Investigation Report

Investigation of a complaint against Northern Health and Social Care Trust

NIPSO Reference: 19483

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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Appendix 1 – The Principles of Good Administration

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Case Reference: 19483

Listed Authority: Northern Health and Social Care Trust

SUMMARY

The complaint concerned the care and treatment provided to the complainant's late father (the patient) by the Northern Health and Social Care Trust (the Trust) during his time at Antrim Area Hospital (AAH). The complainant said that, despite concerns that the patient was not fit for discharge, AAH discharged him and two days later, the patient was readmitted to AAH with sepsis. The complainant believed that this situation was as '*a direct result of [the patient's] premature discharge and could have been avoided if the medical staff had taken the time to listen to [her] concerns.'* The complainant believed that this experience was physically detrimental to the patient and that it had significant negative impact on both her and the patient's wife. The complainant also said that she felt *'pressurised'* by the social worker to complete papers associated with the patient's discharge in circumstances when she was attending to other personal family health issues.

The investigation examined the details of the complaint, the Trust's response and both national and regional guidelines. I also sought independent professional advice from a Consultant Surgeon, a Social Worker and a Nurse.

The investigation established that there were failings by the Trust in relation to the discharge of the patient on 10 November 2017. These included the Trust's failure to act in accordance with a number of standards and guidance; failure to follow-up with the complainant in relation to the concerns she raised; and a failure to provide appropriate support for the patient and complainant throughout the discharge process.

As a consequence of the failings in the discharge process and the resulting absence of up-to-date information on the patient's condition, I was unable to conclude whether the patient's discharge itself, on 10 November 2017, was appropriate. Specifically, this is because the Consultant Surgeon IPA advised that there were '*no clear clinical indicators (observations and blood tests) that would have indicated that [the patient] should have remained in hospital'* and *'there were no overt signs of*

sepsis recorded on 9 or 10 November'. Subsequently, the patient was neither reviewed by a senior clinician on the day of his discharge nor subject to ongoing monitoring of National Early Warning Score (NEWS) indicators on the day of his discharge. Therefore, the investigation was also not able to conclude whether the patient's subsequent readmission to AAH was caused by the failings in the discharge process.

The complaint therefore was partially upheld.

The investigation established that, as a result of the failings identified, the patient and the complainant sustained the injustice of lost opportunity to appropriately discuss concerns about the patient's fitness for discharge, to avail of the Trust's Reluctant Discharge Protocol and be part of the discharge process; the patient sustained the injustice of lost opportunity to have further medical review and appropriate monitoring of his condition; the complainant sustained the injustice of frustration and upset; and the complainant and the patient's wife suffered the injustice of anxiety.

I made a number of recommendations, including an apology to the complainant for the failings identified. I also recommended that the Trust ensures that relevant staff are made aware of the relevant standards and guidance; that the Trust reviews its policy and practice on medical review of patients prior to discharge; and that staff are reminded of the need to respond to concerns raised about patients and document the responses made. I also recommended that the Trust commends good record-keeping standards to staff and conducts an audit of practice on relevant wards.

THE COMPLAINT

1. I received a complaint about the discharge of the complainant's father (the patient) from Antrim Area Hospital (AAH). The Northern Health and Social Care Trust (the Trust) manages AAH.

2. The complainant said that AAH failed to listen to her concerns that the patient was not well enough to be discharged and, as a consequence, the patient was readmitted to AAH two days later with sepsis. The complainant said that this experience negatively impacted on the patient. The complainant also said that it was '*stressful and worrying'* for her and the patient's wife, who was also unwell.

3. The complainant also said that she felt *'pressurised'* by the Trust social worker (the social worker) to complete paperwork related to the patient's discharge, both in the context of having raised concerns that the patient was unfit for discharge and in circumstances where she was engaged in dealing with other family health matters.

Issues of complaint

4. The issue of complaint accepted for investigation was:

 Whether the discharge of the patient on 10 November 2017 was appropriate and reasonable?

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

6. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- Consultant Surgeon IPA; MBBS FRCS; a Consultant surgeon for 31 years;
- Nurse IPA; BSc MA RGN; a senior nurse with 18 years nursing experience; and
- Social Work IPA; CQSW; a social worker with over 30 years social work experience.

The clinical advice received is enclosed at Appendix four to this report.

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

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

The general standards are the Ombudsman's Principles[1]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling
- The Public Services Ombudsmen Principles for Remedy

9. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

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

- Northern Health and Social Care Trust '*Reluctant Discharge Protocol'*, October 2017 (Trust Reluctant Discharge Protocol);
- Northern Health and Social Care Trust '*Complaints and Service User Feedback Policy and Procedure'*, August 2016 (Trust Complaints Policy);
- Department of Health, Social Services and Public Safety '*Care Management (Circular HSC (ECCU) 1/10) Provision of Services and Charging Guidance'* (DHSS Circular);
- Department of Health *'Ready to Go? Planning the discharge and the transfer of patients from hospital and intermediate care'*, March 2010 (DoH Discharge Guidance)
- The Nursing and Midwifery Council (NMC) '*The Code. Professional standards of practice and behaviour for nurses and midwifes'*, March 2015 (NMC Code);
- Royal College of Physicians 'National Early Warning Score', 2012 (NEWS[2]);
- Northern Health and Social Care Trust NEWS Observation and Scoring, July 2013 (Trust NEWS Guidance);
- Northern Ireland Social Care Council Standards of Conduct and Practice for Social Workers (NISCC Standards).

Relevant sections of the guidance considered are enclosed at Appendix three to this report.

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything that I consider to be relevant and important in reaching my findings.

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

[2] NEWS is an aggregate score made up of six physiological parameters, with the aim of improving detection and response to clinical deterioration in acutely unwell patients. Parameters measured are: Respiratory Rate, Oxygen saturations, Systolic BP, Pulse rate, Level of consciousness (AVPU score) and Temperature.

