Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Northern Health and Social Care Trust

NIPSO Reference: 201916077

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

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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SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust in relation to the care and treatment the Emergency Department staff of Antrim Area Hospital provided to the complainant's son (the patient).

Advice was obtained from an independent Consultant in Emergency Medicine and the investigation established there were no failures in care and treatment provided to the patient by Trust staff on 4 March 2019. The Independent Professional Advisor however did make suggestions in relation to learning and service improvements and I asked the Trust to reflect on the advisor's comments.

I also wish to acknowledge that although I did not establish failures in the care and treatment of the patient, this in no way diminishes the distressing events that the patient and indeed the complainants experienced.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust). This complaint was about the care and treatment the Emergency Department (ED) staff in Antrim Area Hospital (AAH) provided to the complainants' son (the patient) during his admission on 4 March 2019.

Background

2. On 4 March 2019 the patient, who was 20 months old, sustained injuries while playing on a three-wheeler toy in the complainants' kitchen. As a result of the patient's injuries the complainants attended the ED of AAH with the patient. Following triage the patient was seen by Dr A, staff grade in Emergency Medicine, who then sought advice from other ED clinicians as well as additional advice from the Maxillo Facial[1] (MaxFax) Team at the Ulster Hospital (UH) and the on-call Paediatric[2] Dentist in the Belfast Health and Social Care Trust. The complainants ultimately attended their Dental General Practice where the patient's two upper teeth were extracted on the same day.

Issue of complaint

3. The issue of complaint accepted for investigation was:

Whether the complainants' son received appropriate care and treatment from Antrim Area Hospital on 4 March 2019.

INVESTIGATION METHODOLOGY

4. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by complainant. This documentation included information relating to the Trust's handling of the complaint.

[1] Diagnosis and treatment of diseases affecting the mouth, jaws, face and neck.
[2] Relating to the branch of medicine dealing with children.

Independent Professional Advice Sought

5. I obtained independent professional advice from the following independent professional advisor (IPA):

- **Emergency Medicine Consultant,** MRCP, FRCS, FRCEM with 26 years' experience including the treatment of children of all ages.

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

Relevant Standards and Guidance

7. 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[3]:

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

8. 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.

9. The specific standards and guidance relevant to this complaint are:

   - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance) and;
   - Antrim Area Hospital's Doctors Emergency Department Handbook,

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

August 2018 (ED Handbook).

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied I took into account everything that was 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.

THE INVESTIGATION

Whether the patient received appropriate care and treatment from the Trust following his visit on 4 March 2019.

Detail of Complaint:

12. The complainants raised concerns about the care and treatment the Trust provided to the patient. They said that Dr A failed to examine the patient which led to a chain of contact with other hospitals being in vain. Consequently, the complainants believed this resulted in an extended wait within the ED with the patient not receiving treatment. They believed they had no option other than to leave the hospital as they felt completely disillusioned and feared staff were inept.

Evidence Considered:

13. I considered the following policies and guidance:
    - The GMC Guidance
    - The ED Handbook

The Trust's response to investigation enquiries

14. The Trust explained that the following triage the patient *'…was given pain relief and allowed some time to settle. [Dr A] has recorded [the patient's] history. She*

has documented that 2 central incisors mostly pushed back in/ out of the gum and wobbly. Examination would have been difficult, as [Dr A] has noted [the patient] was upset and crying.' The Trust was asked to clarify what assessment Dr A carried out on the patient. It explained that '*An assessment of the child would have included a visual inspection, determination of level of consciousness and if appropriate any relevant physical findings. Examination of children can be challenging depending on age/injury/level of distress…Dr A has documented in the notes that the child had a normal GCS, normal pupillary reflexes to light and accommodation and that the child was upset and crying. She noted that the upper central incisors were pushed into gum and wobbly. This would indicate that she has looked at the child and felt to assess that the tooth was wobbly.'*

