A Report by the Ombudsman

in relation to a complaint about the care and treatment of a patient at St Mary's Care Centre, Mullingar, Co. Westmeath

An investigation by the Ombudsman under

Section 4(2) of the Ombudsman Act, 1980

December, 2008

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Our purpose is to help raise public service standards. Individuals, businesses or organisations who feel they have been unfairly treated can make complaints to the Ombudsman. Our service is free. We aim to ensure that people are treated with dignity, respect and sensitivity in their dealings with the public service. We will make every effort to deal with your complaint properly, fairly and impartially.

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FOREWORD

This report highlights serious inadequacies in the care given to a woman in her late eighties who was admitted to a HSE nursing home for respite care in December 2005. My investigation under the Ombudsman Act 1980 found a series of communications and other failures on the part of the nursing home and its professional staff which had serious negative consequences for the elderly patient and her family. The level of care was so unsatisfactory that the patient's family took their mother home from the nursing home after three days. My investigation concludes that these failures in patient care contributed, amongst other things, to the patient developing pressure sores and blisters which proved troublesome and difficult to treat. And when the patient's daughter complained about these failures in care, there were significant shortcomings in the HSE's handling of the complaint. Indeed, these shortcomings added to the daughter's sense of grievance and compounded the shortcomings in the level of care provided.

The elderly woman had suffered a stroke in 2001 and had been cared for at home by her daughter since then. The respite stay was the first occasion since the stroke on which the woman had been cared for away from home. In her complaint to my Office the patient's daughter, who was herself a trained nurse, identified a number of specific failures in care, including:

- that appropriate feeding arrangements for her mother had not been followed;
- that her mother had become dehydrated while in the nursing home;
- that her mother's medication had not been administered properly while in the nursing home;
- that on her return home from the nursing home her mother was found to have pressure sores and blisters (which the daughter attributed to inadequate care in the nursing home) as well as a urinary tract infection; and
- that the nursing home had failed to tell her, on the day of discharge, that her mother had developed these pressure sores and blisters.

My investigation found that, broadly speaking, the complaint as made was well founded. I found that there were shortcomings in patient care - involving staff in the medical, nursing and speech and language therapy areas - which contributed

to the development of pressure sores. In the area of communications, there was a failure to contact the daughter by phone (as she had suggested) when difficulties arose and a failure to inform the daughter of her mother's pressure sores at the point when the mother was being taken home.

Arising from my investigation, I made a number of recommendations to the HSE, including:

- that the nursing home develop written protocols on the referral of patients (both respite and long-stay) for para-medical services such as speech and language therapy;
- that staff have on-going education and training to ensure effective communication both internally and with patients and their families;
- that the nursing home develop protocols for the admission of respite patients with a view to ensuring that all of the patient's needs are identified and provided for in a timely fashion;
- that records be kept of any difficulties in the administration of medication to patients and that such records should show the amount of medication administered and consumed;
- that in this particular case the HSE make a "time and trouble" payment of €3,000 to the complainant in recognition of the effort involved in pursuing her complaint.

I am happy to say that the HSE has accepted these recommendations and has produced an Action Plan (Appendix B to this report) for their implementation.

There are valuable lessons to be learned from this investigation, both in terms of patient care and in terms of dealing with complaints concerning patient care. I hope that the HSE, and all in the public health system involved in providing care for the elderly, will be open to learning these lessons.

Emily O'Reilly
Ombudsman
December, 2008

Chapter 1

Background

(The complainant's name and that of her late mother have been changed in this Report to protect their identities).

The complainant, Mrs Jane Moore, (a qualified nurse), looked after her elderly mother, (Mrs Ann Kelly) for five years at home before her death in March, 2006. Her mother had suffered a stroke in 2001, which had left her physically and mentally incapacitated. She was totally dependent and was unable to communicate her needs to others. With regard to her ability to take food, Mrs Kelly had difficulties in swallowing, and her food was therefore, fed to her by means of a syringe at home. Her medication was also administered in this manner having been crushed into her food.

Mrs Moore received outside assistance in caring for her mother from a home help on week days, one hour in the morning to help get her mother up, washed and dressed, and for one hour in the evening to help put her mother to bed.
In December 2005, for the first time since her mother had suffered the stroke, Mrs Moore (for family reasons) sought to avail of one week's respite care for her mother in St Mary's Care Centre, Mullingar, which is a public nursing home run by the Health Service Executive (HSE).

Mrs Kelly was admitted to St Mary's on the afternoon of Monday, 12 December, 2005, but her daughter took her home just three days later, because she was unhappy with the level of care afforded to her mother. On admission to St Mary's, Mrs Moore provided a full and detailed account of her mother's needs to the nursing staff. This included information with regard to her mother's diet, medication, daily routine and caring needs. She also provided a sample dinner to show the correct consistency of food, a selection of fortified drinks which her mother normally took at home, and sufficient changes of clothes for her mother whom she had asked to be taken out of bed each day.

According to the complainant, during the five year period she had cared for her mother, Mrs Kelly had never suffered from bedsores. However, on taking her mother home from St Mary's on Thursday afternoon (15 December), she noticed that she had developed large black blisters on her sacrum (base of her spine), and on both her heels. In addition, she said that her mother was dehydrated and had

developed a urinary tract infection, which was diagnosed and treated by a doctor from Midoc (an out-of-hours service provided by GPs in partnership with the HSE) whom the complainant had telephoned on her return home.

Following this medical assessment, the complainant immediately telephoned the Director of Nursing in St Mary's to express her upset and anger at her mother's condition, whom she felt had been neglected. She outlined a number of issues regarding her mother's care which caused her concern. These included inadequate levels of nutrition, hydration, medication dosages and the fact that her mother had not been taken out of bed for the duration of her stay. The complainant also felt that her mother had not been turned sufficiently, and appeared to be in the same position in the bed on Thursday as when she had left her. The Director of Nursing assured Mrs Moore that a full investigation would be carried out, and requested her to forward her complaint in writing to the General Manager, Community Care Services, HSE, so that each issue could be fully examined.

While the blisters on her mother's sacrum and left heel did ultimately improve, the blister on her right heel proved resistant to treatment, and subsequently tested positive for MRSA in January, 2006. Her mother had to have her right heel debrided (dead skin removed) on three occasions in Mullingar General Hospital. Mrs Kelly subsequently developed pneumonia and died on 24 March, 2006.

Initial response by HSE to Mrs Moore's complaint:

In response to Mrs Moore's written letter of complaint (dated 17/12/05), she received a reply one month later from the General Manager, Community Care Services, HSE, thanking her for bringing her concerns to the attention of the HSE. In her letter, the General Manager acknowledged that the level of care afforded to Mrs Moore's mother, following her admission to St Mary's Care Centre, fell short of the standards of excellence to which management and staff continually strived to achieve. She said that the complaint had led her to initiate a review of existing protocols and procedures in relation to patient care. Following the General Manager's decision to initiate a review of existing procedures, she referred the incident to the HSE Healthcare Risk Management Service, which carried out a desk top examination of all written records and documentation pertaining to the patient's care. All staff involved in the care of

Mrs Kelly were interviewed as part of the review. A review team was established comprised of the General Manager, the Community Services Manager, the Director of Nursing, the Speech and Language Therapy Manager, the Medical Officer, the Director of Public Health Nursing, and representatives from Risk Management.

On completion of the review, a report was produced which documented details of the care afforded to the complainant's mother in chronological order. This report was based on the interview notes as well as information obtained from Mrs Kelly's medical and nursing records. It also examined the adequacy of existing control measures at St Mary's, and made a number of recommendations with regard to required new control measures for the Centre. (see Chapter 5)

On 27 March, 2006, (three days after Mrs Kelly passed away) the General Manager wrote to Mrs Moore advising her that the review had been completed, and that a copy of the final report would be sent to her the following week. One month later, Mrs Moore contacted my Office stating that she had tried to contact the General Manager, but that she was never available, and was not returning her calls. She stated that she had not received a copy of the report, as promised. Following contact from my Office, the report was subsequently forwarded to Mrs Moore by the Community Services Manager on 11 May, 2006, for her comments. In response, she, along with her sister, sought a meeting with the staff directly involved in their late mother's care, including the Clinical Nurse Manager, who had overall responsibility for the management of the ward in which Mrs Kelly had been placed. This meeting was scheduled to take place on 29 June, 2006, and the complainant was advised that the Clinical Nurse Manager would be present. However, on that day the Clinical Nurse Manager decided that she would not attend the meeting as she feared it might become confrontational. The complainant, therefore, felt that there was no point in proceeding with the meeting as many of her questions would have been directed at the Clinical Nurse Manager who had been on duty during the most critical time of her mother's care.

Contact with my Office/action taken:

Mrs Moore originally contacted my office towards the end of April, 2006, indicating that she felt her complaint was not being taken seriously by the HSE,

as she was getting no response from the people who were dealing with it. She stated that she rang the General Manager on numerous occasions, and called into her office, but she was never available. As mentioned previously, she did subsequently receive a copy of the report in relation to her mother's care on 11 May, 2006, and a meeting was arranged with the staff involved in June. However, Mrs Moore felt let down by the HSE when the Clinical Nurse Manager failed to attend the meeting, as arranged. She felt unable to pursue her complaint further. It was agreed by the HSE and the complainant that my Office would examine the complaint at that stage.

Mrs Moore submitted a list of questions to my Office regarding her late mother's care which she felt needed to be addressed. My investigative staff, in an effort to obtain answers to these questions and to bring resolution to the complaint, met and discussed the primary issues of concern with the key members of staff involved in the care of the complainant's mother. Discussions also took place with the Director of Nursing and the Risk Manager attached to St Mary's.

In addition, telephone contact was made with:

- the complainant's sister, who had visited her mother for a number of hours on the Tuesday and Wednesday afternoon during the period of her mother's respite stay;
- the woman who provided home help services and who attended her mother on the evening she returned home;
- the Public Health Nurse who visited her the following morning; and
- her General Practitioner.

On foot of this, the preliminary views of my Office were conveyed to Mrs Moore in writing based on the responses provided by the relevant staff in St Mary's to the issues raised. She was invited to comment on them.

