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The investigation of a complaint
against
Betsi Cadwaladr University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 202300527

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Introduction

This report is issued under s.23 of the Public Services Ombudsman (Wales) Act 2019.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Ms D. Relevant staff involved are referred to by their posts/designations.

Summary

Ms D complained about the care and treatment her sister, Ms A, received from Wrexham Maelor Hospital (“the Hospital”) in July 2022. Ms A had several medical conditions, including epilepsy (a condition which causes seizures), cerebral palsy (a condition that affects movement and co-ordination) and learning disabilities. She lived in a nursing home, had limited communication, and required 24 hour care and support.

The Ombudsman found that the Health Board’s management of Ms A’s personal care needs, her nutrition and hydration, and communication with her fell below an adequate standard. On the occasions that the Learning Disability (“LD”) team and Ms A’s family were not present to assist, the nursing care on the ward fell short of acceptable standards, especially at weekends and overnight. No additional staff were brought in to support care delivery. There was no person-centred nursing care plan setting out the care objectives and adjustments that were needed to provide Ms A with effective care. This meant that staff did not fully understand her needs.

The Ombudsman also found that there were multiple occasions when Ms A’s pain was identified by her family and the LD team, but it was unclear whether nursing staff were consistently able to identify pain, as the assessment tool used was not adapted for Ms A’s particular needs. This failure meant that Ms A suffered unnecessarily.

The Ombudsman found that there was a poor standard of record keeping in relation to Ms A’s seizures. This was dangerous and represented a poor level of care. It was unclear whether nursing staff recognised Ms A’s seizures themselves, and had her family not been present, it is likely that many of her seizures would have gone unnoticed. Administration of medication was also found to be inadequate. Poor compliance with anti-seizure medication may have contributed to the increase in Ms A’s seizure activity.

The Ombudsman made a number of recommendations, which the Health Board accepted. These included:

- An apology to Ms D, on behalf of Ms A for the failings identified, and for Ms D having to pursue her complaint.
- A review of care planning practices on the ward to ensure care plans are embedded into basic care.
- A review of a sample of person-centred care plans to ensure they include any adjustments to meet a patient's individual needs.
- Implementation of a regular ward audit of nursing documentation, to include care plans and seizure charts.
- A review of the approach to pain assessment for people with learning disabilities to ensure adjustments and appropriate tools are used.
- Providing training to ward staff in respect of mental capacity and best interest decision making.
- Engagement with the social services departments of all local authorities within the Health Board area to implement a joint care pathway to ensure safe staffing levels when vulnerable people with additional needs are admitted from care/nursing homes.
- Providing confirmation that its Patient Safety and Experience Committee will monitor compliance with ongoing actions to satisfy the Ombudsman's recommendations.

The Complaint

1. The investigation considered Ms D's complaint about the care and treatment her sister, Ms A, received from Wrexham Maelor Hospital ("the Hospital"), between 30 June and 12 July 2022. The investigation focused on whether Betsi Cadwaladr University Health Board ("the Health Board"):

- a) Failed to fully support Ms A, including with her personal care, nutrition and hydration, and in its communication with her.
- b) Failed to monitor and manage Ms A's pain, including medication administration.
- c) Failed to monitor and manage Ms A's epilepsy, including medication administration.

Investigation

2. My investigator obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Ms D. They also obtained evidence from one of my Professional Advisers, Ms Gwen Moulster, a Learning Disability Nurse ("the Adviser").

3. The Adviser was asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by referring to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about.

4. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

Relevant legislation, guidance and policies

5. British Journal of Nursing (BJN): “Assessing the patient’s needs and planning effective care” (2021).
6. Science Direct: “Perceived trigger factors of seizures in persons with epilepsy” (Balamurugan et al. 2013).
7. Epilepsy Foundation: “Seizure Triggers” (2023).
8. Equality Act 2010.
9. Mental Capacity Act 2005.
10. Kings College London: “Learning from Lives and Deaths - people with a learning disability and autistic people” (LeDeR) (2022).
11. Mencap: “Treat me well: Reasonable adjustments for people with a learning disability in hospital” (2018).
12. Nursing and Midwifery Council (NMC) “The Code - Professional standards of practice and behaviour for nurses, midwives and nursing associates” (2015).
13. NHS Professionals: “Record keeping guidelines” (2021).
14. NHS Wales: “Health and Care Quality Standards” (2023).
15. NHS Wales Shared Services Partnership: “Person Centred Care” (2023).
16. Welsh Government: “The Duty of Quality Statutory Guidance and Health and Care Quality Standards” (2023).
17. Public Health Wales: “Learning Disability Health Improvement Programme” (2023).
18. Public Health Wales: “Learning Disabilities Care Bundle” (2022).

