Investigation Report

Investigation of a complaint against Northern Health & Social Care Trust

NIPSO Reference: 201916865

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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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SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust in relation to the care and treatment the staff of Antrim Area Hospital provided to the patient from 20 July 2014 until 5 August 2014. The patient's daughter raised concerns about the treatment provided to the patient during her admission, and the subsequent identification of the patient's severe mitral value regurgitation. She also said there were delays in transferring the patient to the Royal Victoria Hospital for surgery.

Advice was obtained from an independent consultant cardiologist and a coronary care nurse. The investigation established there were no failures in care and treatment provided to the patient by Trust staff during her admission.

I also wish to acknowledge that although I did not find failures in the care and treatment of the patient, this in no way diminishes the experience of the patient and her family during a distressing period of illness.

THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) from a Member of Parliament (MP) on behalf of his constituents, (the patient and the patient's daughter). The complaint related to the care and treatment the staff of Antrim Area Hospital (AAH) provided to the patient from 20 July 2014 until 5 August 2014.

Background

2. On 20 July 2014, after collapsing at home an ambulance transferred the patient, who was 75 years old, to the Emergency Department (ED) of AAH. The patient presented to the ED as being unresponsive. Clinicians completed initial examinations and tests, including chest x-ray, bedside echocardiogram[1] (echo) and a cardiology review. Following a discussion with Dr A, Consultant Cardiologist[2], the patient was considered not stable for transfer to the Royal Victoria Hospital (RVH) Belfast, for further treatment on her heart. Clinicians subsequently admitted the patient to the Intensive Care Unit (ICU) to treat her pulmonary oedema[3]. While in the ICU the patient had a further echocardiogram on 23 July 2014 and was seen by the cardiology team throughout her time in ICU. On 25 July 2014, Dr B, Consultant Cardiologist, reviewed the patient and considered a possible diagnosis of either Takotsubo cardiomyopathy[4] or ischaemic mitral regurgitation[5]. On 29 July 2014 the patient had clinically improved and she was discharged to the Coronary Care Unit (CCU) of AAH for further treatment by Cardiologists.

3. While in the CCU a transthoracic echocardiogram[6] (TTE) was completed on 1 August 2014 on the patient. The TTE indicated severe mitral regurgitation and

[1] A non-invasive test which uses sound waves to build up a detailed picture of the heart. It looks at the structures of the heart, and gives information on the size, shape, and performance of the heart and its valves.
[2] a doctor with special training in diagnosing, treating and preventing the diseases of the heart and blood vessels
[3] condition caused by excess fluid in the lungs
[4] A temporary condition in which there is a sudden enlargement of the heart muscles, usually caused due to extreme emotional or physical stress.
[5] Intermittent mitral regurgitation (blood flowing the wrong way in the heart through the mitral valve)
[6] the most common type of echocardiogram, which is a still or moving image of the internal parts of the heart using sound waves. In this case, the probe (or ultrasonic transducer) is placed on the chest or abdomen of the subject to get various views of the heart. It is used as a non-invasive assessment of the overall health of the heart, including a patient's heart valves and degree of heart muscle contraction.

a transoesophageal echocardiogram[7] (TOE) was requested. On 2 August 2014, before completion of the TOE, the patient deteriorated and was readmitted to ICU. On 4 August 2014 Dr B and Dr C, Consultant Cardiologists carried out a TOE and Dr B discussed the patient's case with a RVH CCU Specialist Registrar. The patient was transferred the following day to the RVH where she underwent mechanical mitral valve replacement and coronary artery bypass grafting on 13 August 2014. The patient sadly passed away on 14 June 2022. A chronology detailing the events leading to the complaint is contained at Appendix five to this report.

Issue of complaint

4. The issue of complaint accepted for investigation was:

Whether the patient received appropriate care and treatment in Antrim Area Hospital from 20 July 2014 to 5 August 2014 in accordance with appropriate policies and standards.