Decision to hold a Formal Investigation:

Mrs Moore felt that, while the letter from my Office had clarified a number of areas, she continued to be dissatisfied in relation to some issues. Given the serious nature of these issues, I decided to undertake a formal investigation of the case under the provisions of Section 4 (2) of the Ombudsman Act, 1980. The Statement of Complaint (see Chapter 2) sets out the issues remaining in dispute.

It, together with a copy of my Office's letter containing the questions and responses which had issued to Mrs Moore, were forwarded to the Community Services Manager, to allow the staff involved an opportunity to make further comments (see Chapter 3).

Apart from the concerns about the standard of care provided to Mrs Kelly in St Mary's, the two critical issues dealt with in the Statement of Complaint were:

1) the circumstances of the assessment of the patient's capacity to swallow food (into which her medication was crushed) which is normally undertaken by a Speech & Language Therapist; and
2) the allegations by the complainant that she was never advised about the condition of her mother's pressure areas before she took her home from the Care Centre.

In accordance with agreed procedures, I prepared an initial draft report of my investigation of the complaint, extracts from which I made available to relevant HSE staff. Their comments, where appropriate, have been incorporated in this report. A copy of the final draft report was sent to the Local Health Manager for the HSE - Dublin Mid-Leinster region, and his response is attached at Appendix A. His principal comments and my responses to them are incorporated in the body of the report.

Chapter 2

Statement of Complaint:

1. On admission to St Mary's on Monday, 12 December, 2005, Mrs Kelly's skin was assessed as being intact, although because of her age, it was tissue paper like, dry and discoloured. By Wednesday, 14 December, her heels and sacrum were noted to be red. When the complainant brought her mother home from St Mary's on the afternoon of Thursday 15 December, she observed two large blisters on her mother's sacrum, a large blister on her right heel and a smaller one on her left heel. The condition of the blister on Mrs Kelly's right heel did not improve, was subsequently tested positive for MRSA, and had to be debrided on three occasions.

2. The complainant has continuously alleged that she was never advised about her mother's red pressure areas or blisters by the Clinical Nurse Manager in St Mary's. Their existence was verified by Mrs Kelly's Home Help on Thursday evening, 15 December, 2005, and by the Public Health Nurse who visited her on Friday, 16 December, 2005. The complainant had telephoned the Director of Nursing on Thursday 15 December, 2005 to advise her regarding her mother's condition and to make a complaint.

3. The following factors were alleged by the complainant to have contributed to the development of her mother's pressure areas:

* Inadequate nutrition and hydration throughout the period from Tuesday morning through to Wednesday afternoon when her mother was commenced on a subcutaneous saline drip;
* Refusal by the nursing staff to allow either the complainant or her sister to feed their mother with a syringe from Tuesday morning until she was taken home;
* Failure to have her mother assessed by a Speech and Language Therapist with regard to her swallowing difficulties, although a referral had been made by the resident Medical Officer on Tuesday morning.
* Failure to take her mother out of bed because seating could not be provided by the Occupational Therapy Department;
* Failure to turn her mother every two hours to relieve her pressure areas as was the norm at home;

* Failure to administer her mother's medication in accordance with that documented by the complainant and prescribed by her regular GP;
* Failure to measure her mother's urinary output on Tuesday 13 December, 2005, or to test it when, on observation, it became concentrated;
* Failure to carry out blood tests when her mother developed a high temperature;
* Failure to advise the complainant of her mother's condition despite the fact that she had left her mobile phone number with hospital staff requesting to be contacted if they experienced any difficulties with regard to her mother's care.

4. Mrs Moore received a written reply to her complaint in January, 2006 from the General Manager, which acknowledged the shortcomings in her mother's care, and invited her to make contact if she wished to discuss the issues further. Mrs Moore alleges that she did telephone the General Manager on a number of occasions after that, but she did not return her calls. When a meeting with hospital staff was arranged, to include the Clinical Nurse Manager, the latter decided at the last minute not to attend. Mrs Moore, having arrived for the meeting, considered it pointless for the meeting to proceed on being informed that the Clinical Nurse Manager would not be there.

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Issues with regard to MRSA:

Although this issue did not form part of the Statement of Complaint, Mrs Moore had sought information in her original letter as to whether nursing staff were taking precautions to avoid the spread of MRSA in St Mary's, and stated that there was no handwash at the sink when she went to wash her hands. This issue is included in Chapter 4 of this report under the Analysis Section.

Chapter 3

HSE's response to the Statement of Complaint:

Nursing:

A member of the nursing staff indicated that it was her understanding, following her initial contact with the Speech and Language Therapist on Tuesday 13 December, 2005, that she would return to the ward the following day to assess Mrs Kelly, and not just to collect the Medical Officer's signed referral letter. She stated that she had alerted the Speech and Language Therapist to the fact that the patient was being syringe fed at home, and that this practice could not be continued in the Care Centre. This, she said, would have clearly indicated that there was an urgent need for assessment. She felt that this was at variance with what the Speech and Language Therapist had said in her response.

In relation to Mrs Kelly's pressure areas, it was stated that she had no pressure sores on discharge, but that her pressure areas were red.

Speech and Language Therapist:

The Speech and Language Therapist remarked that, in accordance with agreed procedures, her duty of care to the patient commenced on acceptance of the medical referral. In this instance, the referral form had not been signed by the Medical Officer when he requested the assessment, and she stated that she could not, therefore, accept it. She commented that the Professional Standards for Speech and Language Therapists, the Local Department Referral Policy, and Standard Operational Procedures all state that a written referral to the Speech and Language Therapist is required for dysphagia (swallowing difficulties) and should be signed by the medical/surgical team/GP. She said that she recalled that the appropriateness of syringe feeding was the issue raised at the time, but that no sense of urgency was conveyed to her by the nurse who contacted her in relation to carrying out a swallowing assessment. She noted that while Mrs Kelly's daughter had provided specific details to nursing staff in relation to her mother's swallowing impairment and necessary food modification, none of this information had been conveyed to her.

Due to other work commitments, the Speech and Language Therapist did not get back to the ward on Wednesday, 14 December, 2005 as previously arranged. She

said that no messages, however, were left for her on her work mobile number or her landline, which has a voicemail facility, indicating the need to prioritise this patient. Neither was any message left with the multi-disciplinary therapy team at St Mary's for her attention. She stated that she was not made aware of the changing medical status of this patient, which would indicate the need to prioritise her case.

Chapter 4

Analysis of the issues:

- **Complainant not advised by the Clinical Nurse Manager that her mother had developed red pressure areas or blisters**:

Over a five year period, Mrs Moore had looked after her mother, she had never suffered from bed sores. On admission to St Mary's on Monday, 12 December, 2005, her mother's skin was assessed and recorded in the nursing notes as being intact and in good condition. She was assessed, however, as having a high Waterlow score of 22, (which meant that she was very susceptible to developing pressure sores). When her daughter brought her home on Thursday afternoon, 15 December, 2005 (three days later), she noticed that her mother had large black blisters on her sacrum, and on both her heels. This was confirmed by the woman who provided home help, who observed the blisters on Thursday evening, and who was present when Mrs Moore telephoned the Director of Nursing to make a complaint about her mother's condition. It was also verified by the Public Health Nurse, who attended Mrs Kelly at her home the following morning.

According to the Clinical Nurse Manager, while the complainant's mother had developed red pressure areas by Wednesday, 14 December, she did not have any blistering while she was in her care. The nursing records refer to Mrs Kelly's pressure areas being red on Wednesday, 14 December, and on Thursday, 15th, both her heels were very dark red in colour. The records indicate that her heels had been massaged during Wednesday night owing to their redness. The records also refer to the fact that Mrs Kelly had a bed bath on Thursday morning prior to her being taken home.

If blistering was present, at that stage, it was not recorded in the nursing records. The Director of Nursing stated that *" the poor state of the patient's pressure areas was most likely a result of her nutritional and hydrational status, together with the fact that she had a chest infection".*

In commenting on the draft final report, the Local Health Manager (LHM) stated that nursing staff were confident that, while Mrs Kelly had red areas on her sacrum and on her heels when leaving St Mary's, there were no blisters present. In response, I must point out that Mrs Moore advised my staff that her mother

had been placed on a trolley in her bedclothes, without her nappy having been changed, before she left the Nursing Home. She wondered, therefore, how the nursing staff could be so confident about her mother's pressure areas.

It is difficult to reconcile the statement by nursing staff that the patient did not have blisters in St Mary's, with the evidence provided by Mrs Moore's Home Help, who assisted her in changing her mother's nappy on Thursday afternoon, and who witnessed her shock on discovering them. Regardless as to whether the blistering occurred before Mrs Kelly left the Nursing Home or not, I think it is fair to conclude that the nature of the care the complainant's mother received over the previous three days must have been a contributory factor in the development of the blisters. In her letter to Mrs Moore in January, 2006, the General Manager stated that it was her opinion that the level of care afforded to her mother, following her admission to St Mary's Care Centre, fell short of the standards of excellence which management and staff continually strive to achieve.

It is also fair to conclude that, on the balance of probabilities, the complainant was not advised by the Clinical Nurse Manager that her mother had developed red pressure areas before she took her home from St Mary's. The evidence in relation to this conclusion rests with the independent evidence provided by Mrs Moore's Home Help who said that she witnessed her shock on discovering them. In addition, while the nursing records refer to Mrs Kelly's pressure areas being red on Wednesday and very dark red on Thursday during her stay, there is no record in the nursing notes that the complainant was so informed, or of any reaction from the complainant on being so advised. It is not unreasonable to suggest that Mrs Moore, a qualified nurse, would have asked immediately to see the pressure areas had she been advised of their existence. Mrs Moore indicated that, had she seen the condition of her mother's pressure areas before taking her from home St Mary's, she would have immediately requested to speak to the Director of Nursing to make a complaint.

In commenting on an initial draft of this report, the Clinical Nurse Manager stated that she had advised the complainant that her mother's pressure areas were red, in the presence of a staff nurse, prior to her taking her mother home. While my staff had raised this issue previously, this was the first time that mention was

made of another nurse being present when the complainant was allegedly informed about her mother's pressure areas being red.