15. The Trust went on to explain *'It is noted that the case was discussed with [Dr B] [ED Registrar]. It is not clear from the notes whether [Dr B] examined the patient directly or not. [Dr A] has advised that [Dr B] saw the patient with her in the room. He advised discussing the case with Maxillofacial team in the Ulster Hospital. Often a case is discussed with another doctor which can take several forms, i.e. - notes discussion, general discussion regarding a condition and management thereof or actually going and seeing the patient and then giving advice regarding management plan. The level of documentation regarding this varies,...more commonly it would be put in the notes - 'discussed with' or 'advised by' after the discussion has taken place.'*

16. The Trust also explained that Dr A discussed the patient's case and took advice from senior colleagues, Drs C and D, Consultants in Emergency Medicine. Dr A also discussed the patient with *'..the Maxillo Facial team in the Ulster Hospital and the paediatric on call dentist in the RVH; the advice was consistent with protocols that [the patient] should be seen by his own dentist initially and onward referral made if required…'*

17. In relation to the patient's ED notes the Trust explained *'The patient's ED notes were written up contemporaneously on 4 March 2019 by [Dr A]. The notes dated 6 March are a retrospective account of the interaction after completed by*

Dr A and scanned into the notes after the patients family complained. This is made quite clear by the initial sentence "record of events on day of attendance as I recall it". It is not uncommon to add a retrospective note into the patients ED attendance as long as it is clearly dated and noted as such..' It went on to explain that Mr A, Consultant in Emergency Medicine advised that '…Dr A had made comprehensive notes, her history, examination and management plan were entirely appropriate for [the patient]…' In relation to the retrospective note dated 13 March the Trust explained '..*the legibility of her [Dr A's] retrospective note dated 6 March was not sufficient... [Mr A] has advised [Dr A] that rewriting notes like this should not be done and that the correct way to add something subsequently to notes/report would be via an addendum.'*

Clinical records

18. The ED clinical record documents that the patient was registered in the ED on 4 March at 10:31. At 10.40 observations, including neurological observations were taken and a PEWS[4] Score of 1 recorded. The PEWS score documents under Heart Rate *'distressed ++'* and level of consciousness documented as *'Alert'.*

19. The nursing comments on the ED clinical record documents *'PEWS 1 due to ↑HR, very distressed. Teeth (2 front teeth upper jaw) visable [sic], but not secure appears to be angled back. Paracetamol given, bleeding slowly, mum & dad present.'*

20. Dr A's examination documents *'…GCS 15/15 PERLA, upset, crying. Upper central incisors pushed ??? gum and wobbly. R/V Reg [Dr B]. Refer to maxfax.'*

21. The Working Diagnosis section of the ED clinical record documents *'minor HI, injury to central upper incisors.'* The Management Section documents *'d/w with maxfax SHO…in consultation with her consultant, advised Pt to go to own dentist as baby teeth and do not need fixed. The teeth s??? need to be*

[4] The Paediatric Early Warning Score (PEWS) identifies paediatric patients at risk for clinical deterioration.

checked but dentist needs to do that ?????? or I can d/w Paediatric dentist. Paediatric dentist contacted…advised…to be seen by own dentist first. Same advice by ED Consultant [Dr C]. Parents adamant want him fixed want to talk to consultant in charge. [Dr D] will see.' Dr D documents *'advice as above, 1. oral analgesia 2. see GDP this week.'*

22. The prescription records documents that 168mg paracetamol was given at *'11:00'* and 100mg of ibuprofen was given at '*12MD'*

23. The ED computer records document that Dr A entered that the decision to discharge was taken at 13:34. The computer records also documents that the patient left the department at 15:39. The Trust stated that this record was entered as *'live'.* The Trust response to the complainants, dated 11 April 2019 states the patient *'…was discharged home at 15:38.'*

24. The patient's dental record documents the patient was seen by his general dental practitioner at 14:00.

25. The nurse present in the ED at the time of admission, in response to Trust investigation enquires documents *'…met [patient] and his parents walking out. I asked Dad did they get sorted and he replied 'sort of and we are on our way to the Dentist'…'* No time was recorded.