THE INVESTIGATION

Detail of Complaint

12. On 24 October 2017 the patient was admitted to AAH. On 7 November 2017, the patient was transferred to Belfast City Hospital (BCH) for a procedure on his nephrostomy tubes and then was returned to AAH on the same day. On 9 November 2017, the social worker discussed the patient's discharge with the complainant. The complainant requested that the patient's discharge be deferred as the patient was '*in a very poor condition … in no position to understand what was being said*'. The complainant also said that the patient was unable to voice his concerns as he was so unwell. On the following day, 10 November 2017 at 09.30, the social worker contacted the complainant to inform her that the patient was being discharged that day. The complainant expressed concerns to the social worker that the patient was not well enough for discharge. The complainant said that the social worker stated she would pass this information to medical staff. The patient, however, was discharged at 14.30 on 10 November 2017 with no further contact from the Trust to the complainant in response to her concerns. The patient was readmitted to AAH on 12 November 2017 with severe pyelonephritis[3].

13. The complainant also said she was asked by the social worker on 10 November 2017 to complete papers related to the patient's discharge. The complainant explained that she was unable to do so at that time due to a conflicting appointment related to her son's health. The social worker subsequently informed the complainant that she had made arrangements for her to complete the papers at the health centre where the complainant was attending a health appointment with her son, to which arrangement the complainant felt *'pressurised'* to agree.

[3] Pyelonephritis is an infection of one or both kidneys usually caused by bacteria travelling up from the bladder. Complications of acute pyelonephritis include Sepsis.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - Trust Reluctant Discharge Protocol;
    - DHSS Circular;
    - DoH Discharge Guidance;
    - NMC Code;
    - NEWS; and
    - NISCC Standards.

    The relevant extracts are enclosed at Appendix three.

The Trust's response to investigation enquiries

15. As part of investigation enquiries, the Trust was provided with an opportunity to respond to the complaint.

16. The Trust confirmed that the patient '*was transferred to BCH to have his nephrostomy tubes replaced'* and *'was also reviewed by palliative care team who recommended a CT brain scan to be carried out due to the new onset of confusion.'*

17. In relation to the patient's discharge process, the Trust stated that the plan to discharge the patient to the nursing home *'was discussed and recorded with [the patient] and [the complainant] to ensure that he was fully informed and in agreement.'* The Trust confirmed that this was done by the social worker and that the patient was discharged on 10 November 2017.

18. The Trust further stated, *'[the patient] was reviewed by the medical team on the ward round on 9 November 2017, no new issues were identified. [He was] assessed as medically fit for discharge (meaning he no longer required to be cared for in an acute hospital setting) and his condition was stabilised enough for him to return to the nursing home. … This decision is always made by a doctor.'*

19. The Trust also stated, in relation to input to the decision to discharge from the multi-disciplinary team, that *‘[the patient] had been admitted from the nursing home, under these circumstances full Multi-Disciplinary Team (MDT) input is not requested unless it is considered that OT or physio input could be of further benefit.’*

20. The Trust further explained that the *‘term "medically fit for discharge" is used when a patient no longer requires acute medical or surgical consultant led care. … there were no acute general surgical issues that required [the patient] to remain in hospital.’*

21. The Trust stated that it was agreed with BCH that the patient would be subject to continued review by BCH as *‘there is no urology service in [AAH]’.*

22. The Trust stated that the discharge planning process began on 7 November 2017 by referral to the hospital social work team. The Trust stated that the *‘multidisciplinary team (medical staff, social work, nursing and palliative care team) all reviewed the level of care [the patient] required and it was agreed that his needs could be managed by a nursing home.’*

23. In relation to the patient’s readmission to AAH on 12 November 2017, the Trust stated, ‘*[the patient] was re-admitted … with decreased urinary output. … since discharge back to the nursing home staff had reported a low urinary output, lethargy and poor oral intake. A CT of the urinary tract showed swelling of the right kidney and the diagnosis of pyelonephritis was made. [The patient] was managed with intravenous antibiotics and intravenous fluids; his suprapubic catheter was not draining. This was discussed with the Urology team at BCH who advised that if his nephrostomy tubes were flushing well there was no concern about the suprapubic catheter. This was unforeseen as the nephrostomy tubes were draining prior to his original discharge.’*

24. In relation to the decision to discharge the patient, the Trust stated that the patient’s nursing notes of 9 November 2017 noted *‘at 18:00 that care continued, [the patient] had no complaints of pain and observations were recorded and stable’.* The Trust stated that the notes on 10 November 2017

documented *'at 01:40 … "Nephrostomy tubes patient and draining, observations recorded and stable, patient slept well and no complaints noted. No variances to care"'* and at *'14:30 … "vital signs were recorded and will continue to be monitored, eating and drinking, comfortable, to go to nursing home today, no concerns noted."*

25. The Trust stated that *'as [the patient's] discharge plan had been in place and no concerns were raised by nursing staff, no further review was then required by medical staff prior to discharge. Medical and nursing staff make every effort to deal with relatives concerns at ward level. If relatives remain concerned they are usually advised to contact the relevant secretary to arrange a mutually convenient appointment with the consultant.'*

26. The Trust also stated that in relation to communication of the complainant's concerns, [the Trust consultant surgeon] could *not 'recall specific concerns being relayed to him'.*

27. In relation to the process by which the complainant's concerns were addressed and communicated, the Trust stated, '*on 9 November 2017, it is documented that the hospital social worker met with [the complainant] and a number of concerns were raised including that [the complainant] did not feel her father had taken on board discussion regarding his future care; it was felt that [the patient] did have difficulty in retaining information.'* The Trust also stated that, *'it is documented in [the patient's] medical records on 9 November 2017 that [the social worker] passed on [the complainant's] concerns regarding her father to the deputy ward manager.'*

28. The Trust further stated that, *'[the complainant] disputed that [the patient] was fit for discharge. [Social workers] cannot relay medical assessments. It is normal procedure for the [the social worker] to inform medics/nursing staff that family are concerned about the patient's 'fitness' and request that they contact the family. The Reluctant Discharge Protocol meeting is only convened when families indicate they are not willing to proceed.'*

