

# Investigation Report

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## Investigation of a complaint against the Belfast Health & Social Care Trust

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**NIPSO Reference: 202000307**

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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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**Case Reference: 202000307**

**Listed Authority: Belfast Health and Social Care Trust**

## **SUMMARY**

This complaint is about care and treatment the Belfast Health and Social Care Trust, (the Trust) provided to the Complainant's late wife (the patient). The Trust admitted the patient after she attended the Emergency Department of the Royal Victoria Hospital on 23 February 2020 with shortness of breath. It diagnosed and initially treated the patient for community acquired pneumonia. It later treated her for lung adenocarcinoma<sup>1</sup> with pericardial<sup>2</sup> and pleural effusions<sup>3</sup>. The complainant believed the Trust did not adequately treat the accumulation of fluid in the patient's lungs and around her heart. He also said the Trust caused injury to the patient when it removed her chest drain, and that it should have readmitted her earlier when her condition deteriorated at home in April 2020.

I upheld elements of the complaint. The investigation did not identify a failure regarding the procedure the Trust followed to drain fluid from the patient's lungs and pericardium<sup>4</sup>. It also did not find sufficient evidence to suggest the Trust caused the patient injury when it removed a chest drain, or that it failed to provide appropriate aftercare following the procedures. However, the investigation found the Trust failed to consider and arrange an earlier CT scan<sup>5</sup> for the patient. It also identified the Trust failed to document its consideration of using pleurodesis<sup>6</sup>, or any other plan, to manage the recurrence of fluid. The investigation established that the Trust ought to have arranged an urgent chest x-ray for the patient following its telephone conversation with the Complainant on 9 April 2020. It also identified that the Trust failed to provide appropriate advice to the patient or complainant regarding what action they should take if fluid reaccumulated at home. I considered the failings led to a loss of opportunity for the patient to receive an earlier diagnosis and access

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<sup>1</sup> Adenocarcinoma is a type of non-small cell lung cancer (NSCLC), NSCLC is a type of epithelial lung cancer.

<sup>2</sup> Pericardial effusion is a build-up of fluid in the space around the heart.

<sup>3</sup> An abnormal collection of fluid between the thin layers of tissue (pleura) lining the lung and the wall of the chest cavity.

<sup>4</sup> The pericardium is a fibrous sac that encloses the heart and great vessels.

<sup>5</sup> A computed tomography scan is a medical imaging technique used to obtain detailed internal images of the body.

<sup>6</sup> A procedure which involves putting a mildly irritant drug into the space between the lung and chest wall on one side of the chest.

earlier treatment. I also considered they caused both the patient and the Complainant anxiety and uncertainty.

My investigation also identified that the Trust failed to document the reason for the wait the patient experienced for the VAD pericardial window procedure. I considered this a service failure.

I recommended the Trust apologise to the Complainant for the failures identified. I also recommended actions for the Trust to undertake to prevent the failures recurring.

## THE COMPLAINT

1. This complaint is about care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the Complainant's wife (the patient) from 23 February 2020 to 28 April 2020.

### Background

2. At the time of her admission, the patient received steroid treatment for pemphigoid<sup>7</sup>. She had a recurring, persistent cough and shortness of breath, which prompted her to attend the Royal Victoria Hospital's (RVH) Emergency Department (ED) on 23 February 2020. The Trust admitted the patient and treated her for community acquired pneumonia. The patient's blood oxygen levels fell during her admission, and the Trust transferred her to the intensive care unit (ICU) on 29 February 2020. The Trust returned the patient to the ward on 2 March 2020.
3. The Trust diagnosed the patient with metastatic adenocarcinoma<sup>8</sup> on 3 March 2020. The Trust inserted a chest drain<sup>9</sup> to release fluid from a large pleural effusion<sup>10</sup>. This drain remained in place until 13 March 2020. The Trust also drained pericardial fluid from the patient on 11 March 2020.
4. The Trust discharged the patient from hospital on 17 March 2020. The patient developed a cough on 4 April 2020. She called her GP who diagnosed her with a chest infection and prescribed antibiotics. The complainant said the patient's cough worsened and she experienced shortness of breath. The GP prescribed the patient a second dose of antibiotics on 8 April 2020 after another telephone consultation.
5. The complainant said he contacted the Trust's respiratory team on 9 April 2020 as he doubted the GP's diagnosis. The Trust told him the patient should not

