29 January 2014

Complaint reference:
13 007 261

Complaint against:
Portsmouth City Council

Local Government OMBUDSMAN

The Ombudsman's final decision

Summary: The Nursing Home, acting for the Council was at fault for not involving Ms R in her mother's end of life care planning. This caused Ms R distress. To put the matter right, the Council will apologise for the Nursing Home's failing. The Nursing Home was also at fault for not referring Mrs S for a swallowing assessment. But I do not conclude this caused her any injustice.

The complaint

1. Ms R complains about her late mother's end of life care in a nursing home. (the Nursing Home') Portsmouth City Council ('the Council') arranged and funded Mrs S's care. Ms R complains:

a) The Do Not Attempt Resuscitation ('DNAR') form was not in the Nursing Home's care notes

b) A night nurse had a poor attitude

c) The handover was inadequate on 21 April

d) Mrs S had a chest infection and should have been nursed upright.

e) The Nursing Home used plastic pillows and a heavy duvet. These were inappropriate

f) There was no fan to help cool Mrs S. When asked, the Matron said electric fans should not be used

g) There was no oxygen available

h) There was no assessment of Mrs S's swallow reflex (nursing staff did not make a referral to the Speech and Language Therapist for this)

i) A nurse used the wrong needle to give a controlled drug on 22 April

j) The district nurse decided not to set up a syringe driver, although the out of hours GP had prescribed this.

k) There were no/inadequate measures to prevent cross-infection between staff with colds and vulnerable residents.

What I investigated

2. I have investigated complaints (a) to (i). My reasons for not investigating complaints (j) and (k) are at the end of this statement.

The Ombudsman's role and powers

3. The Ombudsman investigates complaints of fault where someone says it has caused them (or a person they act for) injustice. If the Ombudsman finds fault but no injustice, she will not ask the council to provide a remedy. If she finds both fault and injustice, she may ask for a remedy ***[Local Government Act 1974, sections 26(1) and 26A(1)]***

4. The Ombudsman has the power to start or discontinue an investigation into a complaint within her jurisdiction. ***[Local Government Act 1974, section 24A(6)]***

5. If, after completing an investigation, the Ombudsman decides she is satisfied with action which the council has taken or proposes to take and it is not appropriate to prepare a report, she may issue a statement of reasons for the decision. ***[Local Government Act 1974, section 30(1)B]***

6. In investigating complaints where an authority exercises a role entirely or partly by an arrangement with another person (or organisation), action taken by or for the other person in carrying out the arrangement is action by the authority. ***[S25(7) Local Government Act 1974]***

How I considered this complaint

7. I discussed the complaint with Ms R. I considered:

   - Ms R's complaint to the Ombudsman and supporting documents
   - Ms R's complaint to the Nursing Home and its responses
   - The Council's response to my enquiries
   - The Nursing Home's response to my enquiries
   - Some of Mrs S's records from the Nursing Home.

8. The Nursing Home, Council and Ms R have all seen and had an opportunity to comment on a draft of this statement.

What I found

What should have happened

9. Councils have a duty to arrange residential care for people over 18 where three conditions are met:

   - A person must need care and attention;
   - The need for care and attention must be because of age, disability, or illness;
   - The care and attention must not be available otherwise than by providing accommodation with care. ***[S21 National Assistance Act 1948]***

10. Councils may arrange residential care by contracting with a third party. ***[S26 National Assistance Act 1948]***

11. A case in the High Court said that a council was under a continuing duty to ensure that a person's assessed needs were being met when it arranged residential care with another care provider. ***[R v Service Houses and London Borough of Wandsworth ex p Goldsmith and Chatting [2000] 3 CCLR 325]***

12. The Ombudsman's view is that in arranging to place someone in residential care under the National Assistance Act 1948, a council's duty to meet eligible needs does not finish once the placement is made. Councils remain under a continuing

duty to ensure that any arrangements made under the1948 Act continue to be sufficient to meet the needs of the resident. This requires an analysis of the arrangements in place at the care home.

13. The Care Quality Commission ('CQC') is the independent registration body and regulator of health and adult social care services in England. CQC issued guidance in March 2010, *Essential Standards of Quality and Safety,* to help registered care providers comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 ('the 2010 Regulations'). When investigating complaints about standards of care in a residential or nursing home placement which a council has arranged and funded, the Ombudsman considers the 2010 Regulations and whether the Essential Standards set out in CQC guidance have been met. If they have not, she considers whether any identified faults have resulted in injustice to the person affected.