29. The Trust further stated, *'whilst staff make every effort to communicate with families during the discharge planning process, I acknowledge that all discussions involving medical staff may not have been recorded and learning has been identified as a result of this complaint. [The complainant] should have been updated regarding the concerns she had raised prior to her father's discharge and I sincerely apologise if this did not take place to allay the concerns she had to her satisfaction.'* The Trust confirmed that the social worker raised '*[the complainant's] concerns appropriately as would be expected through nursing lines who had responsibility for the patient'* and that *'the decision to declare a patient medically fit for discharge was made by the medical team.'*

30. The Trust also stated, *'there is no documentation to evidence whether or not [the complainant] was updated by medical staff prior to her father's discharge.'*

31. The Trust further stated, *'the Trust does have a current discharge policy … (Reluctant Discharge Protocol which includes a protocol for situations where the patient (relative/carer) is reluctant for discharge). Decisions regarding patients being fit for discharge are made by senior medical staff and are based on the patient's overall clinical condition, the outcome of any investigations and in consideration of the future management plan in conjunction with the multidisciplinary team.'*

32. In relation to the engagement between the social worker and the complainant about signing documents associated with the patient's discharge to the nursing home, the Trust stated, *'from discussion with social work there is a dispute that the focus was on financial recovery and the action of the social worker was to attempt to make things easier for the daughter by having her sign the forms closer to home. It is Trust policy that forms are signed prior to discharge. The social worker involved has significant experience and a focus on patients with palliative care needs, so it would be justifiable that she would have approached this situation with empathy. Whilst I recognise [the complainant] contests this, I would suggest that the social worker followed the required processes and attempted to accommodate [the complainant's] needs. However I acknowledge that our social work records could have contained more detail.'*

Relevant records

33. I reviewed the patient's clinical records from the period of his admission to AAH on 24 October 2017 until the date of the patient's original discharge on 10 November 2017. The records included the patient's NEWS Observation and Scoring Chart and his clinical notes.

34. On the patient's NEWS Observation and Scoring Chart, it is recorded on 9 November 2017 at 0.00 that the patient's Systolic Blood Pressure[4] was 61 and on 10 November 2017 at both 06.10 and 09.00 that it was 69. These readings were recorded under a score of *'3'* in this parameter.

35. On 9 November 2017, at 14.30, it is recorded in the patient's clinical notes that a capacity assessment was undertaken with the patient by a doctor. The record documented that *'when asked if he (the patient) remembered talking with [the Trust Consultant Surgeon] 10-15 mins prior he did not seem to. … When I re-prompted him about why he was here he seemed confused and did not reply.'* It is recorded that the doctor concluded, *'this patient, in my opinion, does not have capacity.'*

Relevant Independent Professional Advice

36. As part of investigation enquiries, I received independent professional advice from a Consultant Surgeon IPA, a Nurse IPA and a social worker IPA. I considered the advice provided by the IPAs under four sub-issues. These were whether the patient was medically fit for discharge, whether the complainant's concerns were appropriately escalated to medical staff, whether the patient was appropriately monitored before his discharge and completion of the patient's discharge forms.

[4] Systolic pressure is the pressure of the blood in the arteries when the heart pumps. It is the higher of two blood pressure measurements; for example, if the blood pressure is 120/80, then 120 is the systolic pressure.

(i) Whether the patient was medically fit for discharge

The Consultant Surgeon IPA

37. In relation to whether the patient was appropriately assessed as medically fit for discharge, the Consultant Surgeon IPA advised that *'because [the patient] had been cleared from the problem for which he had been admitted under the general surgeons - ? bowel obstruction - they thought he was medically fit for discharge, especially as he was going to a nursing home rather than home.'* The Consultant Surgeon IPA also advised that *'there is no evidence in the clinical notes that he was becoming septic'.* The Consultant Surgeon IPA further advised that *'the medical decision from the general surgeons made on 7 November for discharge was reasonable at that time as then he had not shown signs of deterioration'* and '*there was little evidence that the doctors could have seen that he was developing urological sepsis. His temperature was not raised, the only indicators which were not very specific were a rise in pulse rate and a rise in C reactive protein. There were no overt signs of sepsis recorded on 9 or 10 November'.*

The Social Worker IPA

38. The Social Worker IPA advised that there was a requirement to *'communicate with and engage carers in decision making and support processes.'* He advised that *'the coordination of all support services which reflect a safe discharge from hospital are the responsibility of the Hospital Social Worker.'*

39. The Social Worker IPA advised on protocols associated with discharge from hospital. He advised that this is outlined in the DHSS Circular. The Social Worker IPA advised that as the patient was not being discharged to his own home but to a *'residential setting where support systems were already in place … there was no need to consider a multi-agency assessment' for discharge.'*

40. The Social Worker IPA advised that '*medical discharge processes remain the responsibility of medical staff who are qualified to and experienced in making*

these decisions. It would not be appropriate for [the social worker] to interject in a medical decision.'