Relevant Independent Professional Advice

26. The IPA advised that the patient attended the ED as a result of '*…sustaining an injury to his front teeth and a minor head injury.'* He also advised that *'…The current emergency care standard is a triage time of 15 mins of arrival. I would be confident form [sic] the records that [the patient] was seen within 15 mins of arrival in the ED.'* In relation to the findings of the triage examination the IPA advised *'…The triage findings are clear in that [the patient] was distress [sic] as a result of sustaining an injury to his teeth. They mention that his PEWS was 1 (paediatric emergency warning score) is due to the fact that his heart rate was higher than expected …and this was attributed to the fact that he was crying,*

which is perfectly reasonable and commonly seen with this type of presentation.'

27. The IPA was asked about Dr A's initial examination of the patient. He advised *'…the timing of [the patient's] assessment was perfectly reasonable.'* He went on to advise *'…I would conclude that an examination was performed but that this was limited and may have just been a visual inspection of the injury rather than palpating (touching) and feeling the face for bony tenderness or indeed examining the teeth to see how wobbly they were. However, this visual inspection was perfectly acceptable as the child was distressed and did not have an immediate emergency medicine clinical problem that required intervention, such as the airway being at risk or uncontrollable bleeding….' '…The [sic] was no requirement to have sought more clinical information as there was sufficient evidence, form [sic] inspection alone to have made a valid judgment that [the patient] had a dental injury that could be discussed with the max fax team.'*

28. The IPA also advised *'…Dr A recognised that the examination was limited to inspection only and sought advice (and confirmation) from a more senior dr [sic] that nothing further, in terms of a more detailed examination, was required. The ED registrar, [Dr B], reviewed [the patient]…and recognised that it was dental injury that required no immediate intervention by the ED.'*

29. The IPA went on to advise on how the patient's injuries were classified. *'[The patient] was classified as having a minor head injury, which was completely correct and dental trauma, for which dental advice was appropriately sought…in my opinion [the patient's] management plan was entirely in line with the advice in the ED handbook, in that his presentation was discussed with both RBHSC and UHD.'*

30. The IPA was asked to outline any additional advice sought by Dr A. He advised that Dr A *'…spoke to x2 ED consultant, a ED registrar and x2 specialties, all of whom gave consistent advice, confirming [the patient's] treatment would be best managed by his own dentist.'* He further advised that *'…Dr A in seeking*

this advice acted entirely appropriately. I think that the advice for [the patient] to be seen by his own dentist was entirely appropriate.'

31. The IPA further advised on the treatment the patient received in the ED. *'[The patient] had analgesia…and was discharged with head injury advice. His parents were told to seek treatment for his dental injury from his GDP (general dental practitioner).' '…It is not clear…'* if the parents were offered *'….a complaint leaflet, which would have provided them with advice on how to make a complaint against the Trust. This would have been good practice given the situation.'*

32. The IPA commented on the overall time the patient spent in the ED. He advised '[The patient] *arrived at 10:31 and was discharged at 15:39, so was in the ED for 5hrs 8 mins. Although this was outside of the 4 hr ECS[5], it was perfectly reasonable as the standard is 95% of patients must be seen and discharged withing [sic] this time.'*

33. The IPA was asked to comment on Dr A's clinical notes. He advised *'The notes made by Dr A were completely appropriate and included the presenting complaint, past medical history, examination and management plan. I would have expected either the nursing staff or Dr to have recorded if [the patient] was known to social services as this is a standard question to ask which seems to have been omitted (or may not be available to me).*' He went on to advise '*I note that Dr A was asked to record more detail of the encounter and sequence of events...This would not be an uncommon request if a complaint had arisen but might have been dealt with slightly differently in other EDs….Although there is nothing wrong with adding something to the notes, in order to clarify a sequence of events, provided it is signed and dated correctly, in this instance it may have given the impression to the parents that something had not[sic] been recorded incorrectly in the notes and thus questioning Dr A competence, which I think is unfair.'*