19. Royal College of Nursing: “Impact of staffing levels on safe and effective patient care” (2023).

20. The NHS Wales Duty of Candour was introduced in Wales on 1 April 2023. The overriding principle (set out in accompanying Welsh Government Guidance) is that “being open with service users and their representatives when things go wrong in their care is the right thing to do”. This is in addition to any professional duty of candour a healthcare professional will be subject to under their own professional practice regimes, and specifically applies when a healthcare provider is responding to complaints about a service.

21. The Equality Act 2010 requires healthcare providers to provide reasonable adjustments for disabled people to ensure they are not disadvantaged when accessing healthcare. While it is not the function of the Ombudsman to make definitive findings about whether a public body may have breached the Equality Act 2010, I will identify where equality matters are engaged and comment on a public body’s regard for them.

The background events

22. Ms A had a history of epilepsy (a condition which causes seizures), non-insulin dependent diabetes (a condition which causes a person’s blood sugar to be too high), Autism Spectrum Disorder (a diverse group of conditions related to development of the brain), cerebral palsy (a condition that affects movement and co-ordination) and learning disabilities.

23. Ms A lived in a nursing home and required 24 hour care and support.

24. On 26 June **2022** a carer from the nursing home accompanied Ms A to the Emergency Department (“ED”) at the Hospital due to concerns about increased frequency of seizures, a history of leg swelling and a 1 day inability to weight bear.

25. Ms A was diagnosed with a probable lower respiratory tract infection and was commenced on a course of antibiotics. An X-ray revealed a fracture of the right ankle, and a conservative management plan was commenced for the injury.

26. On 27 June Ms A was assessed by a specialist nurse from the Learning Disability (“LD”) team. A risk assessment was completed that day which included information from Ms A’s care provider and her family regarding her history and support requirements.

27. Ms A was admitted to the Hospital for treatment of her chest infection, initially to the Acute Medical Unit and on 30 June to a ward. She was seen regularly by members of the LD team and also received regular support from family members. During her admission there were frequent references to Ms A being in pain as identified by LD team staff or family members which led to pain management measures being implemented. It was also noted that on occasion Ms A was pain-free.

28. Ms A’s seizures required frequent monitoring using a seizure diary, although there were often gaps in its completion and sometimes the entries were incomplete. It was evident that at times there was an increased frequency of Ms A having seizures and on occasion the increasing frequency of seizures were escalated to the medical team.

29. There is evidence of contact between Ms A’s family and members of the LD, Medical and Ward nursing teams. It was agreed early on that the LD team would continue to support Ms A and contact would be made with the community social services team to explore additional support. There is no evidence that any additional support was provided.

30. The neurology team reviewed Ms A and made some suggestions to provide appropriate pain control and about how to improve Ms A’s compliance with taking medication (she was sometimes seen to spit out medication). Poor compliance with medication was a recurrent challenge for staff throughout Ms A’s admission and on one occasion a hypoglycaemic (low blood sugar levels) episode appears to have been associated with Ms A’s refusal to take medication.

31. The respiratory team also reviewed Ms A and concluded that some of the symptoms she exhibited were as a result of poor compliance with medication. Some changes were suggested to the manner in which medication was administered, such as the use of intravenous administration for the more important medications.

32. Ms A's family pointed to instances whereby Ms A was not given appropriate support such as being left in a soiled bedding and being unsupported at mealtimes and with personal care (except when family members or members of the LD team were present). It has been confirmed by the Health Board that the family was told that this was because of low staffing levels.

33. Ms A was discharged back to the nursing home on 12 July.

Ms D's evidence

34. Ms D said that there were several occasions where staff explained things to Ms A in a way she could not understand, and they struggled to understand her needs. As an example, Ms A was left with a call bell available on occasions, so staff clearly did not appreciate she would not be able to use it, or to seek/ask for assistance.

35. Ms D said that there were also occasions when family would visit in the morning to find cold breakfast on the table. As a result, they ensured that wherever possible, a family member was available at mealtimes to assist Ms A. Ms D said that family had to provide hot/cold drinks to Ms A, and that the completion of her fluid charts was inconsistent and food records were completed intermittently, with significant gaps.