(ii) Whether the complainant's concerns were appropriately escalated to medical staff

The Consultant Surgeon IPA

41. In relation to whether the complainant's concerns about the patient were appropriately considered, the Consultant Surgeon IPA advised that, '*it was documented that [the patient] no longer had capacity to make decisions for himself therefore [the complainant's] account that she made representations to delay his discharge as he was so unwell seem quite plausible.'* He further advised that *'there is no evidence in the notes that [the complainant's] concerns were escalated to the medical staff so it is not certain that they were aware of any problem to consider.'*

42. The Consultant Surgeon IPA also advised that, '*once the discharge process had been started there does not seem to have been a review although the patient's medical condition appears to have changed. The responsibility for the care of a patient remains with the admitting team until they are transferred internally or discharged. … there is no evidence of further medical review.'* He also advised that the Trust *'did not apply their own 'reluctant discharge protocol''.*

The Nurse IPA

43. The Nurse IPA advised that the role of Nurses in relation to discharge is to *'ensure that discharge is safe'* and, referencing DoH Discharge Guidance, advised that it should involve '*all members of the multi-disciplinary team'.* Referencing the NMC Code, she further advised that '*where concerns are raised that may impact on a safe discharge action should be taken. If no action is deemed necessary, the rationale for taking no action should be documented.'*

44. The Nurse IPA advised that as the concern was about the patient's medical fitness, and was raised after the patient was medically reviewed, *'the concern should have been escalated to a doctor as it may have indicated a decline in medical fitness for discharge since review.'* The Nurse IPA again referenced the NMC Code that *'nurses should "encourage and empower people to share in decisions about their treatment and care"; share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand; and identify any risks or problems that have arisen and the steps taken to deal with them so that colleagues who use the records have all the information they need'".*

45. The Nurse IPA concluded that the role of the nurse, in relation to the patient, *'would include escalating [the complainant's] concerns to the medical team prior to discharge.'* She further advised that *'[the complainant's concerns resulted in a capacity test by a junior doctor (…foundation year 1)'* which *'concluded that [the patient] did not have the capacity to retain the information that was given to him.'* The Nurse IPA advised that *'this appears to support [the complainant's] concerns about discharge and yet no further action was taken.'* The Nurse IPA concluded that '*nursing staff did not take sufficient action in relation to [the complainant's] concerns because they were not escalated to the medical team who could assess if he remained medically fit for discharge on 10.11.2017.'*

The Social Worker IPA

46. In relation to the actions taken by the social worker in response to the complainant's concerns, the Social Worker IPA advised that the social worker did raise the issue with the Trust staff nurse and that this confirmed that the social worker *'has carried out her responsibility to inform medical staff of [the complainant's] concerns.'*

47. In relation to the discussion on 9 November 2017 between the complainant and the social worker, when the complainant raised the concerns about the

patient's fitness for discharge, the Social Worker IPA advised that *'there is no note of this conversation in the Social work file … except a brief note.'*

48. The Social Worker IPA further advised that *'there is no note in [the patient's] file of [the complainant's] concerns being followed up after the initial communication between the Social worker and the Staff Nurse or any further discussion with her about how these had been addressed.'* The Social Worker IPA advised that follow-up '*would reflect good practice in addressing [the complainant's] initial concerns'* but that *'there is no indication of any further communication with [the complainant] to keep her informed of developments subsequent to this.'* He also advised that *'given [the complainant's] concerns it would be expected that there would be on going communication between all three parties before discharge.'*

(iii) Whether the patient was appropriately monitored before his discharge

The Nurse IPA

49. In relation to the nursing staff's actions in monitoring the patient until his discharge, the Nurse IPA advised that the patient's '*NEWS on the morning of his discharge was 1.'* The Nurse IPA referenced the NEWS national guidance and advised that this guidance '*indicates that a 4-6 hourly repeat is needed.'*

50. The Nurse IPA further advised that, in line with local NEWS guidance, *'if the NEWS is between 1-4 and is different from the patient's baseline, it should be repeated after an hour.'* The Nurse IPA advised that '*on the morning of discharge [the patient's] pulse was significantly higher than on 8th November and his systolic blood pressure was significantly lower than on 8th November. Furthermore, the rise in [the patient's] pulse rate started at a time (evening of 9th) when his daughter had expressed concerns that he 'was not as well' as previously.'* The Nurse IPA advised that '*no further observations were taken despite local guidance clearly advocating a one hour repeat due to the difference in [the patient's] NEWS on 10th November from his baseline.'* The

Nurse IPA further advised that the patient's discharge was planned five hours and thirty minutes after the last NEWS was documented at 09.00 and *that 'staff did not continue to monitor [the patient] up until his discharge … despite the change in his NEWS.'* The Nurse IPA concluded that the patient's NEWS should have been repeated one hour after his 09.00 NEWS in line with local guidance as this applies '*even on the day of discharge because the patient remains under the care of the Trust until they leave the premises.'*

51. In relation to the impact on the patient, the Nurse IPA advised that *'in the absence of a repeated NEWS and medical review it is not possible to say with all certainty if [the patient's] condition had deteriorated or if he was showing signs of sepsis.'* The Nurse IPA further advised that it was '*not possible to know if [the patient's] NEWS would have been better or worse on repeat than it was at 9am on the day of discharge. If it was worse, this should be escalated to the medical team to decide if he still remained medically fit for discharge as this would be a medical decision.'*

52. The Nurse IPA concluded that '*the overall decision to discharge [the patient] to a nursing home on 9th November was an appropriate one. However, it is possible that [the patient] was not medically fit for discharge by the afternoon of the 10th and this was not investigated further (by repeating NEWS) and [the complainant's] concerns were not escalated to the medical team. Thus, the timing of discharge may not have been appropriate.'*

(iv) Completion of the patient's discharge forms

The Social Worker IPA

53. The Social Worker IPA further advised that '*it remains of note that key discussion appears to concern financial arrangements regarding the nursing home placement. This was to the extent of organising for [the complainant] to sign the forms on the same day in her local health centre via a social worker based there.'*

54. The Social Worker IPA advised on the records maintained by the social worker. He advised that '*there are limited notes in the file records in regard to the discharge process. … There is no note of communication with the home or a breakdown of [the patient's] needs and how the home would address these needs. The primary content of the notes indicate a focus on gaining consent from the family, and obtaining a signature from either [the complainant] or [the patient] to undertake to pay nursing home costs. This recording reflects a limited input into the care planning process with its focus on cost recovery.*'

55. The Social Worker IPA concluded that the records '*suggest an emphasis on administration and process rather than a support led intervention.*' He further advised, '*it is difficult to escape the conclusion that other core actions concerning [the patient's] care reflect an urgency to complete the discharge process rather than care needs.*' The Social Worker IPA also advised that '*given the concerns being highlighted by [the complainant] it would have been appropriate to facilitate a meeting between [the complainant] and the medical staff responsible for [the patient's] care. It is of concern that this was not facilitated by the social worker who has a duty to reflect family concerns and provide appropriate support to address these.*'