14. The 2010 Regulations relevant to this complaint are:

- *Regulation 9(1)*: Care providers must ensure service users are protected against the risk of receiving unsafe care or treatment by assessing needs and planning care to meet individual needs and ensure their welfare and safety.
- *Regulation 16:* Care providers must ensure equipment is available in sufficient quantities to ensure the safety of people and meet their assessed needs.
- *Regulation 17*: Care providers should as far as possible make arrangements to protect the dignity, privacy and independence of service users and to enable them to participate in making decisions about their care. Care providers should provide service users (or those acting on their behalf) with appropriate information and support in relation to their care and treatment. This is so service users are respected and involved with their care. And, where appropriate and reasonably practicable, accommodating views on what is important to service users and their representatives about care.
- *Regulation 24:* Care providers must make suitable arrangements to protect the health, welfare and safety of service users where responsibility for care and treatment is shared with or transferred to others by:

a) So far as reasonably practicable, working together to ensure appropriate care planning.

b) Sharing appropriate information about (i) admission, discharge and transfer and (ii) the co-ordination of emergency procedures and

c) Supporting service users or persons acting on their behalf, to obtain appropriate healthcare.

15. The National Institute of Health and Care Excellence (www.nice.org.uk) is empowered to issue integrated quality standards for health and social care. In 2011, NICE issued *Quality Standard 13: End of Life Care for Adults*. This recommends:

- People and their families should be offered information in an accessible and sensitive way, when that information is requested or is useful to make a decision or choice
- People should have a full assessment in response to their changing needs and preferences with a chance to discuss and review a personalised care plan. The assessment should include psychological support, control of symptoms, social and spiritual support and communication

- People should have care which is co-ordinated across all settings day and night and delivered by practitioners who are aware of the person's medical condition, care plan and preferences.
- People in their last days of life should be identified quickly and their care should include rapid access to equipment and administration of medication.

16. The Nursing Home's end of life policy says a member of senior care staff with training in end of life care will:

- Put in place a programme of end of life care when a person is identified as needing this
- Make the person's family aware of the likely progress and involve them in planning
- Discuss the person's and their family's wishes and put these in a plan of care
- Enable the final days to be in familiar surroundings
- Make the person as comfortable as possible
- Allow family to stay as long as they wish
- Ensure care staff are available to stay with the person if they wish
- Continually review the care plan to ensure the person has control where possible

What happened

17. The key events are from the Nursing Home's records unless otherwise stated.

18. The Council arranged and funded residential care for Mrs S under responsibilities in the National Assistant Act 1948 (see paragraph 7).

19. Mrs S lived in the Nursing Home from 2011 until she died in April 2013. She was very frail and had long-term health problems. Around 10 April, Mrs S developed a cold. This turned into a chest infection and she became very poorly quickly, was wheezy and struggling for breath. Her GP visited on 11 April and prescribed antibiotics. The GP signed a 'do not attempt cardio-pulmonary resuscitation' form on 11 April. Ms R told me this form was not in place earlier despite her having discussed it with the GP in July 2012.

20. On 12 April the matron drew up an end of life care plan for Mrs S. This said Mrs S had impaired health and coping including poor swallowing and appetite. There was a risk of constipation and skin break down. There was a risk of fatigue and disturbed sleep. The aim of the care plan was to control symptoms, maintain quality of life and manage pain.

21. The agreed nursing action was:

- Arrange GP visits as needed
- Reassess the care plan, care needs and medication
- Involve Mrs S's daughter in decision-making
- Observe half hourly
- Reassess the route of medication and arrange a GP visit if necessary
- Ensure there was a calm and peaceful environment.

22. The Nursing Home kept daily nursing and care notes for Mrs S. These record a summary of care and nursing interventions. A summary of relevant entries is below:

- On 15 April, Mrs S's chest seemed clearer. The following day she was having difficulty swallowing and didn't want to open her mouth for food or medication. A note of a discussion with Ms R said she would like her mother to be nursed in bed all the time, to change her position as necessary and not to force her to eat or drink or disturb her giving prescribed medication. Ms R said she wanted her mother to be comfortable and safe and to have mouth care as needed.
- On 21 April, it was noted Mrs S's breathing was laboured and she couldn't swallow. She appeared in distress. The GP visited and suggested a syringe driver (a small portable pump giving continuous pain relief.) Ms R agreed with this. The GP gave a dose of morphine at 9pm and wrote up a prescription for pain relief to be given through a syringe driver. The nurse on duty called the district nurses to set up the syringe driver. The district nurse arrived around 10 pm. She went away again as she had no equipment and returned just after midnight. The district nurse wrote in the notes that the syringe driver was not appropriate as Mrs S was comfortable but that staff should call back if things changed.
- On 22 April, the GP visited again and wrote up a prescription for morphine 2.5mg 'as and when required every six hours'. The nurse on duty gave an injection of morphine at 1.25pm. Mrs S died at 2.30 pm. Ms R was there.