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 relating to the Trust's handling 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 Cardiologist, MD FRCP LLM RCPathME, with over 30 years' experience as a Consultant cardiologist including experience

[7] A Transoesophageal Echocardiogram is a special procedure using an ultrasound probe that is swallowed, similar to endoscopy. This tube rests in the lower end of the gullet (oesophagus). From here, it directs a beam of ultrasound to the heart directly and with no structures in the way. It allows a very clear and accurate multi-dimensional picture of the heart to be built up.

in the management of patients with both acute and chronic heart valve disease and in their investigation and referral for surgery (C IPA)

- Registered Nurse, Msc Advanced Nursing Practice, ENB 124 – Coronary Care Course, with over 24 years' experience cardiology experience (N IPA)

The clinical advice received is enclosed at Appendix two 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 this advice was weighed, 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[8]:
   - The Principles of Good Administration

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:
   - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance); and
   - Royal College of Physicians' (RCP) National Early Warning Score

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

(NEWS[9]): Standardising the assessment of acute-illness severity in the NHS, 2012 (the NEWS guidance).

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account 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 in Antrim Area Hospital from 20 July 2014 to 5 August 2014 in accordance with appropriate policies and standards.

In particular the following elements will be considered under this heading:-

- **Appropriateness of treatment, (including monitoring of oxygen levels, re-admittance to ICU)**
- **Identification of severe mitral valve regurgitation**
- **Patient transfer to Royal Victoria Hospital**

Detail of Complaint

12. The patient's daughter raised concerns about the treatment provided, by cardiology staff, to the patient during her admission, including the identification of the patient's severe mitral value regurgitation. She also raised concerns in relation to the length of time the patient initially spent in ICU, the care provided to the patient when in the CCU, including the monitoring of the patient's oxygen levels and the timing of the decision to re-admit the patient to the ICU.

[9] A guide used by medical services to quickly determine the degree of illness of a patient. It is based on the vital signs.

13. The patient’s daughter raised further concerns that the patient was not transferred to the RVH in a timely manner. She said that delays in transfer and missed opportunities to repair the patient’s mitral valve has, caused lasting damage to the patient’s health which could have been avoided.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies/guidance:
    - the GMC Guidance; and
    - the NEWS guidance.

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

Trust response to investigation enquiries

15. The Trust explained that the patient *‘…was seen by [Dr B, Consultant Cardiologist], on 25 July 2014, he considered the diagnosis could be either a Takotsubo cardiomyopathy…or ischaemic mitral regurgitation…At that time [Dr B] felt there was no indication to transfer [the patient] to the RVH as there was no evidence of ongoing ischaemia and her pulmonary oedema was improving. In addition there were several additional medical issues which needed to be resolved...It was only following a further echo on 31 July 2014 after having been discharged from ICU, that severe mitral values issue was detected. At this point, the plan was to perform further investigation in the form of a TOE…and…to begin investigations for work-up for urgent in-patient mitral valve surgery, which would have included coronary angiography,…pulmonary function tests, dental review and Carotid Dopplers. These tests are generally considered essential before a patient can be considered for in-patient cardiac valve surgery, and cardiac surgeons would typically not consider scheduling surgery until these tests are performed…’*

16. The Trust further explained *'Unfortunately [the patient] deteriorated again on 2 August 2014 and was readmitted to ICU. [Dr B] discussed [the patient's] care with the RVH team on 4 August 2014 and she was transferred when a bed became available the following day…'* It went on to explain '*There was no delay in [the patient] being transferred to the RVH; the underlying cause of [the patient's] condition i.e. severe mitral regurgitation, was not apparent during her initial period in ICU and… she was subsequently transferred following her deterioration to the RVH.'*