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<sup>7</sup> Pemphigoid is a rare autoimmune disorder caused by a malfunction of the immune system and results in skin rashes and blistering on the legs, arms, and abdomen.

<sup>8</sup> Adenocarcinoma is a type of cancer that forms in mucus-secreting gland cells, which are found in tissues that line internal organs. When adenocarcinoma spreads from the initial site, it is described as metastatic.

<sup>9</sup> A chest drain is a tube inserted through the chest wall between the ribs and into the pleural cavity to allow drainage of fluid (pleural effusion) or pus (empyema) out of the chest.

<sup>10</sup> Pleural effusions are an abnormal collection of fluid between the thin layers of tissue (pleura) lining the lung and the wall of the chest cavity

attend hospital due to the increased risk of contracting Covid-19. The complainant said the patient's condition deteriorated further. He explained that on 13 April 2020 he called an ambulance for the patient. The ambulance took the patient to hospital and the Trust readmitted her.

6. The Trust inserted a chest drain on 15 April 2020 to drain reaccumulated pleural effusions. On 23 April 2020, the Trust performed a pericardial window<sup>11</sup> to drain a pericardial effusion. The Trust discharged the patient on 28 April 2020 with the chest drain still in place. The patient sadly died on 29 May 2020.

### **Issues of complaint**

7. I accepted the following issue of complaint for investigation:

**Whether the care and treatment the Trust provided to the patient between 23 February 2020 and 28 April 2020 was appropriate and in accordance with relevant policies and standards. In particular:**

- **Drainage of fluid from the patient's lung**
- **Procedure to drain fluid from the pericardium**
- **Trauma to patient's skin as a result of removing drapes<sup>12</sup>**
- **Advice the Trust provided to the Complainant on 9 April 2020**

### **INVESTIGATION METHODOLOGY**

8. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the Complainant raised. This documentation included information relating to the Trust's complaints process.

### **Independent Professional Advice Sought**

9. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors:

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<sup>11</sup> A pericardial window is a procedure done on the sac around the heart. Surgically removing a small part of the sac lets doctors drain excess fluid from the sac

<sup>12</sup> Chest drapes are used in the operating theatre to protect the patient, staff and equipment during procedures.. Drapes can be made of cloth or paper, and reusable or disposable.

- Respiratory consultant, MBBS, MRCP, PhD, since 2015 (R IPA); and
- Consultant cardiologist, MD, FRCP, with over 30 years' experience of looking after patients with acute cardiac conditions (C IPA).

I enclose the clinical advice received at Appendix two to this report.

10. The information and advice which informed my findings and conclusions are included within the body of this report and its appendices. 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**

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

The general standards are the Ombudsman's Principles<sup>13</sup>:

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

12. 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 British Thoracic Society's (BTS) Pleural Disease Guideline, 2010, (BTS Pleural Disease guidance);
- The British Thoracic Society's (BTS) Guidelines for the management of community acquired pneumonia in adults, 2009, (BTS CAP Guidelines);
- The British Thoracic Society's (BTS) Management of a malignant

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<sup>13</sup> These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.



- pleural effusion 2010 (BTS Pleural Effusion Guidelines);
- National Institute for Health and Care Excellence's (NICE) Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism, NICE Guideline NG89, August 2019 (NICE NG89);
  - National Institute for Health and Care Excellence's (NICE) Venous thromboembolic diseases: diagnosis, management and thrombophilia testing, NICE Guidelines 158, March 2020, (NICE NG158);
  - European Society of Cardiology's Guidelines for the diagnosis and management of pericardial diseases, 2015 (ESC Guidance);
  - Heart's management of pericardial effusion, 2001;(Heart);
  - Cancers' Cancer-Associated Thrombosis: An Overview of Mechanisms, Risk Factors, and Treatment, 2018, (Cancers); and
  - The General Medical Council's Good medical practice, updated April 2019 (GMC Guidance).