[5] Emergency Care Standard

34. In relation to the advice received from an external Trust the IPA advised '*Reasonable practice in recording advice would include the date and time, who Dr A spoke to and what the advice was, followed by a signature of who took this advice…the advice recorded was clear and easy... I note that Dr A did not record the timing of these conversations, but the detail was sufficient…'*

35. The IPA concluded that the patient's *'…assessment and management plan was entirely acceptable and within the trust guidance. Dr A acted responsibly in seeking advice from both her seniors and speciality colleagues.'* He did however identify learning/service improvements. Those being; *'Recording if children are known to social services on presentation to the ED in the notes; Repeating observations prior to discharge..'* and *'Advising clinician [sic] on the trusts policy for making complaints at discharge.'*

Complainants' Response to the draft report

36. The complainants stated that felt that the patient was not treated the way he should have been and he was not properly examined.

Trust's Response to the draft report

37. The Trust provided further information about the system used to record patients' time of departure from the ED *'…the Symphony system does time stamp all entries however if the patient left ED without telling anyone then the time recorded as left department is when this is discovered, which is what happened in this case. There is no simple answer to recording this accurately every time a patient leaves without informing staff as there is no real-time patient tracking.'* The Trust advised there was no intent to deceive in relation to the recording of the departure time from the ED. In relation to reviewing how ED departure times are recorded it went on to *state '…Symphony is not an autonomous live tracking system. It depends on actions being recorded and time stamping this e.g. left department. If a patient leaves without informing staff this action cannot be captured contemporaneously this is not understood to be maladministration. Patients are asked to inform reception if they are leaving the department.'*

38. In response to the learning observation identified by the IPA and recording if children are known to social services on presentation to the ED, the Trust stated *'…this information is held on NIECR[6] if involvement within last 5 years and in keeping with Trust Policy, this information would be routinely asked if there is a concern. However the number of times a patient presents to the ED is printed automatically on the patient's ED record. If there are a number of attendances staff will interrogate this information to identify presenting complaints. This could identify non accidental injury that has not been identified by social services and would be reported through safeguarding processes. This recommendation could be reviewed at ED/Paediatric Safeguarding meeting, which is chaired by designated doctor for safeguarding children and safeguarding children's nurse specialist.'*

Analysis and Findings

39. The complainants raised concerns about Dr A failing to examine the patient in the ED which lead to a chain of contact with other hospitals being in vain. Consequently, the complainants believed this resulted in an extended wait within the ED with the patient not receiving treatment. They believed they had no option other than to leave the hospital just after 13:30 to attend their own general dental practitioner. I further note the complainants' comments that the patient was not treated the way he should have been and their belief that he was not properly examined.

Examination of patient

40. I note from clinical records that the patient had observations taken at 10.40 and the nurse recorded *'PEWS 1 due to ↑HR, very distressed. Teeth (2 front teeth upper jaw) visable [sic], but not secure appears to be angled back. Paracetamol given, bleeding slowly, mum & dad present.'* I further note that Dr A records *'…GCS 15/15 PERLA, upset, crying. Upper central incisors pushed ??? gum and wobbly. R/V Reg [Dr B]. Refer to maxfax.'* and a working diagnosis of '*minor HI, injury to central upper incisors.'* is recorded. I also note

[6] Northern Ireland Electronic Care Record - The Northern Ireland Electronic Care Record (NIECR) is a computer system that health and social care staff can use to get information about your medical history. When treating or looking after you in hospital, they'll need to know about any allergies, long term health conditions or medicine you take.

the Trust's comments that *'…Examination would have been difficult, as [Dr A] has noted [the patient] was upset and crying… An assessment of the child would have included a visual inspection, determination of level of consciousness and if appropriate any relevant physical findings. Examination of children can be challenging depending on age/injury/level of distress…'*