Clinical records

17. I enclose relevant extracts from the clinical records at Appendix four to this report.

Relevant Independent Professional Advice

Appropriateness of treatment/Identification of severe mitral valve regurgitation

18. The C IPA advised on the actions of cardiology staff when the patient was in the ED. He advised that *'Stabilising [the patient's] condition was the priority. Diuretics given intravenously were used to treat pulmonary congestion. This is standard cardiological management and in this case would have been essential. I cannot identify any failings given the situation of a critically ill patient who required a number of management steps (diuretic therapy, investigations, sedation, intubation and ventilation) all within a short space of time.'*

19. The C IPA also commented on the actions of cardiology staff during the patient's first admission to the ICU, 20 July 2014 to 29 July 2014. He advised that the reviews undertaken by cardiology staff were *'…reasonable, noting that [the patient] was reviewed regularly by ITU/anaesthetics and by gastroenterology…'* The C IPA further commented on Dr B's diagnosis following the echo taken on 23 July 2014. He advised *'Acknowledging that an echo was available on admission the timing of scans was reasonable…Review on 25/07/2014 considered a number of possibilities that would explain both the clinical and echo features. A major mitral valve issue was not apparent at that stage, and it was therefore reasonable to put [the patient's] illness down to a transient impairment of LV [left ventricle] function which had improved.*

Takotsubo cardiomyopathy was a reasonable thought, as indeed was a transient episode of myocardial ischaemia.' He also advised '*All…measures were reasonable, timely and appropriate.'* In relation to the patient's length of stay in the ICU the C IPA advised *'…The time course was reasonable and she was discharged from ICU at an appropriate juncture.'*

20. The C IPA commented on the actions of cardiology staff during the patient's admission to the CCU. He advised that *'The actions taken were all timely, reasonable and appropriate.' The CIPA further commented on the review on the patient carried out by Dr B following the TTE on 1 August 2014. He advised 'Dr B advised to withhold antibiotics, to take blood cultures in the event of a fever, to arrange a transoesophageal echo (TOE; this provides better images than a TTE), to stay on CCU and to request another chest X-ray…This plan was appropriate.'*

21. The C IPA also commented on the reasonableness of the Trust's response that it was appropriate to begin work-up tests for the mitral valve replacement rather than transferring the patient directly to the RVH for mitral valve surgery. He advised *'This management plan was reasonable as long as the patient's clinical state was stable and thereby allowed workup for surgery to proceed. In an unstable patient in whom surgery was indicated urgently, earlier transfer to a surgical centre is preferable but this was not the case here.'*

22. The C IPA commented on the patient's re-admittance to the ICU on 2 August 2014. He advised the patient *'…deteriorated unexpectedly…with another severe episode of pulmonary oedema and then required readmission to ICU…There was no indication to readmit to ICU earlier as she was noted to be comfortable the previous day.'* The C IPA further advised on the timing of the TOE. He advised '*The timescale initially arranged was appropriate…TOE is not as easy to perform…and requires more preparation and specialised training. Other than in specialist cardiac centres it is not always available "out of hours". I suspect this is why the TOE was performed when it was (i.e. on a Monday). Given that the TTE had shown severe MR,[mitral regurgitation]*

referral to RVH had already been started so I do not feel that any delay in the TOE had a significant impact.'

23. The N IPA provided advice about the monitoring of the patient's oxygen levels while in the CCU. She advised that the patient's oxygen levels were monitored *'…2-4 hourly… until the episode of acute deterioration 01/11/21 at 2350 hrs…'* and *'…observations were recorded more frequently than national recommendations.'* She further advised that *'…During the sudden deterioration, observation monitoring frequency increased to 15-20 minutes…Documentation demonstrates that observation monitoring and treatment given was appropriate for the acute deterioration of the condition prior to transfer back to ICU…escalation to the clinical team was undertaken immediately when the patient suddenly deteriorated…The sudden onset of deterioration was dealt with efficiently and appropriately for the care of this patient…'* The C IPA also advised that he *'…cannot tell from the records whether this [the oxygen supply] was supplied via the piped supply to the ward or from a portable cylinder. It makes no difference in terms of impacting the patient.'*