36. Ms D said there were gaps in the consistency and frequency of Ms A's enhanced risk assessments. Whilst the assessment said Ms A should be cared for in an area of high visibility, at times she was not, and doors were closed and staff did not enter. Ms D said the level of supervision of Ms A was not appropriate.

37. Ms D said that despite the family telling staff about Ms A's pain indicators/signs, such as grimacing, teeth grinding, irritability, and even yelling out, they had to repeatedly ask whether she could have pain relief, and then often had to wait for her to be given it. Ms D said that an adapted pain assessment tool was not in place for Ms A.

38. Ms D said that a nurse struggled to understand why Ms A was saying no to pain medication, when she was in obvious pain. Family had to explain that due to her learning disabilities, Ms A had no understanding of her medication, or that it was linked to her pain or pain relief. If not present, the family worried whether Ms A would be allowed to decline medication, despite her lacking capacity to give consent.

39. Ms D said that for significant parts of the day, there were no staff present in the bay or in the cubicle and that another patient had to press the buzzer to alert nurses regarding Ms A's seizures on one occasion. Ms D said there was not sufficient monitoring of Ms A's seizure activity, with a heavy reliance on family, and there was no monitoring of seizure activity at night, due to insufficient staffing levels.

40. Ms D said that staffing levels were poor throughout Ms A's admission. She added that family regularly had to assist Ms A with toileting and washing and with changing her bed sheets. Ms D reported that on one occasion, Ms A was left lying in her own diarrhoea for approximately 2 hours and that this was unacceptable in terms of her privacy, dignity, and infection control, in addition to the obvious distress caused to Ms A.

41. Ms D said that the Health Board's complaint response did not address the family's concerns. Despite the complaint investigation highlighting several gaps in the documentation regarding Ms A's care and treatment, and there being no apparent discussions with the staff who were responsible for her care on the ward, the investigation concluded there were no obvious lapses in the care provided to Ms A.

42. Ms D said they were very concerned to see this conclusion as they had serious concerns about the level of care provided. Whilst the Health Board identified learning actions, the family did not believe these addressed the serious concerns raised about the care and treatment that Ms A experienced or ensured that another patient would not experience the same problems.

The Health Board's evidence

43. The Health Board said there was evidence in Ms A's clinical records that showed that efforts were made to ensure her nutrition and hydration needs were met. It said there were some gaps within the food charts, however, there was supplementary evidence in written documentation from both the ward staff and the LD team that meals were offered, and that Ms A was supported with her meals. Upon review, the Health Board acknowledged that the results of these efforts were variable due to a number of factors including Ms A's willingness to eat. Staff had to balance the risk of encouraging her to eat against any potential undue distress, therefore this was a delicate balancing act.

44. The Health Board said that in relation to personal care, there was mainly good evidence of 3-4 hourly personal care, with intentional rounding (the structured process whereby nurses in hospitals carry out regular checks, usually hourly, with patients) and supportive written documentation, which indicated a good standard of personal care. There were occasional gaps within the documentation, which the Health Board acknowledged in its investigation report.

45. The Health Board said there was also good evidence that Ms A's pain was assessed, monitored and analgesia was administered. The Health Board said the routes that Ms A's medication was administered were altered according to her clinical condition and to meet her needs. Consideration was given to ensure the medication prescribed was able to be administered as effectively as possible, and that Ms A's medication administration was also supported by the LD team on numerous occasions.

46. The Health Board said that the medical management plan was for Ms A to have her seizure activity recorded; the use of a seizure diary was recommended. It said there was evidence that this was commenced, though the documentation tool was not consistently completed or in full. There was, however, a clear narrative regarding Ms A's seizure activity throughout her notes indicating that this was both monitored, and that the management plan was amended accordingly. There was evidence that monitoring and communicating Ms A's seizure activity was a clinical priority and that family members were also encouraged to communicate/escalate any identified seizure activity.

47. The Health Board said that Enhanced Care Risk Assessments ("ECRA") were undertaken and reviewed although there were gaps in the frequency of these being completed/reviewed. It said there was evidence that the level of supervision was appropriately increased as a response to increased seizure activity.

Professional Advice

Personal care, hydration and communication

48. The Adviser considered the appropriateness of the care provided to Ms A from 30 June to 12 July, in respect of her personal care, nutrition and hydration and communication.