I enclose relevant sections of the guidance considered at Appendix three to this report.

13. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.
14. 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**

**Issue: Whether the care and treatment the Trust provided to the patient between 23 February 2020 and 28 April 2020 was appropriate and in accordance with relevant policies and standards.**

## **Detail of Complaint**

15. The complainant believed the Trust should have drained fluid from the patient's lungs earlier. He also believed the Trust should have inserted a catheter<sup>14</sup> when it first drained the fluid.
16. The complainant said the Trust further delayed a procedure to drain fluid from the patient's pericardium. He also questioned the aftercare provided to the patient. The complainant said that had the patient received better care, she would not have developed an ischaemic<sup>15</sup> foot.
17. The complainant said the Trust damaged the patient's skin on two occasions when it removed drapes holding a chest drain in place. He explained the damage to the patient's skin was 'so severe' she required treatment from a dermatologist and had to have the wound dressed until she died.
18. The complainant said he contacted the Trust's respiratory team on 9 April 2020 regarding a deterioration in the patient's condition. He explained the Trust advised the patient to remain at home due to the Covid-19 pandemic.

## **Evidence Considered**

### **Legislation/Policies/Guidance**

19. I considered the following guidance:
  - BTS Pleural Disease guidance;
  - BTS CAP Guidelines;
  - BTS Pleural Effusion Guidelines;
  - NICE NG89;
  - NICE NG158;
  - GMC Guidance; and
  - ESC Guidance pericardial disease

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<sup>14</sup> A catheter is a thin, flexible tube that can put fluids into the body or take them out.

<sup>15</sup> Ischaemic foot is a condition of decreased arterial perfusion.

## The Trust's response to investigation enquiries

### *Drainage of fluid from the patient's lung*

20. The Trust explained its respiratory team assessed the patient on admission as having evidence of *'pneumonia and a gathering of fluid around the lung - a pleural effusion'*. The Trust's initial working diagnosis was *'pneumonia with parapneumonic effusion<sup>16</sup>'*. It said this was the most likely diagnosis given the symptoms, raised blood markers of infection and radiological findings. It said, *'treatment with antibiotics for pneumonia and associated effusion is often sufficient'*. The Trust stated that the *'appropriate initial management of an unexplained pleural effusion is to do an aspiration<sup>17</sup> procedure to remove the fluid, which is what happened'*.
21. The Trust explained it performed a CT scan for the patient on 29 February 2020. It also referred to the patient's biochemistry results. The Trust explained the results confirmed the patient's pleural fluid was *'an exudate<sup>18</sup>'*. It explained the records document the effusion was *'orange in colour and serous<sup>19</sup>'*. The Trust further explained the biochemistry result reported a *'heavily blood-stained pleural effusion'*.
22. The Trust explained that once it drained the fluid, *'there was no fluid remaining for an indwelling catheter to be inserted into'*. It said that to safely insert a catheter, there must be fluid present. The Trust explained *'an indwelling drain catheter would not be the right initial management in an otherwise unexplained pleural effusion'*. The Trust said drain insertion risked further infection given the patient's immunosuppression<sup>20</sup>. It explained this was not a step it would have taken lightly as initial drainage may be sufficient. It acknowledged that *'in [the patient's] case, as can happen in advanced cancer, the fluid did recur'*. It

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16 Pneumonia is a lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid. A parapneumonic effusion is a pleural effusion that forms in the pleural space adjacent to a pneumonia.

17 A pleural aspiration is a procedure where a small needle or tube is inserted into the space between the lung and chest wall to remove fluid that has accumulated around the lung.