56. In relation to the complainant's experience of having to complete the forms while attending a personal appointment with her son, the Social Worker IPA advised '*it does not appear to be best practice to pursue this matter when [the complainant] had other concerns to address in her personal life in addition to dealing with the distressing circumstances surrounding her father's health and care needs. Without the Social worker being aware of all of [the complainant's] circumstances it is suggested that the approach to [the complainant's] needs might have been addressed in a more sensitive manner.*'

Trust Response to Independent Professional Advice

57. In response to IPA advice provided, the Trust stated that '*the IPA advisor has indicated that while it may have been preferable for [the patient] to remain in hospital, there were no signs of sepsis prior to discharge. [The Trust Consultant*

Surgeon] is a general surgeon and urology services are not provided within [the Trust].'

58. The Trust also accepted the IPA's advice that the patient's '*NEWS observations should have been monitored as per guidance until his discharge and any change in his condition should have been documented and escalated appropriately to medical staff.'*

59. In relation to IPA advice, the Trust further stated, *'whilst conversations may have taken place between medical and nursing staff, these have not been adequately documented'* and that *'communication with the family and internally could have been better.'*

60. In relation to the Social Work IPA advice, the Trust stated that there was '*dispute that the focus was on financial recovery and the action of the social worker was to attempt to make things easier for the daughter by having her sign the forms closer to home. … The social worker involved has significant experience and a focus on patients with palliative care needs, so it would be justifiable that she would have approached this situation with empathy. Whilst [the Trust] recognise [the complainant] contests this'* the Trust suggested that *'the social worker followed the required processes and attempted to accommodate [the complainant's] needs. However [the Trust] acknowledge that our social work records could have contained more detail.'*

Responses to the Draft Report

Complainant's Response

61. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where appropriate, comments have been reflected in changes to the report. Where considered appropriate, other comments made are reflected below in paragraphs 62 to 70.

62. In reference to paragraph 22, where the Trust stated the patient's *'discharge planning began on 7th November'*, the complainant said that the patient

attended BCH that day for replacement nephrostomy tubes and did not return to AAH until late evening. She said that given the *patient's "multiple co-morbidities' a thorough discharge process would be expected"* but that the process was effectively executed in less than three days and was undertaken *'without due care and attention'.*

63. In reference to paragraph 24, where the Trust stated it was recorded on 9 November 2017 '*at 1800 hours no complaints of pain',* the complainant said that she had '*no doubt that this is accurate as my Father could not communicate.'*

64. Also in reference to paragraph 24, where the Trust stated it was recorded on 9 November 2017' *'1430 hours, eating and drinking comfortably, no concerns noted'***,** the complainant said she '*emphatically disputed this as being a true reflection of [the patient's] condition*.' The complainant said that the patient was unable to feed himself or hold a cup and that he could not have been *'described as 'comfortable''*. The complainant also said that the patient was so lethargic that she continually had to try to waken him and that she *'had voiced concerns, but was ignored.'*

65. In reference to paragraph 26, where the Trust stated that the Trust surgeon could not *'recall specific concerns being relayed to him',* the complainant said that she raised her concerns each time she was on the ward, speaking with both nursing staff and junior doctors. The complainant also said that *'it is at worst negligent and at best unfortunate*,' that the Consultant Surgeon could not recall the concerns. She said that she would expect that concerns should be raised and discussed at the daily ward rounds and that it was hard to believe that none of the nursing staff to whom she had voiced her concerns had recorded these.

66. In reference to paragraph 28, where the Trust stated *'Reluctant Discharge Protocol meeting is only convened when families indicate they are not willing to proceed',* the complainant said that she was not willing to proceed and made this clear on both 9 and 10 November 2017 but that *this 'had little relevance on events.'*

67. In reference to paragraph 30 of the draft report where the Trust stated *'no documentation to evidence whether or not complainant was updated by medical staff prior to discharge',* the complainant said that there was no communication with her about her concerns prior to discharge and therefore nothing could be documented.

68. In reference to paragraph 60 where the Trust states *'dispute that focus was on financial recovery ……. attempt to make things easier ………. sign forms closer to home',* the complainant said that the forms to be signed were *'Undertaking to Pay'* forms which were *'purely financial'* and had 'no relevance to post - discharge care'. She also reiterated that while she attended *'the Health Centre for an appointment about her disabled son, she had to meet a social worker in the main reception area, forms were signed in full view of anyone nearby, there was no offer of privacy or further discussion.'*

69. In reference to paragraph 72 where the Consultant Surgeon IPA advised that the *'Medical decision made on 7 November for discharge was reasonable …... no overt signs of sepsis recorded on 9 or 10 November'*, the complainant said that although there may have been *'no 'overt signs' apparent to the medical staff, she was aware of the signs of infection and the possible onset of sepsis – especially when nephrostomy or catheter changes were involved.'*

70. The complainant referenced the Trust's objectives, 'Compassion, Openness, Respect and Excellence.' She said that she felt that the Trust failed in all of these. The complainant said that in relation to 'Openness', she said that she was not made aware of Reluctant Discharge Policy.

Analysis and Findings

71. I investigated the complaint by carefully considering whether the discharge of the patient on 10 November 2017 was appropriate and reasonable.

(i) Whether the patient was medically fit for discharge

72. I note that the Consultant Surgeon IPA advised that '*the medical decision … made on 7 November for discharge was reasonable at that time as then he had*

not shown signs of deterioration … There were no overt signs of sepsis recorded on 9 or 10 November'.