49. The Adviser said that from the notes, some nursing staff on the ward did not appear to recognise Ms A's communication needs or her level of understanding, despite family giving advice on the best ways to support her.

50. The Adviser was of the view that there appeared to have been an over-reliance on the family to support and care for Ms A, including with aspects of personal care when insufficient nursing staff were available.

51. The Adviser noted evidence that intentional rounding (a structured process whereby nurses carry out regular checks) was carried out for the most part every 3-4 hours. However, reliance on the family demonstrated that this frequency during the day was inadequate.

52. The Adviser said that the information from the family suggested that the level of care was inadequate, especially at mealtimes and medication times when neither the family nor the LD team were able to be present. The Adviser said that an appropriate standard of care would have been to consider Ms A's additional individual needs at key times (such as mealtimes and medication times) and in this respect, a satisfactory standard of care was not achieved.

53. The Adviser said there were serious staff shortages and was of the view that this had impacted on the standard of care at times, and that on occasion, Ms A did not receive timely dignified personal care. The Adviser noted there was no record of additional staff being sought to assist in Ms A's care at times of extreme staff shortage. The Adviser added that the ward team was over reliant on the LD team. While their input was good, it was not available outside office hours or at weekends, when staffing levels seemed to have been at their lowest.

54. The Adviser explained that the LD team was a small specialist resource, and its availability would have been dependent on the needs of other patients with learning disabilities in hospital at the time. The team should not therefore have been included in the ward staffing resource level.

55. The Adviser said that at times Ms A required additional support that was not available. The Adviser confirmed that this could have been organised by the Health Board by following up with social services and funding the additional support hours needed.

56. The Adviser said that despite serious staff shortages, it was important to maintain minimum standards, which included good clinical observation and record-keeping.

57. The Adviser said there was no evidence of a care plan for Ms A to ensure person-centred care and effective communication with her. She said that whilst the lack of a care plan would be an issue for the effective care of any patient, for more vulnerable individuals who have communication problems, this could result in poor, sometimes catastrophic, outcomes.

58. The Adviser noted that the documentation included a blank example of the Learning Disability Care bundle. She explained that if followed, a clear person-centred approach to care would be in place and recorded, enabling all staff to access relevant information on Ms A's needs. The Health Board was unable to provide a completed care bundle for Ms A which could only lead to an assumption that it was not completed, and no care plans were in place for her.

59. The Adviser said that the lack of clear person-centred care and communication plans - describing the health goals and methods to support effective communication, nutrition and hydration - could have negatively impacted on staff understanding Ms A's needs. The Adviser added that there were no records to suggest person-centred information was routinely used as a basis for care. In fact, some of the records suggested staff did not know the best ways to approach, support and provide clinical interventions to Ms A despite advisory notes from the LD team detailing effective methods to meet her needs. The Adviser said that there was little evidence in the notes provided of ward staff building positive relationships with Ms A, or of getting to know her through a person-centred approach.

60. The Adviser noted frequent occasions where Ms A was given a call bell to call for help if she needed it, despite both the family and LD team highlighting her lack of understanding in relation to this. This demonstrated a lack of awareness of her level of understanding and ability.

61. The Adviser said that as Ms A was mostly left unsupported at night and at times during the day, it is unlikely she could have solicited help when she needed it, and it would have been good practice to ensure more regular checking and closer observation, especially as Ms A had epilepsy. This should have been highlighted in her care plans.

62. The Adviser explained that the Mental Capacity Act 2005 included an expectation that health staff should have assessed capacity and where there was doubt about mental capacity, they should have initiated

a best interest approach. However, it was not clear if the nurses assessed Ms A's mental capacity, especially in relation to eating, drinking, and taking medication.

63. The Adviser highlighted that there were no records of a best interest discussion until a meeting on 8 July which focused on safeguarding concerns and safe discharge. She said that fortunately, the family and the LD team were able to give advice on adjustments in relation to administration of medication, eating and drinking. However, it was clear that on occasion, a refusal to eat or take medication was assumed to be a decision made with capacity, when it may not have been. The Adviser was of the view that a lack of knowledge and understanding about mental capacity and best interest decision making may have had an impact on Ms A's health and wellbeing whilst in hospital.

64. Overall, the Adviser considered that the quality of care at times fell below the standards identified by the Welsh Government.