Patient transfer to the RVH

24. In relation to the timing of the patient's transfer to the RVH the C IPA advised following the findings of the TOE, *'RVH were contacted. The hospital was advised that transfer could be arranged when a [sic] ICU bed at RVH was available...The actions were all appropriate… Referring hospitals have no choice but to be guided by the tertiary centre. It is noteworthy that when [the patient] was transferred on 05/08/2014, surgery did not take place immediately in any event, and was actually undertaken eight days later.'* He went on to advise *'…I do not believe that an earlier referral was indicated. The true nature of [the patient's] MV problem (prolapse) only became apparent on TTE on 1st August, and later clarified on TOE three days later. Referral prior to that time would not have been appropriate… even when eventually transferred, surgery did not take place immediately.'* The C IPA further advised that he did *'…not see evidence that the patient was disadvantaged…'* as a result.

25. The C IPA concluded that '*The patient presented…with the sudden onset of pulmonary oedema requiring urgent ICU care. The cause of her condition was not immediately apparent given that repeated echo scans suggested good LV function and only a mild degree of MR. It was therefore understandable that her condition was felt to be a transient heart muscle problem as opposed to a problem with a heart valve. This difficulty was aggravated by the nature of her valve problem being variable, i.e., initially felt to be mild. It was only when she deteriorated that the TTE revealed severe MR, this due to a flail valve*[10] *seen on TOE…Following TOE, transfer to the local cardiothoracic centre surgery took place the following day and surgery eight days later.'* He further concluded that he had *'…not seen evidence of inappropriate or unreasonable management, or of undue delays. This was not a straightforward case. The patient was critically ill and the underlying diagnosis was initially unclear despite reasonable and timely investigations.'*

Complainant's response to draft report

26. The patient's daughter disagreed with the draft report. She stated the correct diagnosis had been provided by ED doctors and the patient should have been transferred to the RVH in a timely manner when she was stable for mitral valve surgery but instead she was placed on the Liverpool Pathway.[11] She believed the patient's consultants delayed her heart surgery running the wrong tests ie TOE and TEE.

Additional IPA received

27. The C IPA provided additional advice in relation to the comments provided by the patient's daughter. He advised that he *'…had no criticism of the cardiological management…'*

Analysis and Findings

Appropriateness of treatment

[10] Valve having lost its normal support.

[11] A care pathway covering palliative care options for patients in the final days or hours of life. It was developed to help doctors and nurses provide quality end of life care to transfer quality end-of-life care from the hospice to hospital setting.

28. The patient's daughter raised concerns about the treatment cardiology staff provided, to the patient during her admission. She also raised concerns about the length of time the patient initially spent in ICU, the care provided to the patient when in the CCU, including the monitoring of the patient's oxygen levels and the timing of the decision to re-admit the patient to the ICU. I also note the patient's daughter's additional concerns about cardiologists ignoring the diagnosis of ED doctors, the placements of the patient of the Liverpool Pathway and, the appropriateness of the TOE and TEE.

29. In relation to the actions of cardiology staff following the patient's review in the ED on 20 July 2014 the C IPA advised he could not *'… identify any failings given the situation of a critically ill patient…'* I also refer to the C IPA's advice that the findings of the first cardiology review/examination were in line with initial test results etc carried out in the ED department. I also note his advice about the actions of cardiology staff during the patient's first admission in the ICU that *'All…measures were reasonable, timely and appropriate*.' and *'…[the patient] was discharged from ICU at an appropriate juncture.'*

30. I further note the advice of the C IPA that the actions of the cardiology staff, while the patient was in CCU, were *'all timely, reasonable and appropriate.',* and the treatment plan, following the completion of the TTE ON 1 August 2014 *'…was appropriate...'.* I also note his advice that *'There was no indication to readmit to ICU earlier…'* I further note the N IPA's advice that during the patient's time on the CCU *'…The sudden onset of deterioration was dealt with efficiently and appropriately for the care of this patient…'*

31. A review of the patient's ICU records for the periods 20 July 2014 to 29 July 2014 and 2 August 2014 to 5 August 2014 showed no indications that the patient was placed on the Liverpool pathway or receiving end of life care. I hope this provides some reassurance to the patient's daughter.