73. I refer to the DHSS Circular which states that '*at least daily, a senior clinical review of all patients [is undertaken] in acute hospitals.'* The DHSS Circular also states, *'it is essential that the patient's response to treatment and their condition are reviewed daily and the likely impact on the expected date of transfer reviewed and documented;…regular senior reviews take place outside the ward round',* with *'… decisions that the patient is clinically stable and safe for discharge made each day';* and *'… on the day of discharge or transfer, a decision needs to be made that the patient is ready for discharge or transfer.'*

74. I note the Consultant Surgeon IPA's advised that *'there is no evidence in the notes that [the complainant's] concerns were escalated to the medical staff'* and that *'once the discharge process had been started there does not seem to have been a review although the patients medical condition appears to have changed. … there is no evidence of further medical review.'*

75. I note the Consultant Surgeon IPA's advice that *'the responsibility for the care of a patient remains with the admitting team until they are transferred internally or discharged.'*

76. I note that the patient was assessed on the day of his discharge by a junior doctor in relation to his capacity. I note that the outcome of the assessment was that the patient was assessed as *'not having capacity'.* I further note, however, that this assessment was not undertaken by a senior member of clinical staff and it was focused only on the patient's capacity and did not consider his physical condition. I also note that, despite being deemed as '*not having capacity'*, the patient was not referred for further medical review and was discharged very shortly thereafter.

77. I also note that in her response to the draft report as paragraphs 63 and 64 refer, the complainant said that on 9 November 2017, the patient was *'unable to communicate'* and had *'voiced concerns but was ignored'.*

78. I accept the Consultant Surgeon IPA's advice that there were no *'overt signs of sepsis recorded on 9 or 10 November'* and therefore, that the medical decision, on 9 November 2017, to discharge the patient was reasonable and appropriate.

79. I also accept, however, the Consultant Surgeon IPA's advice that *'there is no evidence in the notes that [the complainant's] concerns were escalated to the medical staff'* and that *'once the discharge process had been started … although the patients medical condition appears to have changed. … there is no evidence of further medical review.'* I accept the Consultant Surgeon IPA's advice that *'the responsibility for the care of a patient remains with the admitting team until they are transferred internally or discharged.'*

80. I consider that the Consultant Surgeon IPA's advice that the Trust did not undertake a further medical review with the patient on the 10 November 2017, the day of his discharge, constitutes a failure to act in accordance with the DHSS Circular. I note that the DHSS Circular states that there should be *'at least daily, a senior clinical review of all patients in acute hospitals'* and *'decisions that the patient is clinically stable and safe for discharge are made each day'*. I consider that this was a failing in care and treatment.

81. In relation to this element of the complaint, as to whether the patient was medically fit for discharge, I partially uphold this. Specifically, I uphold that the Trust failed to undertake the steps necessary to confirm that the patient remained medically fit for discharge on 10 November 2017. As a result of this failure, however, and therefore the lack of indicators about the patient's condition at the time of discharge, I cannot conclude whether the patient was medically fit for discharge on 10 November 1017.

(ii) Whether the complainant's concerns were appropriately escalated to medical staff

82. I refer to the Trust Reluctant Discharge Protocol (Appendix three) and I note that there are a number of steps to be taken when there are '*disagreements to the discharge plan'* from patients and/or carers. These steps include that the

‘*Ward Sister/Deputy and, if appropriate, the social worker should work with the patient, carer or relative to explore any concerns they may have and should seek to reach an informal resolution’*, that these discussions ‘*should be properly documented in the patient’s ward notes’.* I note that where disagreement continues, there are a number of steps to be taken cased around meetings with medical staff and the patient/carer/representative.

83. I note that there is no evidence that the initial steps prescribed in the Trust Reluctant Discharge Protocol were implemented as discussions around concerns were not documented in the patient’s ward notes and there is no follow-up related to discussion outcomes documented in any of the records. I note the Consultant Surgeon IPA and the Nurse IPA also advised that there were no records of this in the patient’s ward notes and that the Social Worker IPA advised that follow-up was not documented in the social work records. I also note that the Consultant Surgeon IPA advised that the Trust *‘did not apply their own ‘reluctant discharge protocol’’.*

84. I note that in her comments on the draft report, as paragraph 66 refers, the complainant said she was not willing to proceed and made this clear on both 9 and 10 November 2017. I also note, as paragraph 70 refers, that the complainant said that she was not made aware of the Reluctant Discharge Protocol.

85. I refer to the DHSS Circular which states that where there are disagreements in relation to assessment of patients’ needs, these ‘*should be noted with an outline as to how these are to be resolved/managed.’*

86. I accept the Consultant Surgeon IPA’s advice and the complainant’s evidence that she was not made aware of the Reluctant Discharge Protocol. I consider that the Trust failed to apply its Reluctant Discharge Protocol and act in accordance with the DHSS Circular in how it managed the complainant’s concerns about the patient’s discharge. I consider that this was a failing in care and treatment.

87. I note that it is recorded in the patient's clinical notes that a capacity assessment was carried out on 9 November 2017 at 14.30 at which the doctor assessed the patient as *'not having capacity'.*

88. I refer to the DoH Discharge Guidance which states '*patients who do not have capacity to make decisions are given their rights and obligations under the Mental Capacity Act'* and *'ensure that the patient is fully aware of their circumstances and able to give informed consent. Where the patient cannot represent themselves, the next of kin, carer, relative … must be involved. Their role is to represent the patient's interests, and to challenge any decision that does not appear to be in the best interest of the patient.'* I also refer to the NMC Code which states *'keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process'.*

89. I note that the Consultant Surgeon IPA advised that '*it was documented that [the patient] no longer had capacity to make decisions for himself therefore [the complainant's] account that she made representations to delay his discharge as he was so unwell seem quite plausible'.* I also note the Consultant Surgeon IPA's advice that the Trust should ensure '*better communication with patient's relatives when patients do not have mental capacity.'*

90. I note that the Nurse IPA advised that *'[the complainant's] concerns resulted in a capacity test'* which *'concluded that [the patient] did not have the capacity to retain the information that was given to him'* and that *'this appears to support [the complainant's] concerns about discharge and yet no further action was taken.'*

91. I accept the advice of the Consultant Surgeon IPA and the Nurse IPA. I consider that the Trust failed to give appropriate consideration to both the patient's capacity to contribute to the decision about his discharge and the complainant as the patient's representative who raised concerns. I consider that this represented a failing in care and treatment.