23. Ms R complained to the Nursing Home. Senior staff met with her. After the meeting, a director of the Nursing Home responded to her complaints saying:

- It had passed her complaint on to the Council as a potential safeguarding concern
- The GP did not give the Nursing Home the 'do not attempt resuscitation' form the GP completed in July 2012
- The nurse in charge told the district nurse Mrs S had been on antibiotics for a chest infection
- There are three daily handovers. The matron had put in place a new system with written notes supplementing what staff said during the handover
- The Nursing Home could not store oxygen unless it had been prescribed by a doctor.

24. Ms R contacted the Council about her complaint. The Council's safeguarding team considered the matters raised under safeguarding procedures and decided not to do a safeguarding investigation. The Council told Ms R to contact the Ombudsman when she had used all stages of the Nursing Home's complaints procedure.

Comments from Ms R

25. Ms R told me she did not think there was an end of life care plan for Mrs S. If there was, neither she nor Mrs S had been involved in drawing it up.

26. Ms R told me one day she had to ask for a different duvet and pillow as the ones in use were plastic and too heavy and her mother was sweating.

27. Ms R told me the GP had signed a DNAR form in July 2012. There was no copy on her mother's care records so she had to sign a letter confirming her wishes in the last few days of Mrs S's life.

28. Ms R told me she was distressed that she had to ask staff to call out the GP on the morning of 22 April.

29. Ms R told me her mother flinched when the nurse on duty (Nurse A) gave the morphine injection on 22 April. Ms R is a nurse and she told me the nurse on duty used the wrong needle and injected at a 90 degree angle rather than a 45 degree. The plunger was not withdrawn slightly as it should have been to ensure the needle had not entered a blood vessel. The nurse on duty wrote a statement saying she gave the injection 'as instructed by the GP'

30. Ms R told me the nurse on duty (Nurse B) who attended when Mrs S's GP visited on 21 April had a poor attitude, had headphones on and only spoke to the doctor. Nurse B wrote a statement saying she was sorry for having headphones round her neck. She said she had forgotten they were there. The nurse said the district nurse decided the syringe driver was not necessary as Mrs S was settled.

31. Mrs R also told me the handover to day staff on 22 April was not adequate because the matron did not know about the location of the syringe driver drugs.

Comments from the Nursing Home

32. Responding to my enquiries, the Nursing Home said:

- The handover on 22 April was adequate. Ms R spoke to the matron who was not aware of the syringe driver drugs because she had a meeting at the start of her shift, but senior day staff on duty knew and there were written records in place
- Mrs S had a chest infection and was nursed on alternate sides, inclined to avoid choking on secretions
- One of the domestic staff gave Mrs S different bedding. The matron opened the window to Mrs S's bedroom and suggested to wait and if necessary, a fan could be used. But a fan was not ideal because it caused particles to move and Mrs S had a chest infection
- They only used oxygen where prescribed by a doctor
- There was no referral to the speech and language therapist because Mrs S had gum infections. It was a chewing not a swallowing problem
- The Nursing Home ran out of the correct (blue) needle and so the nurse used a green needle. She is confident she used the correct injection technique.

Was there fault and if so, did this cause injustice?

33. The Council assessed Mrs S and concluded she needed residential care in a nursing home. It contracted with the Nursing Home to deliver Mrs S's care. For the purposes of my investigation, the Nursing Home acted for the Council. So any findings of fault in Mrs S's care are faults by the Council.

General comments on consultation about Mrs S's end of life care

34. The Matron drew up an end of life care plan for Mrs S's care. There is no evidence Ms R or Mrs S were involved with this and Ms R did not know there was an end of life care plan for her mother despite being heavily involved with Mrs S's care. This is fault because it is not in line with:

- Regulation 17
- NICE guidance on end of life care
- The Nursing Home's own end of life care policy

35. The failure to involve Ms R in her mother's end of life care plan before implementing it caused her distress and uncertainty because she could not be reassured her mother's discomfort during the final days would be minimised. Even at the point she complained to the Ombudsman, Ms R believed there was no end of life care plan for her mother.