18 Fluid that leaks out of blood vessels into nearby tissues (pus).

19 Fluid found in the body, especially in the spaces between organs and the membranes, which line or enclose them, and that when occurring in large quantities, is indicative of a pathological condition.

20 The body's inability to fight infections and other diseases.

explained that once fluid reoccurs, it may consider an indwelling catheter appropriate. The Trust explained it considered '*pleurodesis<sup>21</sup> using a sclerosing agent<sup>22</sup>*' as an option to prevent recurrence of pleural effusion and discussed it with the Complainant. However, it said it decided not to proceed with this form of treatment.

23. The Trust explained it did not conduct a Wells assessment<sup>23</sup> because it did not consider pulmonary embolism<sup>24</sup> (PE) a likely diagnosis '*given the presentation, which was very much in keeping with a likely pneumonia and parapneumonic effusion*'. It explained it does not use Wells scores '*indiscriminately*' as it '*guides diagnosis when PE is suspected rather than used as [a] screening tool without appropriate consideration*'.

24. The Trust explained the patient's adenocarcinoma caused the fluid build-up on her lungs. It said the presence of cancer cells in the initial pleural fluid drainage sample indicated that the patient's cancer was regrettably already at stage four<sup>25</sup> by the time it admitted her to hospital. The Trust added '*the timing of draining the fluid would not have any bearing on the accumulation of fluid around the heart*'. According to the Trust, such an occurrence can result at any time '*in the setting of advanced lung cancer*'. It said that '*drainage of the fluid around the lung in this situation does not reduce the chance of fluid gathering around the heart*'.

#### *Procedure to drain fluid from the pericardium*

25. The respiratory team asked the cardiology service to review the patient after a Transthoracic Echocardiogram (TTE)<sup>26</sup> on 3 March 2020 revealed a collection of fluid around the patient's heart. The Trust said that initially there was

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21 Pleurodesis is a procedure which involves putting a mildly irritant drug into the space between your lung and chest wall (the pleural space), on one side of your chest. This is done to try to 'stick' your lung to the wall of your chest and prevent a further collection of fluid or air in this space.

22 Sclerosing agents are chemical compounds that act as irritants and are used to treat pleural effusions.

23 The Wells score is a number that reflects your risk of developing deep vein thrombosis (DVT).

24 Pulmonary embolism (PE) occurs when a blood clot gets lodged in an artery in the lung, blocking blood flow to part of the lung.

25 Stage IV means that the cancer has spread to other organs or parts of the body. It may be also called advanced or metastatic cancer.

26 A TTE is a procedure used to check for problems with the heart. It will also show any problems in the blood vessels around the heart

insufficient fluid to require draining. It stated that *'Draining fluid from around the heart is a procedure, which carries significant risk and is only performed when the benefit to the patient is greater than the risk of the procedure'*.

26. The Trust explained a second TTE on 10 March 2020 showed an increase in the amount of fluid gathered around the patient's heart. The consultant cardiologist reviewed the patient and made the decision to drain the fluid as it may have caused the patient to become unstable and *'haemodynamically compromised'*<sup>27</sup>. The Trust explained that pericardiocentesis<sup>28</sup> is an emergency procedure. It said it planned to drain the fluid the next day to minimise the risk of the procedure to the patient. However, the Trust said the patient's condition deteriorated as her blood pressure dropped. Therefore, *'it became apparent that this procedure needed performed as a matter of urgency'*. The Trust said it conducted the procedure as planned in the catheter laboratory.
27. The Trust explained that the standard treatment to prevent blood clots developing in inpatients is to administer blood-thinning injections. It said physiotherapy is not part of standard protocol for prevention of blood clots. The Trust referred to NICE NG89 and explained the guidance does not recommend carrying out bed exercises for the prevention of blood clots in hospital.

