is evidence that when concerns were raised, for example about the administration of Movicol, these were not appropriately escalated. There was inconsistent information provided to the family when they asked if Mr K could be registered with his own GP.

37. It is difficult, in the absence of objective, factual data, to establish whether or not the concerns raised by the family were always acted upon.

The impact on Mr K

38. Poor communication is an underpinning theme in this complaint and I am not sufficiently reassured that the Care Home have taken the necessary actions to address this issue. A bespoke training package has apparently been delivered, but there is no indication of how they propose to monitor progress in communication skills as a result of the training received. It is not possible to identify the impact of the failings in communication with Mr K's family. It is clear from the complaint correspondence that the complainant found the lack of communication extremely distressing.

The joint investigation

39. The independent review of this case was appropriate and provided a well-balanced report on the care provided. I am conscious that I have added very little in my own review of the case and that this may be disappointing to the complainant.

40. It is clear to me that the underpinning themes in this complaint are poor communication and documentation.

41. Recommendations made in the joint investigation report are entirely appropriate. I am not, however, sufficiently reassured that these have been fully implemented or that an update on progress to date has been shared with the complainant.

Parliamentary and Health Service Ombudsman

Millbank Tower
Millbank
London SW1P 4QP

Tel: 0345 015 4033

Fax: 0300 061 4000

Email: phso.enquiries@ombudsman.org.uk

www.ombudsman.org.uk

Follow us on

If you would like this report in a different format, such as DAISY or large print, please contact us.

TSO
information & publishing solutions

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, telephone, fax and email
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/general enquiries: 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
Email: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Houses of Parliament Shop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/general enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: shop@parliament.uk
Internet: http://www.shop.parliament.uk

TSO@Blackwell and other accredited agents

ISBN 978-0-10-298708-9
9 780102 987089