Pain Management

65. The Adviser considered the appropriateness of the care provided to Ms A in respect of the monitoring and management of pain.

66. The Adviser said it was clear there were multiple occasions when pain was identified by the family and the LD team. However, it was unclear whether the ward nursing staff were consistently able to identify pain, as the tool used was not adapted to support better assessment.

67. The Adviser said that using the All Wales Pain Assessment tool enables a standardised approach but for people who have communication difficulties, using this numerical self-report can be meaningless, making the tool inadequate. In this case there was a need for adjustments to meet Ms A's needs, to ensure a person-centred pain assessment process and effective pain management. The Adviser said that identification of pain was very patchy and dependant on whether someone who knew Ms A well was present.

68. The Adviser said that whilst there was a record that the Pain Team responded to a referral on 1 July when Ms A reacted adversely to the pain medication prescribed, there was no record that the Pain Team responded to the referral made to it on 30 June.

Epilepsy Management

69. The Adviser considered the appropriateness of the care provided in respect of the monitoring and management of Ms A's epilepsy. The Adviser said that there appeared to have been multiple seizure events that were noted by the family, but there was little evidence that nursing staff observed or recognised seizures. Poor record keeping made it impossible to know if the reported seizure activity was accurate, so it was possible that further seizure activity occurred, but was not observed or reported. The Adviser said there was limited evidence of a person-centred seizure baseline having been established to enable nursing staff to recognise specific signs of seizure for Ms A.

70. The Adviser said that despite repeated requests from the medical team for a seizure diary to be maintained, records kept were incomplete. She said that a lack of seizure recording was dangerous and could result in a catastrophic outcome, so this was a serious issue that suggested the need for further training and learning.

71. The Adviser said that in Ms A's case it was difficult to correlate seizure activity with failure to administer timely anti-epileptic medication because of the poor seizure records. However, there was evidence that not taking prescribed anticonvulsant medication was a recognised seizure trigger. It was therefore safe to assume that poor compliance with medication may have been a contributory factor to the increase in observed seizure activity.

72. The Adviser noted that in the LD nurse assessment, there was mention of the frequency of seizures prior to admission and an awareness that non-compliance with medication was an issue. It was also documented that medication needed to be administered covertly however, the family reported repeated occasions when medication was

found in Ms A's bed or on the bedside table. The Adviser said that it was of concern that medication was left on the bedside table of someone with severe learning disabilities.

73. The Adviser said that the evidence of non-compliance indicates that administration of medication was at times inadequate and that an entry on the medicine chart may not have been a safe record that Ms A had swallowed the medication. With Ms A's history and the need for adjustments to support Ms A to take medication, this was concerning.

74. The Adviser said the medical notes demonstrated that the medical team was monitoring the frequency of seizures, the LD team notes also report seizure activity; however, the ward nursing notes were limited. Even on occasions when other notes identified that Ms A had experienced seizures, any nursing actions taken at the time, or any follow up observations were rarely recorded in the nursing notes. In most instances it was unclear if the ward nurses observed or recognised seizures themselves. This possible lack of awareness may also have impacted on other aspects of Ms A's care. For example, if she was post-ictal (the stage after a seizure, prior to recovery), she might have been confused, or have refused personal care, food, hydration, or medication.

75. The Adviser commented that it appeared that if family members had not been present, many of the seizures would not have been noticed and that on at least one occasion, Ms A's brother recorded the seizures on the seizure chart.

76. The Adviser noted that Ms A was seen by the neurology team on 30 June and no changes to her anti-convulsant medication were recommended. She said there was no evidence in the notes that an epilepsy nurse had seen Ms A in response to the referral on 8 July.

77. The Adviser said that the lack of staff knowledge about Ms A's capacity to make an informed decision, and their understanding of the need to make person-centred adjustments could also be contributory factors to increased seizure activity. She added that there was evidence to suggest missed medication, dehydration, missed meals and stress, which are common seizure triggers.

78. The Adviser noted little reference to clinical nurse leadership at ward level and said that although nurse leadership was evident in the LD team, there was little mention of senior nurse involvement in planning, decision making, reviewing, monitoring or supervising care on the ward. There was no indication that the ward manager or senior nursing staff on the ward were engaged in the Health Board's investigation.