My staff contacted this nurse who had since retired from St Mary's. She stated that she had given Mrs Kelly a bed bath on Thursday morning, and that she recalled that her pressure areas were a bit red, but that there was no broken areas of skin. She stated that she was present later that day when the ambulance men came to bring Mrs Kelly home, and that she had helped the Clinical Nurse Manager to lift Mrs Kelly onto the trolley. She said that she was one hundred percent certain that the Clinical Nurse Manager had advised the complainant about her mother's pressure areas being red, which she said was done shortly before the patient was placed on the trolley. When asked what the complainant's reaction was to this information, the nurse stated that Mrs Moore made no comment, and did not ask to see the pressure areas. The nurse stated that Mrs Kelly did not have any bed sores at that time.

The information provided by the retired staff nurse was at variance with that contained in the nursing records. The daily care flow chart indicated that Mrs Kelly received a bed bath on Thursday morning, but this was signed off by a different nurse. In addition, the nursing records indicated that Mrs Kelly's pressure areas were very dark red in colour on Thursday, and not just a bit red as stated by the staff nurse.

My staff discussed the information provided with Mrs Moore, who advised that her son was witness to the conversation between herself and the Clinical Nurse Manager at the time she was taking her mother home. She had phoned her son requesting him to drive her car home while she travelled in the ambulance with her mother. Mrs Moore stated that the Clinical Nurse Manager had pulled the curtain screen around her mother, and with the aid of the two ambulance men, had placed her mother on the trolley. The complainant said that she stood outside the curtain area, along with her son, while her mother was being placed on the trolley. She stated that there was no other member of staff present, and that there was little conversation between herself and the Clinical Nurse Manager at that stage. The complainant's son confirmed this in writing to me, and stated that there was no other member of the nursing staff present at the time that his grandmother was put on the trolley.

In commenting on the draft final report, the Local Health Manager said that "*the report all but dismisses the evidence provided by the staff nurse who was a witness to these discussions. Doubts are cast on her evidence on the basis that this nurse stated that she had given Mrs Kelly a bed bath prior to her going home and a different nurse signed the daily care flow chart. However, a bed bath is given by two nurses or a nurse and care assistant and only one staff member signs the chart. It is difficult to find the justification for accepting Mrs Moore and her son's recollection and dismissing the evidence of the Clinical Nurse Manager and the staff nurse. Throughout the report greater weight appears to be given to information provided by Mrs Moore than the reports and recollections of staff who were present on the ward*."

I have carefully considered the Local Health Manager's comments. However, I remain of the view that the evidence gathered, on balance, supports the complainant's version of events.

In commenting further on the matter of the blisters, the Local Health Manager raised the issue as to why Mrs Moore had not mentioned the blistering during her first telephone call to the Director of Nursing on Thursday afternoon, after she had taken her mother home. In response, I must point out that Mrs Moore clarified that, on her arrival home, she felt compelled to phone the Director of Nursing immediately to complain about the general care and treatment her mother had received during her respite break. She telephoned her a second time, later that evening, when she had changed her mother's nappy, with the assistance of her Home Help, and discovered the severe blistering for the first time.

Factors contributing to the patient's deteriorating condition:

- **Relevant background information:**

On admission to St Mary's on Monday, 12 December, 2005, Mrs Moore provided full details regarding her mother's needs to the nursing staff. These details included information with regard to her diet, her medication, and her daily routine of sitting out in an armchair with her feet elevated on a stool, to avoid pressure sores. She also supplied a selection of fortified drinks which her mother normally took at home. She advised that her mother was sometimes fed by syringe due to her swallowing difficulties, and brought in a sample dinner to

show its consistency to the staff. She stressed that all her mother's food had to be liquidised and fluids thickened, and that her tablets (medication) were crushed and mixed through her porridge in the morning.

On admission, Mrs Moore also provided a letter from her mother's GP setting out details of her mother's diagnosis and medication. She supplied sufficient medication for her mother's stay. The Director of Nursing, however, advised that no information had been provided to St Mary's by the GP or Public Health Nurse, prior to her mother's admission, with regard to her swallowing difficulties or particular feeding needs. She stated that, had information with regard to Mrs Kelly's specific feeding requirements been provided to nursing staff in advance of her admission, the issues in relation to feeding could almost certainly have been reduced if not avoided.

Mrs Moore stayed with her mother on Monday afternoon and was allowed to feed her at tea-time with a syringe, which she had requested from the staff nurse on duty. On Tuesday morning, prior to going away, Mrs Moore visited her mother and asked for a syringe to give her mother a drink. On that occasion, she was refused a syringe by the same staff nurse, who indicated that syringe feeding was not allowed, as this was considered force feeding. This meant that the complainant's sister, Joan, who would have been available to syringe feed their mother during mealtimes in St Mary's, would not be allowed to do so either. Mrs Moore was concerned, at that stage, as to how her mother was going to receive food and fluids, and suggested that, if necessary, a nasal gastric tube be used, as this had been suggested by a speech and language therapist during a previous admission to the General Hospital. However, she said that she was reassured by the staff nurse that her mother would be well looked after, and would be seen and assessed by the Speech and Language Therapist. The complainant requested, before she left on Tuesday morning, that she be contacted should there be any concerns whatsoever regarding her mother, and left her mobile number along with that of her sister Joan.

- **Lack of nutrition, hydration, refusal to allow family syringe-feed their mother, and failure to have an assessment carried out by the Speech and Language Therapist:**

The nursing staff stated that, prior to Mrs Kelly's admission, they were not made aware that she was syringe fed at home, and they were not accustomed to syringe feeding patients. The Director of Nursing stated that feeding by means of a syringe was not normal practice in the nursing home, and that if it was required, staff would need instruction from the Speech and Language Therapist. As a result, they said that they were faced with the dilemma of force feeding or not, a woman with an impaired ability to swallow, which could constitute elder abuse, and also cause her serious further illness. I accept that prior information regarding Mrs Kelly's swallowing difficulties would have been beneficial for nursing staff. Nevertheless, having observed how Mrs Kelly was fed by her daughter on Monday evening, I would have expected that a public nursing home facility should have had adequate procedures in place to respond appropriately to this elderly woman's needs. In the event that nursing staff felt unable to provide adequate care, given the particular circumstances of Mrs Kelly's needs, they should have advised Mrs Moore accordingly rather than reassure her that her mother would be well looked after.

In commenting on the draft report, the Local Health Manager said that Mrs Kelly was very ill upon admission, and was already suffering from a respiratory tract infection. He stated that because her chest was very congested, concerns were raised about the appropriateness of syringe feeding, and the high risk of her aspirating during this process. In response, I must point out that Mrs Kelly's GP had not prescribed antibiotics for her before her admission, and the Medical Officer in St Mary's did not prescribe antibiotics for her chest infection either until Wednesday afternoon. This was despite the fact that he had examined her on Tuesday morning. He did not suggest referring her to the General Hospital until the complainant sought to take her mother home on Thursday morning. Had Mrs Kelly been very ill on admission, I would have expected the Medical Officer to have taken appropriate action on Tuesday morning. Mrs Moore said that her mother was always chesty, but this did not hamper her being fed by syringe. If the medical and nursing staff considered that Mrs Kelly was at high risk of aspirating during the process, they should have taken steps to ensure that she was nourished and hydrated using an alternative method, or notified Mrs Moore that they could not feed her.

The Director of Nursing has acknowledged that the complainant's mother received very little by way of food or fluids during her stay. No record was kept of Mrs Kelly's fluid output on Tuesday. On Wednesday, when the Medical Officer noted that her condition had deteriorated, and that Mrs Kelly was dehydrated, he ordered that she receive fluids through a subcutaneous drip, which only commenced on Wednesday afternoon. The Medical Officer also commenced Mrs Kelly on a course of antibiotics for a chest infection, which was administered via injection, and requested that her fluid output be checked and measured. During the interview with my staff, the Medical Officer stated that there were no cultures in Mrs Kelly's urine at that time, and there was no indication that she was suffering from a urinary tract infection. He indicated that Mrs Kelly had a catheter in place which could make a patient prone to infection, but there was no evidence to indicate that she was suffering from same. When asked by my staff as to whether he was concerned, at that stage, regarding Mrs Kelly's nutritional intake, the Medical Officer advised that he was more concerned about her hydrational status, and that nasal gastric tubes were not easily tolerated. He said that he would have only have considered this option as a last resort. Mrs Kelly developed a high temperature on Wednesday evening, and Paralink (a paracetamol solution) was administered to help bring it down. However, the complainant made the point that no blood tests were carried out to determine the cause of her mother's high temperature.

In commenting on a draft of this paragraph, the Medical Officer responded that a blood test would not have determined the cause of the patient's high temperature. However, the complainant commented that a blood test would have shown whether her mother's white cell count was raised, which would have indicated that she had an infection.

On Thursday evening, after she had taken her mother home, Mrs Moore called a doctor from Midoc, whom she said advised her that her mother was dehydrated, that she did not have a chest infection, but that she had a urinary tract infection. In commenting on this issue, the Medical Officer queried whether there were laboratory findings to back up this information. Mrs Kelly's GP was able to confirm that he had received notification from Midoc that Mrs Kelly had been treated with Siproxin for a Urinary Tract Infection following her return home from St Mary's.

In relation to the assessment by the Speech and Language Therapist, the General Manager acknowledged that the patient was not assessed at all during her three days respite, although an assessment was ordered, and should have been carried out. This arose because the Medical Officer had not signed the request form on Tuesday morning which he was aware he was required to do. Even if the Medical Officer had signed the form, however, it would not have been acted upon as the Speech and Language Therapist did not return to the ward to collect it on Wednesday, as arranged.

The Clinical Nurse Manager said that she had tried to phone the Speech and Language Therapist on Wednesday afternoon, but was unable to contact her on the landline, and that she had not left her mobile phone number with nursing staff. In the absence of the assessment being carried out, and in view of the fact that the Clinical Nurse Manager was unable to make contact with the Therapist, it would seem reasonable that a member of the family, who was present and prepared to syringe feed her mother, should have been allowed to do so. This would have been more acceptable than allowing the patient to go without adequate food or fluids for a period of almost two days.