92. I note that the Social Worker IPA advised that the social worker communicated the complainant's concerns to the Trust Nurse and that in doing this, the social worker had *'carried out her responsibility to inform medical staff of [the complainant's] concerns.'*

93. I accept the Social Worker IPA's advice that, in communicating the complainant's concerns to the Trust nurse, the social worker acted in accordance with her responsibility. I do not find a failing in relation to the social worker's actions in this regard.

94. I note that the Nurse IPA advised that '*where concerns are raised that may impact on a safe discharge, action should be taken. If no action is deemed necessary, the rationale for taking no action should be documented.*' I also note that the Nurse IPA further advised that, '*nursing staff did not take sufficient action in relation to [the complainant's] concerns because they were not escalated to the medical team who could assess if he remained medically fit for discharge on 10.11.2017.'*

95. I refer to the NMC Code which states '*acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.'*

96. I refer to paragraph 76 above. I note that, following referral, the patient was assessed by a junior doctor on the day of discharge in relation to capacity. I also note that no physical medical review was undertaken with the patient and that, although the assessment determined that the patient did not have capacity, there was no further referral and the patient was discharged. I do not consider that this represented an appropriate escalation of the complainant's concerns.

97. I note the complainant's comments on the draft report, as paragraph 65 refers, that she spoke to a number of staff on the ward about her concerns on a number of occasions and that none of these were recorded.

98. I accept the Nurse IPA's advice and consider that the Trust nurse failed to both appropriately escalate the complainant's concerns and to document the response to the complainant's concerns. I consider that this constitutes a failure in care and treatment.

99. I note that the Social Worker IPA advised that, in line with the DHSS Circular, the social worker was required to '*communicate with and engage carers in decision making and support processes.'* I note that the Social Worker IPA advised that '*there is no note in [the patient's] file of [the complainant's] concerns being followed up … or any further discussion with her about how these had been addressed'* and that it '*would reflect good practice in addressing [the complainant's] initial concerns … to keep her informed of developments subsequent to this.'* I note that the Social Worker IPA also advised that '*given [the complainant's] concerns it would have been appropriate to facilitate a meeting between [the complainant] and the medical staff responsible for [the patient's] care. It is of concern that this was not facilitated by the social worker who has a duty to reflect family concerns and provide appropriate support to address these.'*

100. I accept the Social Worker IPA's advice that '*there is no note in [the patient's] file of [the complainant's] concerns being followed up after the initial communication between the Social worker and the Staff Nurse or any further discussion with her about how these had been addressed'* and that follow-up *'would reflect good practice in addressing [the complainant's] initial concerns. However there is no indication of any further communication with [the complainant] to keep her informed of developments subsequent to this.'* I also accept the Social Worker IPA's advice that *'other core actions concerning [the patient's] care reflect an urgency to complete the discharge process rather than care needs in this case.'* I consider that this represented a failure in care and treatment.

101. I partially uphold this element of the complaint as to whether the complainant's concerns were appropriately escalated to medical staff. Specifically, I uphold that in managing the patient's discharge, the Trust failed to act in accordance with its Reluctant Discharge Protocol, the DHSS Circular, DoH Discharge

Guidance and the NMC Code. I do not uphold that the social worker failed to fulfil her responsibilities in relation to escalating the complainant's concerns to medical staff.

(iii) Whether the patient was appropriately monitored before his discharge

102. I note that the Nurse IPA advised that the patient's '*NEWS on the morning of his discharge was 1'* and that according to NEWS national guidance this required *'a 4-6 hourly repeat'*. I also note that the Nurse IPA advised that five and a half hours elapsed between the patient's last NEWS observation at 09.00 and his discharge and that '*staff did not continue to monitor [the patient] up until his discharge … because the patient remains under the care of the Trust until they leave the premises.'*

103. I note that the Nurse IPA also advised that, in line with the local NEWS guidance, when the score is *'between 1-4 and is different from the patient's baseline, it should be repeated after an hour.'* I note that the Nurse IPA advised that '*no further observations were taken despite local guidance clearly advocating a one hour repeat due to the difference in [the patient's] NEWS on 10th November from his baseline.'* I note that the Nurse IPA advised that by monitoring the patient's NEWS in accordance with the required guidance, should the patient's NEWS be *'worse, this should be escalated to the medical team to decide if he still remained medically fit for discharge as this would be a medical decision.'*

104. I accept the Nurse IPA's advice that the Trust nursing staff failed to adhere to local NEWS guidance.

105. I also note that the Trust stated that it accepted the Nurse IPA's advice that the patient's '*NEWS observations should have been monitored as per guidance until his discharge and any change in his condition should have been documented and escalated appropriately to medical staff.'* I consider that this

represents an acknowledgement by the Trust of a failure in care and treatment to the patient.

106. I uphold this element of the complaint that the patient was not appropriately monitored before his discharge.

(iv) Completion of the patient's discharge forms

107. I note that the Social Worker IPA advised that the social worker's actions in pursuit of the completion of financial forms for the patient's discharge '*does not appear to be best practice … when [the complainant] had other concerns to address in her personal life in addition to dealing with the distressing circumstances surrounding her father's health and care needs. … it is suggested that the approach to [the complainant's] needs might have been addressed in a more sensitive manner.'*

108. I note that the NISCC Standards state that social workers *'must respect the rights, dignity and inherent worth of individuals; work in a person-centred way; treat people respectfully and with compassion; engage and participate with service users and carers through building and sustaining purposeful and situation appropriate professional relationships with service users and carers which are person-centred and inclusive; and working in partnership to promote the active participation of service users and carers in all aspects of decisions and actions affecting their lives.'*

109. I note that the Trust disputed that *'the focus was on financial recovery and the action of the social worker was to attempt to make things easier for the daughter by having her sign the forms closer to* home' and that the social worker *'would have approached this situation with empathy.'*

110. I also note that in the complainant's comments on the draft report, as paragraph 68 refers, she said that the forms she had to complete were *'purely financial'* and that '*she had to meet a social worker'* while attending a non-related health appointment with her disabled son and that the *'forms were*

signed in full view of anyone nearby, there was no offer of privacy or further discussion.'