79. The Adviser said that the Health Board's recommendation to introduce Learning Disability champion roles was good practice and that these roles would aid an increase in awareness and understanding amongst their colleagues. In addition, champions could help build targeted communication and care adjustment resources within the ward or department. However, there were no action points related to nurse leadership on the ward, safe staffing and the role of families, or the importance of care planning and good record keeping. The Adviser added that it was important that all nurses recognised their responsibilities to ensure they have the necessary knowledge and skills to provide effective care.

Analysis and conclusions

80. In reaching my conclusions, I must consider whether there were failings on the part of the Health Board and if so, whether those failings caused an injustice to Ms A or her family. In doing so, I have considered whether the actions of the Health Board met appropriate standards rather than best possible practice. I have had regard to the advice I have received, which I accept. However, the conclusions reached are my own.

81. The Equality Act requires healthcare providers to make reasonable adjustments for disabled people to ensure they are not disadvantaged when accessing healthcare, and this applies to both systems and in relation to individualised care. Healthcare providers need to anticipate and support the holistic needs of disabled people and make reasonable adjustments to make sure they are not disadvantaged, and to reduce the health inequalities that they experience. The evidence in this case suggests this did not occur.

82. I have concluded that Ms A's learning disabilities meant she received a poor standard of care that did not take account of her needs as an individual. I set out below several specific areas of failing which together demonstrate a lack of understanding of the approach needed to provide care to meet Ms A's needs as an individual.

a) Whether there was a failure to fully support Ms A, in respect of her personal care, nutrition and hydration and communication with her.

83. I accept the advice I have received that the standard of care in relation to Ms A's personal care, nutrition and hydration and communication fell below an adequate standard.

84. There were several shortcomings in the approach to Ms A's care:

- Without the involvement of the LD team and Ms A's family, the nursing care on the ward sometimes fell short of acceptable standards, especially at weekends and overnight when staff shortages were more pronounced. Further, no additional staff were brought in to support care delivery.
- There was no person-centred nursing care plan setting out the care objectives and adjustments that were needed to provide Ms A with effective care. The lack of a clear person-centred care and communication plan, describing Ms A's health goals and ways to support effective communication, nutrition and hydration meant that staff did not fully understand her needs. There is little evidence that ward staff recognise Ms A's individual needs. On occasion, Ms A did not receive timely dignified personal care.
- Whilst an initial nursing assessment was completed by the LD specialist team, the Learning Disability Care bundle was not completed and no care plans were in place.
- There is a strong indication that many of the nursing staff did not have a good understanding about mental capacity, adjustments for Ms A's disabilities, or adapted communication. This lack of

understanding led to issues with their ability to provide consistent safe and effective administration of medication, to ensure good nutrition and hydration, and may have impacted on pain experience and seizure frequency.

- There is little evidence that senior nursing staff were involved with planning, decision making, reviewing, monitoring or supervising the care provided on the ward.

85. Taking into account the above, I **uphold** this complaint as I am satisfied that these shortcomings represent a serious service failure. The standard of care Ms A received fell short of the required standard.

b) Whether there was a failure to monitor and manage Ms A's pain.

86. The advice I have received is very clear that that there were multiple occasions when Ms A's pain was identified by the family and the LD team. It is unclear whether the ward nursing staff were consistently able to identify pain as the tool used was not adapted for Ms A's particular needs.

87. The identification of whether Ms A was in pain depended on whether someone who knew her well was present at the time. In order to make sure pain management was effective, Ms A's individual needs should have been considered. There was a failure to do so.

88. I am satisfied that the failings identified amount to service failure. It is clear from the notes that Ms A was at times in pain, which was not only distressing for her, but for her family as well. I consider that Ms A would likely have been very frightened when alone in hospital without family present, and experiencing periods of pain. This failure meant that Ms A suffered unnecessarily and, on this basis, I **uphold** this complaint.

c) Whether there was a failure to monitor and manage Ms A's epilepsy.

89. I am concerned to note a lack of record keeping or seizure diary in relation to Ms A's seizures. Even on occasions when other notes identified she had experienced seizures, any nursing actions taken at the

time, or any follow up observations were rarely recorded in the nurses' notes. The lack of seizure recording is dangerous and represents a poor level of care.

90. There appear to have been multiple seizure events that were noted by the family, but there is little evidence that nursing staff observed or recognised seizures. Poor record keeping makes it impossible to tell if the reported seizure activity was accurate. It is possible further seizure activity occurred but was not observed or reported. In most instances it is unclear if the ward nurses observed or recognised seizures themselves and that if the family had not been there, it is likely that many of Ms A's seizures would not have been noticed.