41. I note the IPA's advice that *'…an examination was performed but that this was limited and may have just been a visual inspection of the injury rather than palpating (touching) and feeling the face for bony tenderness or indeed examining the teeth to see how wobbly they were. However, this visual inspection was perfectly acceptable… The [sic] was no requirement to have sought more clinical information as there was sufficient evidence, form [sic] inspection alone to have made a valid judgment that [the patient] had a dental injury that could be discussed with the max fax team.'* I further note the IPA's advice that *'…Dr A recognised that the examination was limited to inspection only and sought advice (and confirmation) from a more senior dr [sic] that nothing further, in terms of a more detailed examination, was required. The ED registrar, [Dr B], reviewed [the patient]…and recognised that it was dental injury that required no immediate intervention by the ED.'*

42. I acknowledge that the complainants believed that Dr A failed to examine the patient however on consideration of the available evidence I accept the IPA's advice that the examination may have been limited to visual inspection but this visual inspection '…*was perfectly acceptable…'.* Dr A also '..*sought advice (and confirmation) from a more senior dr [sic] that nothing further, in terms of a more detailed examination, was required..'* I refer to Domain 1 sections 15 and 16 of the GMC guidance. I am satisfied that Dr A did examine the patient and therefore I do not uphold this element of complaint.

Contact with other hospitals

43. I note from clinical records that Dr A reviewed the patient with Dr B and was advised to '…*Refer to maxfax.'* I also note from clinical records that Dr A '*d/w with maxfax SHO…'* who advised *'…Pt to go to own dentist as baby teeth and do not need fixed. The teeth s??? need to be checked but dentist needs to do*

that ?????? or I can d/w Paediatric dentist…' I further note that the clinical record documents that Dr A contacted the *'…Paediatric dentist…'* who advised *'…to be seen by own dentist first.'* and the *'…Same advice by ED Consultant [Dr C]…'* was provided.

44. I note the Trust's comments that Dr A discussed the patient's case and took advice from senior colleagues, Drs C and D, and also discussed the patient with *'..the Maxillo Facial team in the Ulster Hospital and the paediatric on call dentist in the RVH; the advice was consistent with protocols that [the patient] should be seen by his own dentist initially and onward referral made if required…'*

45. I further note the IPA's advice that the patient's *'…management plan was entirely in line with the advice in the ED handbook, in that his presentation was discussed with both RBHSC and UHD.'* I also note the IPA's advice that Dr A *'…spoke to x2 ED consultant, a ED registrar and x2 specialties, all of whom gave consistent advice, confirming [the patient's] treatment would be best managed by his own dentist.' '…Dr A in seeking this advice acted entirely appropriately. I think that the advice for [the patient] to be seen by his own dentist was entirely appropriate.'*

46. I acknowledge the complainants' concerns and frustration with the contact made with other hospitals and the advice given. However I accept the IPA's advice that Dr A acted *'..entirely appropriately…'* by seeking this additional advice. I also accept the advice provided to Dr A was consistent from both hospitals and indeed was consistent with advice provided by Dr C and Dr D. Therefore I also accept the IPA's advice that '…*the advice for [the patient] to be seen by his own dentist was entirely appropriate.'* I refer to Domain 1 section 16d of the GMC guidance and the ED handbook. I am satisfied that Dr A sought additional advice from both internal and external clinicians and the advice provided was appropriate. Therefore. I do not uphold this element of complaint. However I would request that the Trust ask Dr A reflect on the IPA's advice about the recording of timings of conversations within her notes.

Treatment given

47. I note the prescription record documents that 168mg paracetamol was given at '*11:00*' and 100mg of ibuprofen was given at *'12MD'* to the patient. I also note the clinical records documents that Dr D gave *'advice as above, 1. oral analgesia 2. see GDP this week.'*

48. I note the IPA's advice about the treatment given to the patient that he *'…had analgesia…and was discharged with head injury advice. His parents were told to seek treatment for his dental injury from his GDP (general dental practitioner).*' I also accept the IPA's advice that *'…the advice for [the patient] to be seen by his own dentist was entirely appropriate…'* I further note the IPA's advice the patient's observations should have been repeated prior to discharge.