It is apparent that there was a lack of clarity with regard to the process of referring a patient for speech and language therapy. The Medical Officer, who requested the referral, would have known from past experience of the protocols in relation to the signing of the referral form, which was essential for the assessment to be conducted. He stated that he would have expected the assessment to be conducted whether the form was signed or not, which was clearly not the case.

In commenting on a draft of this paragraph, the Speech and Language Therapist made the point that nursing and medical staff were routinely made aware of the need for dysphagia referrals to be signed by the GP, according to professional standards set, and she submitted documentation to my Office which supported her position. She advised that numerous letters and memos were circulated explaining this requirement when she took up her position in St Mary's in September, 2003. She confirmed that the referral process was discussed on several occasions with management and the Medical Officer at the nursing centre, and she stated that clients referred for a dysphagia assessment were not

assessed in the absence of a signed referral. Any dysphagia referrals that were unsigned or signed by nursing staff once identified, were returned to the ward. The Speech and Language Therapist stated that it was sometimes necessary for her to instigate SLT referrals following clinical observations, and that on some occasions it could take up to a week or more for a requested referral to be signed by the Medical Officer. In a small number of instances, the request would not be approved. Therefore, she held the view that contacting the Medical Officer to "fast track" the referral was unlikely to have been productive in relation to Mrs Kelly's case. She added that the Medical Officer had the ultimate responsibility for the patient's medical well-being, and he was fully aware of the protocols of referral.

There was also a breakdown in communications between the nursing staff and the Speech and Language Therapist on the Wednesday. According to the nursing staff, had the Speech and Language Therapist returned to the ward on Wednesday, as arranged, Mrs Kelly would have been assessed. However, in commenting on a draft of this paragraph, the Speech and Language Therapist stated that while she had agreed to call on the Wednesday to collect the referral, she did not agree to assess the client. She explained that referrals were routinely collected, recorded and prioritised before assessment occurred. She said that the service that she provided to St Mary's, at that time, had no formal structure to deal with respite cases. Long-term care was not an acute setting, and was viewed as a community based service. The benchmark for response time for dysphagia referrals was contact within two weeks of receipt of referral.

The nursing staff indicated that, had the speech and language assessment been carried out, they could then have been instructed as to how best to proceed with feeding the patient. The Clinical Nurse Manager stated that she tried to make telephone contact with the Speech and Language Therapist on her landline, as no mobile contact had been issued to nursing staff at ward level.

In commenting on a draft of this paragraph, the Speech and Language Therapist stated that she had provided details of her landline (which had a voicemail facility) and her mobile phone number to nursing staff when she took up her position in 2003. These details were also contained on the safe feeding guidelines which she had issued to all nursing staff, and she submitted a copy of

same to my Office. She said that she was in and out of the Office on the Wednesday in question, dealing with other service demands, and that no message was left for her on her landline, and no note was left for her, and no phone contact was made.

The Speech and Language Therapist advised that liaison with other staff could have occurred but did not. She clarified that she was in the Occupational Therapy Room in St Mary's all Wednesday afternoon facilitating the Christmas event for patients, and that since commencement of her post her role was to organise attendance, provide all administration support, and to include and facilitate patients with specific communication difficulties to participate in social and communicative interchange. She added that her involvement in this event was well publicised, and she forwarded information which was available to nursing staff detailing her position in St Mary's on that day. She said that, in the event of an emergency situation, the Therapist in the acute hospital could have been accessed, as was the practice when she was on leave of absence on occasions.

The Speech and Language Therapist also commented that the nursing staff had not conveyed sufficient information to her regarding Mrs Kelly's swallowing impairment and food modification. She said that when a nurse contacted her during the period in question, the emphasis was specific to the appropriateness of syringe feeding, as Mrs Moore had requested this. She said that she was not informed of any specific details, such as the patient's medical, physical or cognitive status, and that she was led to understand that some level of spoon-feeding was continuing. She pointed out that she was not made aware that syringe feeding was to be discontinued, nor was she aware of the patient's risk to pressure areas, or her inability to take medication orally. The focus of the nurse's contact with her was on syringe feeding, she said, and nutritional compromise or at risk factors were not raised at anytime. She added that the central issue was one of nutritional intake, in what she subsequently understood to be a complex case. She stated that had she been privy to the central issues, including the pertinent clinical information, she would have seen a need to prioritise this patient. It is my view, given the nature of Mrs Kelly's problem with nutritional intake, that the Speech and Language Therapist should have returned to the ward on Wednesday to collect the signed referral as she had agreed to do. It is also my

view that the Clinical Nurse Manager should have ensured that she had the Therapist's contact details and mobile telephone number readily to hand, in the event of an emergency situation arising on her ward, and should have been more proactive in ensuring that an urgent message was left for her in relation to Mrs Kelly. If and when contact could not be made by telephone with the attending Speech and Language Therapist, then, under the circumstances, the Clinical Nurse Manager should have sought urgent advice and assistance from the therapist based in the acute hospital.

The Director of Nursing stated that it could be questioned why a decision was not taken to transfer Mrs Kelly to the General Hospital when the Speech and Language Therapist could not be contacted on Wednesday afternoon. She added that nursing administration should also have been contacted for advice and informed of the situation.

The General Manager accepted that the failure to complete an assessment of such an elderly patient resulted in an unacceptable lapse in the quality of care provided to her. She said that this was primarily as a result of poor communications across a number of disciplines involved with the provision of care. On foot of this complaint, the Care Centre has put in place measures to ensure that all members of staff are made fully aware, through training, of the protocols involved in the referral process and adhere to same.

- **Lack of seating:**

Mrs Kelly was not taken out of bed during her stay, as requested by her daughter, due to the fact that the Occupational Therapy Department (OTD) did not have adequate seating available. The complainant made the point that she used to sit her mother out at home each day in an ordinary armchair with cushions. There were chairs in the OTD, but these required repair, and were unfit for use. Efforts were made to locate suitable spare chairs around other wards, but none were available. Adequate seating is a basic requirement within all nursing homes and centres. The OTD should have ensured that adequate seating was available, on request, at all times. The patient would have benefited from sitting out, as she did at home, and this would have helped to relieve her pressure areas. The Manager of the OTD advised that a range of adaptable chairs had since been repaired, and two highly adaptable chairs specifically for respite

services had been ordered, so that a sufficient supply of suitable seating would be available at short notice for patients in future.

- **Turning Regime:**

The Director of Nursing stated that the skin integrity of a patient is assessed on admission, and an appropriate plan of care is then devised. She said that with each intervention with the patient, the nurse monitors and assesses the patient's condition and uses their clinical judgement to determine appropriate turning and treatment. The complainant's mother was initially assessed as requiring to be turned every three hours, as she was being nursed on a Pro-2000 mattress (high grade air mattress). However, by Wednesday, when Mrs Kelly's pressure areas deteriorated, her turning regime was not altered, and according to the nursing records, she continued to be turned at three hourly intervals.

The Director of Nursing stated that she could only assume that a decision was taken to maximise potential for as much rest as possible during the patient's last night in St Mary's, as she was clearly ill.

In commenting on a draft of this paragraph, the Director of Nursing referred to literature which suggested that the re-positioning of patients had no preventative effect on the development of grade 1 pressure ulcers. She stated that "high risk" was determined not only by the force of pressure exerted on the skin, but also by the patient's general health status, and nutritional state. However, the Director of Nursing also submitted literature to me which listed the top ten tips for preventing pressure sores, and these included the regular turning and changing of position at two hourly intervals. It also gave advice about moving a patient safely without risking further damage to the skin. Interestingly enough, one of the top tips advised against rubbing or massaging the skin, and I note from the nursing records that Mrs Kelly's heels were massaged during Wednesday night, due to them being red. This is an aspect of care which should be reviewed in light of the advice and contents of the literature.

It would also appear that nursing staff should have considered altering Mrs Kelly's turning regime during Wednesday night to reflect her changing needs, particularly when it was apparent that her pressure areas had noticeably changed colour.

- **Medication:**

When Mrs Moore's mother was admitted to St Mary's, the Medical Officer continued to prescribe her medication as per her GP's prescription with the exception of Combivent nebules, (drugs administered through a mask which the patient inhales to relieve chestiness) which he prescribed twice daily as compared to three times daily. However, he did advise nursing staff that the dosage could be increased to the usual three times daily, if warranted. Mrs Moore questioned why the Medical Officer altered her mother's dosage during her stay in the Care Centre, and was concerned that her mother had become extremely chesty as a result of administering the lower dosage. The prescription of medication for a patient is a clinical issue, which I am not empowered to examine.

Mrs Moore advised the nursing staff that all of her mother's tablets, which she had provided, had to be crushed and mixed through her food. The nursing records indicate that Mrs Kelly's tablets were crushed and mixed with yoghurt, which she took from a spoon. The records were signed off that the patient had taken all her medication. In commenting on the draft final report, the Local Health Manager stated that Mrs Kelly's medication was signed for and recorded as having been administered, and to conclude otherwise was to suggest that the nursing staff falsified records. In response, I must point out that the nursing staff reported that, while thickened fluids and liquidised food were offered and encouraged to the patient by means of a spoon, very little was accepted. (This would be understandable given that Mrs Kelly was not used to being spoon-fed due to her swallowing impairment). The Clinical Nurse Manager also stated that the patient would not open her mouth. In this context, it is very difficult to understand how the conclusion could be reached that the complainant's mother consumed all of her medication.