a) The DNAR form was not in the Nursing Home's care notes

36. There was no DNAR form before 21 April. Ms R discussed this with the GP months earlier and made her wishes known. The GP did not pass this information on to the Nursing Home. But this was not the Nursing Home's fault. It was the GP's responsibility to liaise with the Nursing Home and to inform staff about Ms R's wishes. It was distressing for Ms R to have to discuss this again. But I do not consider the Nursing Home to be at fault for the GP's omission.

b) A night nurse had a poor attitude

37. The nurse wore earphones around her neck but she was not listening to music on duty. I consider this is insignificant fault. The nurse not speaking to Mrs S and Ms R during the GP consultation is insignificant fault and did not cause any injustice because the focus of this meeting was between the GP and Mrs S.

c) The handover was inadequate on 21 April

38. I am satisfied with the Nursing Home's explanation that the relevant day staff were aware of the location of the syringe driver drugs. There is no regulatory requirement for the Matron to be present at the handover. There is no fault.

d) Mrs S had a chest infection and should have been nursed upright.

39. The Nursing Home says Mrs S was nursed on alternate sides and inclined. The records are silent on this point. There is also no record that Mrs S's GP advised she should be nursed upright. I accept the Nursing Home's submission that Mrs S was nursed inclined on alternate sides. So there is no fault.

e) The Nursing Home used plastic pillows and a heavy duvet. These were inappropriate

40. Ms R asked a member of staff for lighter bedding for Mrs S and this was provided quickly. I am satisfied with the response to Ms R's request and there is no fault.

f) There was no fan to help cool Mrs S. When asked, the Matron said electric fans should not be used

41. The Matron opened a window in Mrs S's bedroom to cool her down. She also explained why an electric fan might not be the best way to cool Mrs S. I am satisfied with the Matron's response and there is no fault.

g) There was no oxygen available

42. Regulation 9 of the 2010 required the Nursing Home to deliver an individual plan of care for Mrs S and Regulation 24 required it to support Mrs S to access healthcare. Oxygen is only available out of a hospital setting where a doctor has prescribed it. Mrs S's GP did not prescribe oxygen so there was no requirement for the Nursing Home to provide this and it was not on her care plan. There is no fault.

h) There was no assessment of Mrs S's swallow reflex (nursing staff did not make a referral to the Speech and Language Therapist for this)

43. The nursing notes record Mrs S was having problems with swallowing on more than one occasion. This information contradicts the Nursing Home's response to my enquiries which said Mrs S had a *chewing* problem, not a swallowing problem.

44. There is no record of staff discussing Mrs S's swallowing difficulties with the GP. I consider the Nursing Home, acting for the Council is at fault. This is because senior nursing staff did not act on Mrs S's observed and recorded swallowing concerns by make a referral to a speech and language therapist or advising the GP.

45. I cannot say whether a SALT assessment would have made any difference to Mrs S's comfort as she often refused to open her mouth in the last few days. So it is possible that Mrs S might not have been able to co-operate with the assessment or that staff may not have been able to implement any advice from the SALT.

i) A nurse used the wrong needle to give a controlled drug on 22 April and her technique was poor

46. I have interviewed Ms R about her recollection of what happened. Ms R says her mother flinched when the nurse gave the injection. I have decided there is insignificant injustice to Mrs S even if I were to find fault in the way the nurse gave the injection. So I have discontinued my investigation of this complaint.

Agreed action

47. I have not upheld complaints (a) to (g) so make no recommendations. I have stopped investigating complaint (i) because there is no significant injustice.

48. I consider the Nursing Home, acting for the Council was at fault for not referring Mrs S for a swallowing assessment (complaint (h)). But I do not conclude on a balance of probability that this caused her injustice. So I make no recommendation.

49. The Nursing Home should have involved Mrs S and Ms R in Mrs S's end of life care planning and the failure to do this caused Ms R distress. The Council commissioned and funded Mrs S's placement and so for my investigation, this means the Council is at fault. To put the matter right, I recommend and the Council agrees to apologise for this failing.

Final decision

50. The Nursing Home, acting for the Council was at fault for not involving Ms R in her mother's end of life care planning. This caused Ms R distress. To put the matter right, the Council will apologise for the Nursing Home's failing. I am satisfied this puts the matter right so I have completed my investigation.

Parts of the complaint I did not investigate

51. I have not investigated complaint (k) because there is no evidence Mrs S suffered injustice.

52. I have not investigated complaint (j) because it is a complaint about an NHS service and is therefore for the Health Service Ombudsman. During my investigation, the local NHS Trust employing the district nurse provided a response to this complaint. Ms R is satisfied with that response and does not wish to complaint to the Health Service Ombudsman.

Investigator's decision on behalf of the Ombudsman