91. There is limited evidence of a person-centred seizure baseline having been established to enable nursing staff to recognise specific signs of seizure for Ms A.

92. It is also concerning that effective administration of medication was at times inadequate, with medication being left on the bedside table or found in Ms A's bed.

93. I accept the advice I have received that not taking prescribed anticonvulsant medication is a recognised seizure trigger and that poor compliance with medication may have been a contributory factor to the increase in Ms A's observed seizure activity. For this reason, I **uphold** this complaint.

94. In addition to the distress caused to Ms A, it has also been a source of frustration to Ms D in having to pursue her complaint with me because the Health Board's own investigation lacked both rigour and candour. My investigation has revealed significant failings on the part of the Health Board but I consider that the Health Board failed to objectively review the complaint and consider Ms A's additional needs prior to issuing its complaint response.

95. Finally, therefore, I must invite the Health Board to review its complaint handling and approach to responses to service users. Whilst not in force at the time of the response here, it was well known that the

NHS Wales Duty of Candour would be implemented. The response to Ms D here fell well short of what this duty promotes and is intended to achieve (see paragraph 20). The Health Board needs to ensure that in future it responds openly and honestly to complaints, and that clinicians involved in formulating/feeding into the response also reflect on both the duty, and their own professional standards obligations when doing so.

Recommendations

96. I am pleased to note that the Health Board has already taken the following action in response to the concerns raised by Ms D:

- Sharing of its investigation report across the medical directorate and LD team to ensure learning.
- Delivery of training to staff in respect of LD awareness and epilepsy awareness and monitoring.
- Introduction of a Learning Disability champion on each medical ward to ensure best practice is adopted within their local area.
- Auditing of patient nursing assessments on the ward to identify themes such as gaps with content/consistency and to identify barriers with the completion of assessments.
- LD team liaison with Ms A's family to assist with the completion of a LD passport.

97. In addition to the action already taken, I **recommend** that the Health Board, within **1 month** of the date of the final report:

- a) Provides Ms D, on behalf of Ms A, with a fulsome apology for the failings identified in this report. The apology should also make reference to the significant time and trouble she has been put to in pursuing this complaint in order to gain answers to her concerns.

98. I **recommend** that the Health Board, within **3 months** of the date of the final report should:

- b) Review care planning practices on the ward to ensure care plans are embedded into basic care.
- c) Review a sample of person-centred care plans to ensure they include any adjustments to meet a patient's needs that need to be made.
- d) Implement a regular ward audit of nursing documentation, to include care plans and seizure charts.
- e) Review the approach to pain assessment for people with learning disabilities to ensure adjustments and appropriate tools are used.
- f) Provide confirmation that its Patient Safety and Experience Committee will monitor compliance with ongoing actions to satisfy these recommendations.

99. I **recommend** that the Health Board, within **6 months** of the date of the final report should:

- g) Provide training to ward staff in respect of mental capacity and best interest decision making.
- h) Engage with the social services departments of all local authorities within the Health Board area to implement a joint care pathway with social care to ensure safe staffing levels when vulnerable people with additional needs are admitted from care/nursing homes.

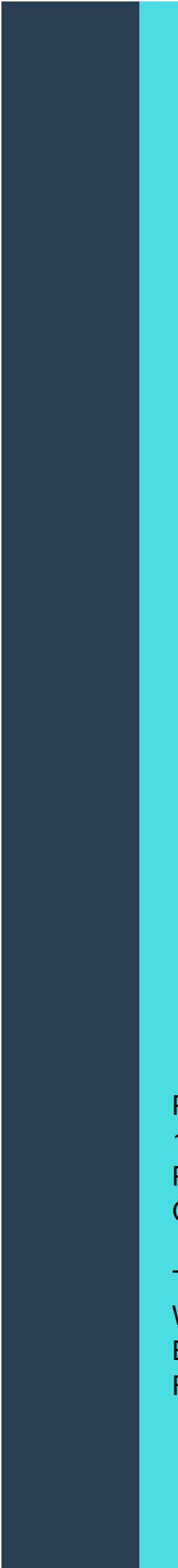
100. I am pleased to note that in commenting on the draft of this report the Health Board has agreed to implement these recommendations.

Michelle Morris

Michelle Morris

26 June 2024

Ombwdsmon Gwasanaethau Cyhoeddus/Public Services Ombudsman



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