The HSE's Investigation Report indicated that it is the usual practice in St Mary's for medications to be administered from the patient's own supply, and any medications unused are returned to the patient before going home. Mrs Moore had expressed concerns about the level of medication administered to her mother, owing to the fact that she was not accepting food from the spoon into which her tablets had been crushed. These concerns were reinforced by the high

number of tablets which she said were returned to her on taking her mother home (which included 5 Lasix, 5 Nu-seal aspirin and 26 Combivents). Furthermore Mrs Moore said that, before she took her mother home on Thursday afternoon, she raised the question with the Medical Officer and the Clinical Nurse Manager as to why her mother's Lasix (diuretics which help to flush out fluid particularly around the heart) had not been administered via injection, when she had been refusing food and medication from a spoon. Mrs Moore alleged that both members of staff just looked at each other and said nothing. During the interviews with my staff, the Medical Officer and the Clinical Nurse Manager both confirmed that Mrs Kelly had received her Lasix tablets, which they said had been crushed along with her other medication, and given to her in yoghurt. They said that they could not recall Mrs Moore raising the issue with them regarding her mother's Lasix, or how they had been administered to her mother. However, in commenting on a draft of this paragraph, the Medical Officer stated that it had been explained to Mrs Moore that Lasix would have made her mother's hydrational status worse. The only reasonable conclusion which can be drawn from the Medical Officer's comments is that Mrs Kelly did not, in fact, receive her Lasix medication while she was a patient in St Mary's. I note, with concern, that the Drug Prescription and Administration Sheets had been signed by the nursing staff to the effect that Mrs Kelly had received all of her medication, including her Lasix, during each day of her stay in the Nursing Home.

In relation to the dispensing of medication, the Director of Nursing explained that while patients are asked to bring in their own medication for their use during respite care, it is the practice for the dispensing nurse to provide patients with tablets from the medicine trolley, if the nursing home has them in stock. This, it was suggested, could account for the return of a high number of Mrs Kelly's own tablets on her being taken home. The Director of Nursing also confirmed that medicines were signed for by the dispensing nurse when undertaking the medicines round.

Notwithstanding the explanation concerning the amount of tablets returned to the complainant on taking her mother home, I feel that it is reasonable to conclude that Mrs Kelly could not have received the required dosages, given the

Medical Officer's own admission, and the feeding difficulties that occurred during her stay.

- **Refusal to supply two antibiotic tablets on going home:**

When the complainant went to take her mother home on Thursday afternoon, she was advised against doing so by the Medical Officer, who advised that her mother should be transferred to the General Hospital. The Medical Officer had commenced Mrs Kelly on a course of antibiotics the previous day for a chest infection. The complainant requested that she be provided with two antibiotic tablets for her mother to carry her over until she got a prescription the next morning from her GP. Her request was refused by the Clinical Nurse Manager who stated that it was not the practice to supply tablets to patients going home. The Medical Officer, at the interview with my staff, explained that it would have been unethical of him to supply medication for a patient who was being taken home against his medical advice, and who was no longer under his care. The Medical Officer stated that he had strongly recommended that the complainant's mother be transferred to the General Hospital, but Mrs Moore had insisted on taking her home. In a further comment, the Medical Officer stated that in taking her mother home at midday, Mrs Moore had ample time to visit her GP, and the chemist which opened until 9.00pm. However, Mrs Moore did not arrive home with her mother by ambulance until approximately 3.30pm, as there were delays in obtaining an ambulance to transport her.

My Office raised the matter with the medical staff at the Department of Health & Children, and were given to understand that it was the practice in nursing homes and hospitals to provide tablets to patients to cover them on discharge, especially if it was considered that the patient might not get to see his or her GP that same day. Enquiries of other healthcare professionals in public nursing homes with relevant experience supports the position that patients receive sufficient medication on discharge, to cover them until they get to visit their own doctor. It appears that there are no written guidelines to direct Medical Officers on this issue.

- **Lack of information/contact with the complainant:**

Mrs Moore said she had left her mobile number with nursing staff for them to contact her should they encounter any difficulties in relation to her mother's care. She stated that she phoned St Mary's on Tuesday evening, and was told that everything was fine. On Wednesday evening, her sister Joan (who had stayed with her mother throughout Tuesday and Wednesday afternoon), phoned her to convey her deep concerns about Mrs Kelly's condition. Mrs Moore immediately contacted the ward, and said she was advised that her mother had a chest infection and had been placed on a drip. She said that she was given reassurances regarding her mother's condition, and was advised that she was receiving her medication by syringe. Mrs Moore told the nurse that she intended to take her mother home the following day. She felt that she should have been advised by the nursing staff about her mother's deteriorating condition when she rang on Wednesday evening, and no mention was made to her about her mother being transferred to the General Hospital.

In response to this issue, the nursing staff stated that procedures had been put in place to overcome the difficulties with regard to feeding Mrs Kelly, and they had hoped to have the benefit of the Speech and Language Therapist's assessment by Wednesday 14th. The nursing staff stated that they did not contact Mrs Moore on her mobile because they were aware that she, as principal carer, was availing of respite. However, the nurses said that they did explain to her sister, Joan, how their mother was progressing, and outlined that they had sought physiotherapy, speech therapy, occupational therapy and chiropody assessments for her.

They stated that they understood from Mrs Moore's sister that she would inform Mrs Moore of her mother's condition, and added that it would be considered normal practice for communication to be shared between family members. While I acknowledge the motivation of the nursing staff in not contacting Mrs Moore, I feel it is reasonable to conclude that, on balance, they should have phoned her, as Mrs Kelly's principal carer, at the earliest opportunity, given her specific request that she be so contacted. This would have provided an opportunity for them to outline the difficulties they were having in caring for her mother, and to explain what steps were being taken to overcome these issues.

- **Difficulties in pursuing the complaint with the HSE:**

When the General Manager wrote to Mrs Moore on 17 January, 2006, on foot of her written complaint, she indicated in her letter that the complaint had led her to initiate a review of existing procedures in relation to patient care. The General Manager invited Mrs Moore to telephone her if she wished to discuss the issues further. Mrs Moore responded on 30 January, 2006, indicating that she found the contents of the General Manager's letter to be inadequate, and advised her that she had also written to the Community Services Manager, enclosing two photographs of her mother's pressure areas. She requested a meeting with the General Manager, the Community Services Manager, and the medical and nursing staff in St Mary's who were responsible for her mother's care.

Following this request, Mrs Moore said that she heard nothing further from the General Manager, although she called in person to see her, and tried on a number of occasions to talk to her over the phone. She stated that the General Manager was never available, according to her staff, and that she did not return her calls. Mrs Moore said that she then contacted the former Local Health Manager, and explained that she was getting no response from the General Manager, who was supposed to be investigating her complaint. The Local Health Manager apparently agreed that he would contact the General Manager on her behalf. Mrs Kelly sadly passed away on 24 March, 2006.

On 27 March, 2006, Mrs Moore received a second letter from the General Manager, referring to previous correspondence and phone calls in relation to her complaint, and advised her that the review of the case was being completed. She further advised that a copy of the final report would issue to Mrs Moore the following week, and that a meeting would then be arranged to discuss the contents. By 26 April, 2006, when Mrs Moore had not received the promised report, she contacted my Office seeking assistance in pursuing her complaint.

In commenting on the above criticisms, the General Manager stated that the reason the first draft was not sent to Mrs Moore as promised in her letter dated 27 March, 2006, was due to the fact that her mother had just passed away. She advised that Mrs Moore was in direct contact with the Community Services Manager, on an ongoing basis, and was kept fully informed of the progress of her complaint. She submitted a log of events which outlined the interaction

between staff within the HSE, and between the HSE and the complainant. However, this log did not support the contention that contact had been made with Mrs Moore during the critical period from 30 January to the end of March, 2006, while her mother was still alive. The General Manager added that Mrs Moore was aware that the review was taking somewhat longer than was first anticipated and had accepted this. Notwithstanding any contact Mrs Moore may have had with the Community Services Manager, I feel that it was poor administrative practice on the part of the General Manager not to return any of the complainant's calls during the period January to March, 2006, particularly when she had invited Mrs Moore to contact her in her original letter.

In commenting on the draft final report, the Local Health Manager stated that while Mrs Moore may not have been in direct contact with the General Manager, she was in communication with the Community Services Manager and his staff, who were dealing with the matter on the General Manager's behalf. He said that insufficient mention was given to the General Manager's submission to my Office to this effect. In response, I wish to reiterate that the submission made to my Office does not support the contention that there was ongoing telephone contact between the complainant and the Community Services Manager. There is a record of only one telephone conversation having taken place between them dated 25 January, 2006. The General Manager's submission reveals that the final version of the review was not fully completed when she wrote to the complainant on 27 March, 2006, as two responses were still outstanding, so it would not have been possible to issue the final version to Mrs Moore the following week, as promised.

Following contact from my staff, a copy of the HSE's Review Team's Report was ultimately forwarded to Mrs Moore by the Community Services Manager on 11 May, 2006. He sought Mrs Moore's observations regarding the contents of the report, and advised her that arrangements would be made for her, and her sister Joan, to meet with nursing management (including the Clinical Nurse Manager) to discuss their concerns.

A meeting was subsequently arranged for 29 June, 2006. However, the Clinical Nurse Manager declined to attend the meeting on that day, at the last minute, as she anticipated that it might prove confrontational. In commenting on this issue,

the Director of Nursing stated that the meeting with the complainant had been scheduled without prior consultation and agreement with the Clinical Nurse Manager. She recalled how Mrs Moore clearly blamed St Mary's and the staff, particularly the Clinical Nurse Manager, for her mother's death when she met her on the day of the proposed meeting. She said that it was inappropriate for this meeting to have been arranged without adequate consultation with that member of staff, or having an agreed statement of the terms of reference as to how the meeting would be conducted. She added that the short meeting that did take place was hostile and confrontational, and clearly not in the best interest of the staff member concerned. The Community Services Manager said that he supported the Clinical Nurse Manager in her decision, indicating that if the meeting became confrontational, it would not benefit either of the parties. The complainant commented that she was annoyed that the Clinical Nurse Manager was not present, as she had been given a legitimate expectation that she would attend.

It is generally accepted as good practice for members of staff involved with the direct provision of care to meet with complainants if so requested, as they would be in the unique position to explain what happened or to answer specific questions. It is also understandable that if it is perceived that such a meeting might prove inordinately confrontational, then the value of same can be lost with little gain by either side. The handling of nursing complaints are generally the overall responsibility of the Director of Nursing, who would have access to all of the nursing records, and could discuss the issues with all of the nursing staff involved in the patient's care.