49. Given the evidence, it is my opinion that the patient received appropriate treatment. Therefore I do not uphold this element of complaint. However, I would also ask the Trust to reflect on the IPA's comments that the patient's observations should have been taken prior to discharge although I accept that this may have been difficult given the complainants' decision to leave the ED.

Time spent in ED

50. I note from clinical records that the complainants and patient were registered in the ED at 10:31. I further note that Dr A entered that the decision to discharge was taken at 13:34. I also note that although the ED computer record documents that the patient left the department at 15:39, the Trust response to the complainants dated 11 April 2019 states the patient *'…was discharged home at 15:39.'* I note the Trust comments that this entry is recorded as *'live'.* and the additional comments provided by it that '…*if the patient left ED without telling anyone then the time recorded as left department is when this is discovered, which is what happened in this case.*

51. I note the complainants' comments that they were not discharged but left the hospital, believing they had no other option, just after 13:30 and that an ED nurse spoke with the complainants as they left the hospital I further note the patient's dental records, from his own dental practice, document he received

treatment from the dentist at 14:00. Although the complainants' comments and the patient's dental records in relation to timings differ from the ED computer record, I have no reason to disbelieve the complainants' comments that they left the hospital without being discharged at a time before 15:39 and acknowledge the Trust's comments that this was the time the departure was discovered.

52. I note the IPA's advice about the length of time the complainants spent in the ED. *'…The current emergency care standard is a triage time of 15 mins of arrival. I would be confident form [sic] the records that [the patient] was seen within 15 mins of arrival in the ED.' '[The patient] arrived at 10:31 and was discharge at 15:39, so was in the ED for 5hrs 8 mins. Although this was outside of the 4 hr ECS , it was perfectly reasonable as the standard is 95% of patients must be seen and discharged withing [sic] this time.'*

53. Given that I accept the complainants' comments that they left the ED prior to the recorded time of 15:39 and this is reflected in the patient's dental record, I am satisfied the length of time the patient and complainants spent in the ED was reasonable and in line with the ECS. Therefore, I do not uphold this element of complainant. However, I wish to acknowledge the complainants frustration at the length of time spent in the ED given the injury to patient and the advice that was ultimately provided.

54. In relation to the recording of the complainants' and patient's time of departure, whilst the Trust have stated this was 15:39. I note the complainants' have stated they left the ED at 13.30 and also note the Trust's explanation as to why this was not recorded until 15.39. I further note the wording within the Trust's letter to the complainants, dated 11 April 2019, which states the patient *'…was discharged home at 15:39.'* and it is my opinion the description of this time as 'discharged', in the letter to the complainants', was misleading and understandably led to confusion during local resolution. Therefore, I would ask the Trust to reflect on how ED departure/discharge times are explained in responses to complaints.

CONCLUSION

55. I received a complaint about the actions of the Trust in relation to the care and treatment the staff of ED in AAH provided to the patient during his admission on 4 March 2019.

56. The investigation of this complaint did not find a failure in the Trust's care and treatment of the patient. In relation to these matters the IPA concluded that the patient's '*…assessment and management plan was entirely acceptable and withing [sic] the trust guidance….'* However, I note the comments of the IPA about learning and service improvements in relation to, recording if children are known to social services on presentation to the ED; repeating observation prior to discharge and; advising patients, or their representatives, on the Trust's policy for making complaints at discharge. I would ask the Trust to reflect on these observations. I note and welcome that the Trust comments, in relation to the learning identified about recording if children are known to social services, that this *'…could be reviewed at ED/Paediatric Safeguarding meeting, which is chaired by designated doctor for safeguarding children and safeguarding children's nurse specialist.'* I also recognise the number of times a patient presents to the ED is recorded and is currently used to identify presenting complaints which could identify non accidental injury that has not been identified by social services and would be reported through safeguarding processes. Although I did not find a failure in relation to the patient's care and treatment, I wish to acknowledge the clear distress both the patient and complainants experienced as a result of the patient's accident.

MARGARET KELLY
Ombudsman **July 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.

APPENDIX TWO

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.