32. I acknowledge the concerns of the patient's daughter; however I accept the advice of both the C IPA and N IPA. I did not identify any failure in relation to

the appropriateness of treatment the patient received between 20 July 2014 and 5 August 2014. Therefore I do not uphold this element of the complaint.

Identification of severe mitral value regurgitation

33. The patient's daughter raised concerns about the identification of the patient's severe mitral value regurgitation. I note from the clinical records the findings of the echos and TTE taken on, 20 July 2014, 23 July 2014, 31 August and 1 August 2014.

34. I note the C IPA's advice on admission the cause of the patient's condition *'…was not immediately apparent given that repeated echo scans suggested good LV function and only a mild degree of MR…'* I also note his advice that following the echo taken on 23 July 2014 *'…A major mitral valve issue was not apparent at that stage…'* Dr B's diagnosis was appropriate and *'…It was therefore understandable that her condition was felt to be a transient heart muscle problem as opposed to a problem with a heart valve...'*

35. I acknowledge the concerns of the patient's daughter in relation to the identification of the patient's severe mitral valve regurgitation. However, based on the evidence available to me I accept the C IPA's advice that the *'…underlying diagnosis was initially unclear despite reasonable and timely investigations.'*, which included the completion of echo scans. I did not identify any failure in the patient's care and treatment in relation to the identification of her severe mitral valve regurgitation. Therefore I do not uphold this element of the complaint.

Patient transfer to Royal Victoria Hospital

36. The patient's daughter raised concerns that the patient was not transferred to the RVH in a timely manner and these delays caused lasting damage to the patient's health which could have been avoided. I note from clinical records that following assessment in the ED the patient was not stable for transfer to the RVH. I further note that the RVH was contacted to arrange transfer of the patient, following the TOE on 4 August 2014. I also note that immediate

transfer, at that time, was not possible as there was no bed availability but that the patient was transferred to the RVH on 5 August 2014.

37. I note the C IPA's advice that referral prior to the true nature of the patient's mitral valve problem being identified and clarified *'…would not have been appropriate…'* and that he did *'…not believe that an earlier referral was indicated...'* I further note his advice that he did *'…not see evidence that the patient was disadvantaged…'* as a result of the timing of the transfer to the RVH. I also note the advice of the C IPA that the patient had surgery eight days later in the RVH.

38. While I understand the patient's daughter was concerned about the delay in transfer to the RVH, given the available evidence, I did not identify any failure in the patient's care and treatment regarding her transfer to the RVH.

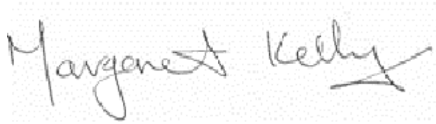
CONCLUSION

39. I received a complaint about the actions of the Trust in relation to the care and treatment the staff AAH provided to the patient during her admission from 20 July 2014 to 5 August 2014.

40. 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 C IPA concluded that he had *'…not seen evidence of inappropriate or unreasonable management, or of undue delays…'*

41. Throughout my examination of this complaint, I recognised the distress experienced by the patient and her family because of the acute onset of symptoms as well the continued distress of resultant health concerns. I hope this report goes some way to address those concerns. I recognise the patient's daughter may not agree with my conclusion. However, I wish to assure her I reached it only after my full consideration of the facts of this case.

42. The Trust accepted my findings.



MARGARET KELLY
Ombudsman **07 September 2022**

Appendix 1

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 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing 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.

2. 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 where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. 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.

4. **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 and actions 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

5. **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.

6. **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 learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.