Nevertheless, on balance, it would seem that the presence of the Clinical Nurse Manager at a meeting with the complainant and her sister would have been beneficial for the reasons outlined above. Should the meeting have proved to be inordinately confrontational, it would have been open to the staff members involved to withdraw from it. The Local Health Manager, in commenting on the draft final report, stated that he did not accept that the presence of the CNM at the meeting with the complainant would have been beneficial, and had she felt compelled to withdraw from it, this would have further damaged the communication process. However, I continue to hold the view that it would have

been preferable for the CNM to have attended the meeting, which could have helped to bring closure to the issues being raised.

- **Issues with regard to MRSA:**

A swab from Mrs Kelly's right heel tested positive for MRSA in January, 2006, almost one month after she had left St Mary's. As mentioned in this report, she had to have this particular heel debrided (cleaned and dead skin removed) on three occasions in the General Hospital following her return home. During the course of her complaint, Mrs Moore raised the issue as to whether nursing staff in St Mary's were taking precautions to avoid the spread of MRSA. She said that there was no handwash at the sink on Monday evening, when she went to wash her hands, and there were no signs around the ward advising visitors to wash their hands. In addition, there did not appear to be any disposable gloves or aprons on the ward.

In response to this issue, the Director of Nursing advised that there was an MRSA policy in place in St Mary's, and forwarded a copy to my Office. She said that she was satisfied that "Cutan", a proprietary handwash and moisturiser was available at all sinks throughout the Care Centre, and was kept liberally in stock should it need replacing. She also confirmed that it was replaced immediately the dispenser became empty. In addition, the Director of Nursing stated that Mrs Kelly was placed in a bed beside a doorway close to where alcohol gel was positioned on the wall. She stated that there had been no incidence of MRSA related infections or illnesses on Mrs Kelly's ward in a number of years.

It would not be feasible for me to determine where the late Mrs Kelly contracted MRSA. As I understand it, MRSA can be obtained even through a small pin hole in the skin. A swab of the infected areas would have had to be taken within 24 hours of Mrs Kelly leaving St Mary's in order to determine if it was actually present at that time.

There is conflicting information with regard to the availability of handwash on the Ward. While Mrs Moore and her sister both stated that they had not seen any handwash on the ward, the Director of Nursing said that it was there. It is crucial that handwash is widely made available at ward level, and that dispensers are

replenished immediately they become empty, given that handwashing is one of the most effective methods of preventing the spread of MRSA in nursing homes and hospitals. It is also extremely important for nursing homes, as well as general hospitals, to display notices reminding staff and visitors alike that they must wash their hands.

Chapter 5

On foot of this complaint, the HSE Risk Management Team initiated a review of existing protocols and procedures in relation to patient care. As I understand it, this review group has been subsumed into a national group which was established to review the system of admission to nursing homes around the country, and local representatives from the original review team are members of this national group. The following recommendations, however, were made by the original review team for implementation in St Mary's :

a) That the referral form for admission of patients to respite care should be standardised to incorporate all specialities, for example, physiotherapy, dietetics, occupational therapy and speech and language therapy. In this way, the nursing home would have more comprehensive information regarding the patient's requirements in advance of care being provided. (A Regional Group was established with input from all care sites, and an information letter was circulated to all GPs detailing the information required to include the patient's present and previous medical history, and a current valid drug prescription. A national referral form for older person services is being prepared, and a copy of the draft form prepared by the Regional Group was forwarded to the Chairperson of the national group);

b) That all specialities should attend respite planning meetings, including medical staff, and that the outcome of these meetings should be communicated to all relevant staff. (Referrals to various disciplines are generated at these meetings, and all specialities currently attend the respite planning meetings);

c) That standardised letters for discharge of respite patients, together with an interdisciplinary feedback system between community services, should be developed by the Review Group. (This recommendation will be reviewed on completion of the work of the national group if not incorporated in their work);

d) That a standardised system for delivery and collection of referral letters to paramedical services within the ward should be put in place. (This has been implemented);

e) That information leaflets should be provided for families and for General Practitioners, that feedback survey forms should be made available to respite patients to ascertain areas for improvement, that a review of activities and services provided during respite should be undertaken. (This has been implemented);

f) That two highly adaptable chairs specifically for respite services be ordered. (This has been implemented).

Chapter 6

Findings:

It is my finding that the late Mrs Kelly received inadequate patient care during her period of respite care in St Mary's Care Centre, Mullingar from 12 December, 2005 to 15 December, 2005. These inadequacies contributed to the development of dark red pressure sores and ultimately black blisters on her sacrum and heels. These are outlined as follows:

- Failure by the Medical Officer to sign the referral form on Tuesday 13 December requesting the Speech and Language Therapist to carry out an assessment of Mrs Kelly's swallowing difficulties (in accordance with the policy in St Mary's), on being advised by nursing staff that she was syringe-fed at home;
- Failure by the Speech and Language Therapist to return to the ward on Wednesday 14 December to collect the signed referral, as arranged with nursing staff;
- Failure by the Clinical Nurse Manager on Wednesday afternoon to ensure that an urgent message was left for the Speech and Language Therapist either on her landline, or her mobile phone, seeking her urgent assistance with regard to Mrs Kelly's feeding difficulties, or to seek urgent assistance from the Speech Therapist in the acute hospital, which was the custom when the regular Speech and Language Therapist was absent on leave;
- Failure by nursing staff, as a result of the assessment not being carried out, to provide adequate nutrition, hydration and medication to Mrs Kelly (not withstanding that the nursing records had been signed off that she had received all her medication) throughout her stay by refusing to allow a family member who was present to feed her pending completion of the Speech & Language Therapist's assessment;
- Failure by nursing staff to alter Mrs Kelly's turning regime once they noticed that her pressure areas had become dark red in colour;
- Failure by the Occupational Therapy Department to provide seating for Mrs Kelly to enable her to sit out of bed;

In the area of communications, my findings are as follows:

- Failure by nursing staff to contact the complainant by phone, as she had requested, to advise her of any difficulties they had encountered in caring for her mother, and in relation to her mother's deteriorating condition;
- Failure by the Clinical Nurse Manager to advise the complainant of her mother's deteriorating pressure areas when she arrived to take her mother home;
- Failure by the General Manager to respond to Mrs Moore's telephone calls or to make contact with Mrs Moore over a two month period, (from 17 January, 2006 until 27 March, 2006) having written to her, inviting her to discuss the issues with her further, if she so wished. In addition, failure by the General Manager to forward a copy of the Review Group's final report to Mrs Moore as promised within the specified timeframe;
- Failure by the Clinical Nurse Manager to give due notice that she would not be attending the meeting with the complainant and her sister, as arranged.

Chapter 7

Recommendations:

Notwithstanding the recommendations by the Review Group which have already been implemented following examination of this complaint, I wish to make a number of recommendations of my own.

I recommend that St Mary's Care Centre, in conjunction with the Health Service Executive - Dublin Mid-Leinster:

- Develop written protocols with regard to the referral of patients (both respite and long-stay patients) for all para-medical services, including speech and language therapy assessments. These protocols should be understood and implemented by all members of staff, including medical staff, and new or temporary staff in the Centre, and should provide for urgent referrals when regular para-medical staff members are unavailable;
- Provide ongoing education and training programmes for all staff members to ensure that they communicate effectively with each other, with the elderly residents, and their families;
- Revise and develop protocols for the admission of a person for respite care, particularly if it is a first respite admission, to ensure that all of the patient's needs are identified, and provided for in a timely manner. Consideration might be also be given to meeting with the patient's carer/s in advance, and having the patient examined by the Medical Officer on day of admission;
- Revise protocols for nursing staff to reflect best practice with regard to the turning of patients who are susceptible to developing pressure sores;
- Develop protocols for nursing staff with regard to the seeking of advice from the Director of Nursing on crisis intervention, and develop a policy regarding the transfer of residents to acute hospital services;
- Provide education and training for all nursing staff in caring for residents who may be unable to communicate their own needs;
- Arrange for Nursing staff to ensure that the wishes of residents and their relatives are documented, listened to and acted upon, and that carers/relatives are kept fully informed with regard to their relatives'

condition. If any difficulties arise with regard to the management of any patient, their principal carer or next of kin should be immediately advised;

- Record difficulties with regard to the administration of medication to patients in the nursing records and on the prescription sheet, and these records should accurately reflect the amount of medication administered and consumed;
- Review its procedures to ensure that all significant observations on a patient's condition are recorded in the nursing records, and that entries accurately reflect the interaction between nurse and patient, and include important interactions with his/her carer or relative;
- The General Manager should review the complaints handling process to ensure that complainants are kept fully informed and updated as to the status of their complaint, and to ensure that there is a system in place which will ensure proper engagement between a complainant and HSE staff.

I also recommend that the HSE:-

- Should explore with the relevant stakeholders the possibility of introducing guidelines for Medical Officers with regard to the supply of medication for patients who are leaving hospital or nursing home care, to ensure continuity of care until they can arrange to be seen by their own GP;
- That the HSE - Dublin Mid-Leinster makes a "Time and Trouble" payment of €3000 to Mrs Moore in recognition of the effort expended by her in the pursuit of her complaint.

Emily O'Reilly
Ombudsman
July, 2008

Appendix A
The HSE's response to the draft Report

Local Health Manager
Primary, Community & Continuing Care
Longford/Westmeath Primary Care Unit
St Loman's Hospital
ATH CLIATH LAR-LAIGHEAN DUBLIN MID-LEINSTER
Mullingar
Co Westmeath

Telephone: (044) 93 95508 Fax: (044) 93 84431
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11th April 2008
Ref. LHO/BM

Mr. Pat Whelan
Director General
Office of the Ombudsman
18, Lower Leeson Street
Dublin 2

Re: Draft Investigation Report - Mrs June Moore.

Dear Mr. Whelan,

I wish to acknowledge receipt of the above report and outlined below are my comments and observations on the report, following discussion with my colleagues involved in the investigation.

Throughout the report, great emphasis is placed on the fact that Mrs Kelly was not syringe fed during her short stay in St. Mary's Care Centre. However, it is important to note that, upon admission, staff were advised that she was "sometimes" fed by means of a syringe at home and was not, therefore, totally dependent on food intake via syringe. She was able to take very small quantities of food from a spoon and this was the method used by nursing staff at St. Mary's Care Centre to give food and medication to Mrs Kelly.