111. I accept the Social Worker IPA's advice that the social worker's approach to completion of the forms did not represent good practice and could have been managed more sensitively. I also consider that the social worker's approach was not in accordance with the NISCC Standards. I consider that this was a failing in care and treatment. I therefore uphold this element of the complaint.

Overall Record Keeping

112. I note that the Social Worker IPA advised that '*there are limited notes in the file records in regard to the discharge process. … There is no note of communication with the home or a breakdown of [the patient's] needs and how the home would address these needs.'* I note that the Social Worker IPA concluded that the records *'suggest an emphasis on administration and process rather than a support led intervention'* and '*that other core actions concerning [the patient's] care reflect an urgency to complete the discharge process rather than care needs.'*

113. I note that the Trust stated that it *'acknowledge[d] that our social work records could have contained more detail.'*

114. I note that the NISCC Standards state that social workers should be accountable and responsible for *'maintaining clear and accurate records as required by procedures established for your work'.*

115. I accept the Social Worker IPA's advice that the social work records in relation to the discharge process *'are limited'.* I consider that this represents a failure to meet the requirements of the NISCC Standards and constitutes maladministration.

116. I consider that there were failures in care and treatment in relation to the discharge of the patient on 10 November 2017. These were that:-

a. the Trust failed to act in accordance with its Reluctant Discharge Protocol

and the DHSS Circular in how it managed the complainant's concerns about the patient's discharge;

b. the Trust did not undertake a senior clinical review with the patient on the day of his discharge;
c. the Trust failed to give appropriate consideration to the patient's capacity to contribute to the decision about his discharge and to the complainant as the patient's representative who was raising concerns;
d. the Trust nurse failed to take action in relation to the complainant's concerns and did not document that no action was taken;
e. the Trust nursing staff failed to adhere to local NEWS guidance; and
f. the social worker's approach to completion of the forms did not represent good practice, was not in keeping with NISCC Standards and could have been managed more sensitively.

117. In consideration of the above, I partially uphold the complaint.

118. Due to the unavailability of up-to-date information about the patient's condition on 10 November 2017, which resulted from the failings a to e detailed in paragraph 116 above, I cannot conclude whether the patient's discharge on 10 November 2017 was appropriate. It is also not possible to conclude whether the patient's subsequent readmission to AAH was caused by the failings in the discharge process.

Injustice

119. I considered carefully whether the failings I identified caused an injustice to the patient and the complainant. I note that the complainant believed that the experience was detrimental to the patient and that it impacted negatively on both her and her mother, whose recovery was also affected as her mother was also unwell at the time. I also considered that the complainant expressed that she was distressed and felt pressurised by the arrangements put in place to complete the financial forms.

120. I found that, as a result of the failures identified, the patient and the complainant sustained the injustice of lost opportunity to appropriately discuss

concerns about the patient's fitness for discharge, to avail of the Trust's Reluctant Discharge Protocol and be part of the discharge process; the patient sustained the injustice of lost opportunity to have further medical review and appropriate monitoring of his condition; the complainant sustained the injustice of frustration and upset; and the complainant and the patient's wife suffered the injustice of anxiety. I consider, however, that it is not possible to conclude whether the patient's discharge on 10 November 2017 was appropriate or if the patient's deterioration, which led to readmission to AAH two days later, was attributable to the failings in the discharge process. I acknowledge the Consultant Surgeon IPA advised that, based on the records, he considered that the patient was medically fit for discharge; however, I consider that overall, the Trust failed to provide the patient with a sufficient review by a senior doctor and that the lack of a coordinated approach to the patient's discharge gives rise to a continued concern.

CONCLUSION

121. I received a complaint about the actions of the Trust. The complainant said that AAH did not appropriately consider her concerns that the patient was not fit for discharge and that the patient was readmitted to AAH with sepsis two days after his discharge.

122. I investigated the complaint and found a number of failures in the care and treatment of the patient and the complainant. These included failures to act in accordance with a number of relevant standards and guidance; failure to follow-up with the complainant in relation to the concerns she had raised; and a failure to provide appropriate support for the patient and the complainant through the discharge process.

Recommendations

123. I recommend within **one** month of the date of the final report that the Trust provides the complainant with a written apology in accordance with the NIPSO 'Guidance on issuing an apology' for the failings identified and the loss of

opportunity, frustration, upset and anxiety caused to them as a result of these failures.

124. I also consider there are a number of lessons to be learned which provide the Trust with an opportunity to improve its services. I further recommend that the Trust implements an action plan to incorporate the following recommendations and should provide me with an update within **three months** of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings) to:

   i. ensure relevant clinical staff on the ward are aware of their responsibility to escalate in relation to NMC code;

   ii. review the Trust's record-keeping in this case to ensure that nursing and social work staff are meeting the standards required of them in this respect;

   iii. undertake a review of the Trust's position about providing patients with a review by a senior clinician prior to discharge and daily review by a Consultant in adherence with guidelines;

   iv. conduct an audit on discharge planning and practice on the ward;

   v. feed-back the findings in this report to the relevant staff so that they can reflect on their practice and discuss with their appraiser/manager as part of their next appraisal. Evidence should be kept of any reflection and discussion; and

   vi. carry out a random sampling audit of patients' records on the surgery ward, with a particular emphasis on completion of discussions about concerns raised and actions taken in respect of these. The Trust should take action to address any identified trends or shortcomings.

Margaret Kelly
Ombudsman **June 2021**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.

- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being Customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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