The report does not comment upon that fact that Mrs Kelly was very ill upon admission and was already suffering from a respiratory tract infection. Because her chest was very congested, concerns were raised about the appropriateness of syringe feeding and the high risk of her aspirating during this process. It is not clear from the report that other interventions were taking place to ensure that Mrs Kelly's condition did not deteriorate. A Pro-2000 mattress was ordered immediately upon admission and was in place on the Monday evening. A physiotherapy referral was made and Mrs Kelly received chest physiotherapy on the ward. She was receiving sub-cutaneous fluids from Wednesday, thereby ensuring that her hydration levels were maintained.

Oral antibiotics were given to treat her chest infection and she was also treated by the chiropodist.

When dealing with the matter of Mrs Kelly's pressure sores, the report states "Mrs Kelly subsequently developed pneumonia-septicaemia, and died on 24 March 2006". An initial reading of this statement could lead to the conclusion that these pressure sores directly contributed to Mrs Kelly's death. In actual fact, Mrs Kelly died of pneumonia, which she had for two to three weeks prior to her death. Cerebrovascular accident and ischemic heart disease were identified as Antecedent Cause I and 2 respectively. There is no mention on her death certificate of septicaemia. Mrs Kelly died more than three months after her stay in St. Mary's Care Centre, at the age of 89 years.

On the matter of informing Mrs Moore about her mother's pressure areas, the Clinical Nurse Manager and staff nurse have both confirmed that Ws Moore was advised that Mrs Kelly's sacrum and both heels were red and that gel socks had been applied. I do not accept that, as stated in your report, "it is fair to conclude that, on the balance of probabilities, the complainant was not advised by the Clinical Nurse Manager that her mother had developed red pressure areas before she took her home from St. Mary's".

Your report appears to draw conclusions from the fact that the Clinical Nurse Manager did not mention that another staff member was present when she spoke with Mrs Moore prior to her taking her mother home. However, your staff did not enquire from the Clinical Nurse Manager whether or not there was a witness to the discussions. The report all but dismisses the evidence provided by the staff nurse who was a witness to these discussions. Doubts are cast on her evidence on the basis that this nurse stated that she had given Mrs Kelly a bed bath prior to her going home and a different nurse signed the daily care flow chart. However, a bed bath is given by two nurses or a nurse and care assistant and only one staff member signs the chart. It is difficult to find the justification for accepting Mrs Moore and her son's recollection and dismissing the evidence of the Clinical Nurse Manager and the staff nurse. Throughout the report greater weight appears to be given to information provided by Mrs Moore than the reports and recollections of staff who were present on the ward.

Nursing staff are confident that, whilst Mrs Kelly had red areas on her sacrum and heels when leaving St. Mary's Care Centre, there were no blisters present. The Director of Nursing took notes during the telephone conversation which took place at 3.30 p.m. on Thursday, 15th with Mrs Moore following her mother's return home and Mrs Moore made no reference to blisters at that time. No reference was made to the presence of blisters until 8.55 p.m. that night. It should be noted that blisters can develop very rapidly in a person of Mrs Kelly's age and state of health.

Your report states that "I think it is fair to conclude that the nature of the care the complainant's mother received over the previous three days must have been a contributory factor in the development of the blisters". This statement is then followed by a reference to correspondence from the General Manager to Mrs Moore in which she acknowledged the fact that the care provided to Mrs Kelly fell short of the standards of excellence which management and staff continually strive to achieve. The purpose of taking this reference out of context and linking it with the investigator's own opinion would appear to be an attempt to give credence to that

conclusion, when, in actual fact, the General Manager was referring to the breakdown in communication which led to the difficulties in having Mrs Kelly's swallowing difficulties optimally managed.

With regard to medication given to Mrs Kelly during her stay at St. Mary's Care Centre, you state in your report "I feel that it is reasonable to conclude that Mrs Kelly could not have received the required dosages Mrs Kelly's medication was signed for and recorded as being administered and to conclude otherwise is to suggest that the nursing staff falsified records. I believe that this is unfair to the staff involved who have co-operated fully with the HSE's own internal investigation of the matter and the Ombudsman's subsequent formal investigation. Furthermore, Mrs Moore took her mother home against medical advice when the medical officer in St. Mary's advised that she be transferred to the Midland Regional Hospital at Mullingar. You take issue with the fact that Mrs Moore was not provided with medication for her mother on discharge and support your view with reference to discussions with colleagues in the Department of Health. Following discussions with relevant staff and checking of ambulance records, I can confirm that Mrs Moore had ample time to contact her GP and collect medication from a pharmacy for her mother following her removal from St. Mary's. Furthermore, as Mrs Moore chose to take her mother out of St. Mary's and refused to follow medical advice, the medical officer had no clinical responsibility in the matter and it would have been entirely wrong for him to issue Mrs Kelly with medication. I feel that the Ombudsman's office would have been well advised to engage appropriate clinical expertise in this investigation rather than relying upon informal discussions with staff from Department of Health and information downloaded from Irishhealth.com, which was referred to in previous correspondence.

On the matter of pursuing her complaint, Mrs Moore was aware of the process involved in carrying out the desktop review. All staff involved in the care of Mrs Kelly were interviewed as part of the review. The report was based on the interview notes as well as the medical and nursing records. Whilst this process did take longer than was originally anticipated, it is not clear from the report that communication was ongoing with Mrs Moore and that she was kept fully informed of the progress of the review. Whilst she may not have been in direct contact with the General Manager, she was in communication with the Community Services Manager and his staff, who were dealing with the matter on the General Manager's behalf. This has not been given sufficient mention in the report despite the fact that, upon receipt of the draft extract issued previously, the General Manager made a submission to the Office of the Ombudsman to this effect.

When referring to the desktop review, a large number of the recommendations of the report are not included in this draft final report. An action plan was forwarded to the investigator from the Ombudsman's Office on 21st November 2006 which details a number of other recommendations not included in the report. I would appreciate if this information could be included in the final report.

With regard to the meeting that was due to take place on 29th June 2006, the report states that Mrs Moore felt there was no point in proceeding with the meeting as "many of her questions would have been directed at the Clinical Nurse Manager who had been on duty during the most critical time of her mother's care". The Clinical Nurse Manager was on duty for 8 hours on

Wednesday, 14th December and from 8 a.m. on Thursday 15th December. In effect she was on duty for approximately 11 hours out of the 72 hours that Mrs Kelly was on the ward. Mrs Moore was advised that the Clinical Nurse Manager would not attend the meeting upon her arrival at St. Mary's. Whilst I accept that she had an expectation that the Clinical Nurse Manager would be present at the meeting, she was assured that all of her questions and concerns would be recorded and she would be given a written response to all concerns that could not be addressed during the course of the meeting. She refused this option and was very angry and aggressive. {...} Whilst your report acknowledges that the Director of Nursing could have dealt with Mrs Moore's concerns, it still goes on to conclude that the presence of the Clinical Nurse Manager at the meeting would have been beneficial. I do not accept that this would have been the case and I believe that had the meeting gone ahead and had the Clinical Nurse Manager felt compelled to withdraw during the course of the meeting, this would, no doubt, have further damaged the communication process.

I wish to express my own dissatisfaction and that of the staff at St. Mary's with the time-frame in which this process is taking place. The Office of the Ombudsman carried out interviews with staff in St. Mary's at the end of August 2006 and staff were advised at the time that a report would issue in approximately six weeks. The issues raised by Mrs Moore were dealt with during the course of these interviews and staff were of the understanding that the Ombudsman's Office was working in the capacity of facilitator. It later transpired that Mrs Moore was given feedback from these interviews. However, staff were not given a copy of this correspondence prior to its issue, despite having been given previous assurances that this would be the case. The Community Services Manager was advised in April 2007 that the Ombudsman had decided to undertake a formal investigation. Extracts of the draft report were not issued to relevant staff until October 2007, six months later. Responses by staff were returned to your office by the end of November 2007. However, the final draft report was not issued to me until 4th March 2008. As you will appreciate, staff have found this entire process very stressful and the fact that it has taken such a long time to complete has added to this anxiety and stress. I wish to state that the staff of St. Mary's Care Centre fully co-operated with the Ombudsman's office during the course of this investigation and made detailed submissions in response to the initial draft extracts. I am disappointed that these submissions were not given due consideration and weight in the report and, at all stages throughout the report, conclusions are drawn which appear to favour the complainant's version of events.

I trust my comments and observations will be considered prior to the publication of the final report. I also wish to request that all formal submissions issued by HSE staff to the Ombudsman's Office in response to the draft extracts and the draft final report, be included in the appendices of the final report.

Yours sincerely,

Joseph Ruane
Local Health Manager
Longford/Westmeath

Appendix B

Action Plan in response to recommendations from the Ombudsman's investigation Report (July 2008) on a complaint by Mrs Jane Moore against the HSE.

Health Service Executive (HSE) Action Plan

	Ombudsman's Recommendations relating to St Mary's Care Centre, Mullingar Co Westmeath (in conjunction with HSE Dublin Mid-Leinster)	HSE's planned Actions in response to Ombudsman's Recommendations	Date to be completed	Lead Person
1.	Develop written protocols with regard to the referral of patients (both respite and long-stay patients) for all para-medical services, including speech and language therapy assessments. These protocols should be understood and implemented by all members of staff, including medical staff, and new or temporary staff in the Centre, and should provide for urgent referrals when regular para-medical staff members are unavailable.	(a) The draft Standard Operating System Procedures (SOPS) for speech & Language Therapy referrals will be reviewed and amended as required. The policy in this regard will incorporate consideration of the needs of short stay residents. (b) A specific policy on Dysphagia will be developed which will include protocols for referrals to the appropriate therapy staff re the prioritisation of such referrals. (c) The referral systems for all relevant allied health professionals will also be reviewed and amended, as appropriate	All by 31st October 2008	(a) Speech and Language Therapy Manager (b) Speech and Language Therapy Manager, Director of Nursing, Medical Officer (c) Service Managers - Occupational Therapy Manager - Physiotherapy Manager- Speech and Language Therapy Manager
2.	Provide ongoing education and training programmes for all staff members to ensure that they communicate effectively with each other, with the elderly residents, and their families.	(a) Regular Team Meetings will continue to take place in the Care Centre. (b) The Person-Centred Care Project which addresses the various elements of communication processes (i.e. inter staff, between staff and residents, between staff and families) will continue**.** (c) The induction and on-going training of staff will be reviewed with specific focus on consumer affairs and raising awareness about policies and procedures consistent with national standards/guidelines**.** (d) Linkages with HSE Consumer Affairs Office for the purposes of training will be further developed (e) The system of dissemination of new Policies, Procedures and Guidelines will be reviewed.	(a) to (h) All by 31st October 2008. (i) December 2008 subject to availability of trainers	(c) Director of Nursing Service Managers, Local Health Manager, Area Manager for Consumer Affairs**.** (d) Local Health Manager (e) Director of Nursing, Service Managers (f) Director of Nursing, Service Managers (g) Director of Nursing, Service Managers

		(f) Systems of communication with families, including but not limited to, identification of agreed family representatives, will be reviewed. (g) Staff will be actively involved in the development of new or revised policies/protocols at the Care Centre. (h) The terms of reference of Residents Groups will be reviewed (i) Specific training events will be organised to upskill staff in the following areas of communications and client care:- Complaints management Tissue Viability Dysphagia Medication Administration including the crushing of medications		(h) Director of Nursing, Area Manager for Consumer Affairs (i) Director of Nursing, Speech and Language Therapy Manager, Occupational Therapy Manager, Area Manager for Consumer Affairs

3.	Revise and develop protocols for the admission of a person for respite care, particularly if it is a first respite admission, to ensure that all of the patient's needs are identified, and provided for in a timely manner. Consideration might be also be given to meeting with the patient's carer/s in advance, and having the patient examined by the Medical Officer on day of admission;	(a) Respite Care Policy will be reviewed to include examination/development of the following:- Pre-admission criteria and protocols. Duties/responsibilities of referrers. Advance information required by Care Centre and the appropriate timescale to be agreed with the Centre prior to the patient's admission. Visit by relevant staff, if feasible, to first referral applicants at their home prior to admission for respite care. Protocol for recording of information at every stage of the care continuum. Medication policy for respite patients (in conjunction with general medication policy). Assessment care planning and care plan review for respite patients. (b) An assessment tool will be identified to assist with assessing patient needs on admission. (c) The assessment/referral form which is currently in use will be reviewed and updated, as necessary, as part of the overall review process (d) the Liaison Public Health Nurse will continue to attend weekly multi-disciplinary team meetings where new referrals, both long stay and respite care patients, are discussed and prioritised and specific patient needs are highlighted.	31st October 2008	Director of Nursing, Risk Manager, Director of Public Health Nursing, Medical Officer, Service Managers

4.	Revise protocols for nursing staff to reflect best practice with regard to the turning of patients who are susceptible to developing pressure sores.	Tissue Viability Policy will be reviewed/further developed incorporating the following:- Protocols for assessment of tissue viability. Identification of indicators of risk. Treatment of pressure ulcers. Protocols for seeking expert advice. Continuous up-skilling of staff in current international best practice.	31st October 2008	Director of Nursing Occupational Therapy Manager
5.	5 Develop protocols for nursing staff with regard to the seeking of advice from the Director of Nursing on crisis intervention, and develop a policy regarding the transfer of residents to acute hospital services;	(a) Written guidelines for transfer of patients to acute hospital services will be developed. (b) Clinical Nurse Managers/Nurse In Charge will continue to consult with Director of Nursing on a daily basis, as required. (c) 24-hour telephone support will continue to be provided by the Director of Nursing. (d) Structured Clinical Nurse Manager meetings will continue to take place. (e) Weekly Multidisciplinary Team meetings will also continue which provide a forum for discussing individual patient issues. (f) 24-hour medical support will continue to be provided by a designated Medical Officer and an Out of Hours Medical Service. (g) In the event of an emergency, patients will continue to be transferred to the acute hospital which is in close proximity to the Elderly Care Centre. A standardised transfer form between the Elderly Care Centre and the Acute Hospital has been developed and is operational.	31st December 2008	Director of Nursing-Elderly Care Centre Director of Nursing - Acute Hospital General Manager

6.	Provide education and training for all nursing staff in caring for residents who may be unable to communicate their own needs;	(a) Training of staff in communicating with patients with dementia, which has already been undertaken by a number of staff, will continue. (b) FETAC training, which also promotes effective communication with staff, residents and relatives, and which has also been undertaken by a number of staff, will continue. (c) The availability of further appropriate training will be reviewed in the context of availability of resources. (d) Development of in-house training programmes will be explored.	31st October 2008	Director of Nursing
7.	Arrange for Nursing staff to ensure that the wishes of residents and their relatives are documented, listened to and acted upon, and that carers/relatives are kept fully informed with regard to their relatives' condition. If any difficulties arise with regard to the management of any patient, their principal carer or next of kin should be immediately advised	a) In-house training on the HSE National Complaints policy will be arranged. (b) See also Items 2 and 6 above.	31st December 2008 - subject to availability of trainers	Director of Nursing, Area Manager for Consumer Affairs

8.	Record difficulties with regard to the administration of medication to patients in the nursing records and on the prescription sheet, and these records should accurately reflect the amount of medication administered and consumed.	(a) A revised drug prescription chart which has been implemented will be reviewed on a three-monthly basis. (b) All prescribed medications administered will continue to be recorded by qualified nursing staff. In cases where medication cannot be administered, this fact and the reasons for non-administration will also continue to be recorded. (c) Existing policy will be reviewed and revised as necessary regarding:- Supply of medications for respite patients. Storage of respite patients' medication. Policy on use of resident's own stock of medication. Crushing of medication - as outlined in Standard 15 of the new National Residential Care Standards.	31st October 2008	(a) (b) Director of Nursing, Chief Pharmacist for Acute Hospital (c) Director of Nursing, Medical Officer, Local Health Manager, Chief Pharmacist for Acute Hospital Nursing Midwifery Planning and Development Unit
9.	Review its procedures to ensure that all significant observations on a patient's condition are recorded in the nursing records, and that entries accurately reflect the interaction between nurse and patient, and include important interactions with his/her carer or relative	(a) Individual Care Plans will continue to be audited on an on-going basis. (b) The recording of observations, which is an integral part of this process, will also continue. (c) Training will continue to be provided to all nursing staff regarding these Care Plans. (d) The Documentation Liaison staff member will continue to feed back to the Regional Documentation Group. (e) Care Plan documentation will be reviewed to maximise effectiveness. (f) Care Plan Policy for respite patients will be developed to include:- Inclusion of patients and relatives in the process. Identification of an assessment tool to be used	31 December 2008	(a) (b) (c) (d) (e) Director of Nursing, Nursing Midwifery Planning and Development Unit (f) Director of Nursing, Nursing Midwifery Planning and Development Unit, Medical Officer

		for each respite patient on admission. Accurate documentation in the written records of every stage of the process exactly demonstrating practice. Care Plan Reviews which must take place at regular intervals and especially when there is a changes in the health status of the patient. Protocol for inclusion of the Medical Officer in assessment and review process.		

10	The General Manager should review the complaints handling process to ensure that complainants are kept fully informed and updated as to the status of their complaint, and to ensure that there is a system in place which will ensure proper engagement between a complainant and HSE staff.	(a) The HSE National Complaints Policy which sets out statutory requirements in relation to acknowledgement, investigation, and response to complaints will continue to be implemented. (b) The implementation of this policy will be reviewed to ensure that the following are in force:- Protocols for front-line staff to deal with complaints in the first instance. Appropriate timescales with respect of communication with complainants while an investigation is in progress. Named person to take overall responsibility for managing the process. (c) Further review of training needs on HSE National Complaints Policy will be undertaken. (d) Further linkages with the HSE Consumer Affairs Office for the purpose of training staff in consumer focus will be developed.	31st October 2008	Director of Nursing, Service Managers, Local Health Manager, General Manager, Area Manager for Consumer Affairs.
	Ombudsman's Recommendations relating to the Health Service Executive (HSE)	**HSE's planned Actions in response to Ombudsman's Recommendations**	**Date to be completed**	**Lead Person**
1.	(The HSE) Should explore with the relevant stakeholders the possibility of introducing guidelines for Medical Officers with regard to the supply of medication for patients who are leaving hospital or nursing home care, to ensure continuity of care until they can arrange to be seen by their own GP.	This matter will be examined further in association with appropriate medical professionals. The HSE will revert to the Ombudsman with its response in this regard when the examination is complete**.**	30 November 2008	Principal Area Medical Officer
2.	That the HSE - Dublin Mid-Leinster makes a "Time and Trouble" payment of €3000 to Mrs Moore in recognition of the effort expended by her in the pursuit of her complaint.	This matter will be dealt with by the approriate offices within the HSE	31October 2008	LHM

	Medical Nursing Issues	**HSE Response**	**Date to be completed**	**Lead Person**
1	Syringe Feeding of Patients Ref: Page 20 of Investigation Report	This matter will be examined further in association with the appropriate medical professionals. The HSE will revert to the Ombudsman with its responsein this regard when this examination process is complete.	30 November 2008	Principal Area Medical Officer
2	Crushing of Tablets - in particular Nu-Seals Aspirin Ref. Page 30 of Investigation Report	This matter will be examined further in association with the appropriate medical professionals. The HSE will revert to the Ombudsman with its responsein this regard when this examination process is complete.	30 November 2008	Principal Area Medical Officer
3	Non-provision of medication by the Medical Officer to Mrs Moore for Mrs Kelly (RIP) on Mrs Kelly being taken home against the medical advice of the Medical Officer Ref: Page 32 of Investigation Report	This matter will be examined further in association with the appropriate medical professionals. The HSE will revert to the Ombudsman with its responsein this regard when this examination process is complete	30 November 2008	Principal Area Medical Officer

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