#### *Removal of Drapes*

28. The Trust explained *'the drapes for the chest drain procedure were fitted with due care and attention'*. It said *'there was no evidence of any skin blistering in the region being covered by the drapes'*.
29. The Trust stated that the medical records showed *'desquamation'*<sup>29</sup> of the skin. It said the dermatology team treated the patient and *'a care plan was put in place after their advice'*. The dermatology team continued to review the patient

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<sup>27</sup> A patient is hemodynamically comprised when there is abnormal or unstable blood pressure, which can cause inadequate blood flow to the patient's organs.

<sup>28</sup> Pericardiocentesis is a procedure done to remove fluid that has built up in the sac around the heart (pericardium). It is done using a needle and small catheter to drain excess fluid.

<sup>29</sup> Desquamation refers to the shedding of the outer layers of the skin.

throughout her admission. The Trust apologised for any discomfort the patient experienced because of the trauma to her skin.

*Advice provided to the Complainant on 9 April 2020*

30. The Trust explained the patient's GP diagnosed her with a possible chest infection and treated it with antibiotics in early April 2020. It said the patient's family asked the hospital's respiratory service if the patient should attend the ED. The Trust explained *'In such situations in normal times, we are usually guided by the GP's assessment and if they had not felt that an A&E attendance was indicated urgently and as they had instituted treatment for infection, we were happy to align with that approach'*. It said that given the first surge of Covid 19 and the patient's weakened immune system, it was *'even more appropriate to avoid an A&E attendance unless it was felt absolutely necessary'*. The Trust said the patient remained at home at this time under the care of her GP.

**Relevant Trust records**

31. I enclose a summary of the records considered during the investigation at Appendix four to this report.

**Relevant Independent Professional Advice**

*Drainage of fluid from the patient's lung*

32. The R IPA referred to the Trust's treatment of the patient for CAP following her admission to hospital on 23 February 2020. She advised the patient had an *'initial CXR<sup>30</sup> performed, had appropriate blood tests performed and had relevant microbiological investigations requested (bloods cultures, sputum cultures and flu swab were requested)'*. The R IPA also advised the patient received appropriate oxygen therapy and antibiotics *'in a timely manner in ED'*. The R IPA advised this was in line with BTS CAP guidelines.
33. The R IPA advised the patient had an elevated D-Dimer score<sup>31</sup> on admission on 23 February 2020. She advised a doctor suspected the patient's

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<sup>30</sup> CXR refers to Chest x-ray.

<sup>31</sup> D-Dimer score is a blood test used to determine the likelihood of a venous thromboembolic event (VTE).

deterioration was due to a suspected PE, and after discussion with senior clinicians, the physician prescribed the patient clexane<sup>32</sup>. The R IPA advised that if a physician suspects a PE, NICE NG158 recommends they perform a D-Dimer test together with a Wells Assessment<sup>33</sup>. The R IPA advised that the patient had an elevated D-Dimer score. However, the records do not evidence the Trust conducted a Wells Assessment.

34. The R IPA advised that *'in itself, a lack of Wells assessment did not constitute a failure in the patient's care or treatment'*. She referred to the Trust's response to this issue and advised, *'the Trust is incorrect...to state that pulmonary emboli were not considered in this patient early on in her presentation'*. She advised the records provide evidence that doctors did consider this as a potential diagnosis and started treatment as such. The R IPA advised the consultant later dismissed this diagnosis during their ward round on 25 February 2020. She further advised that therefore, the Trust's reason for not conducting a Wells score (because it did not consider PE a likely diagnosis) was *'contrary to what is written in the medical notes'*.
35. The R IPA referred to NICE NG158, which states that if medics suspect a PE, they should carry out a CT scan<sup>34</sup>. The R IPA advised that *'CTPA confirmed extensive pulmonary emboli, collapse of her right lower lobe and partial lingular collapse<sup>35</sup>. Right upper lobe consolidation. Moderated sized right sided pleural effusion and a pericardial effusion'*. The R IPA further advised the BTS Pleural Disease guidelines recommend performing a CT scan as part of the diagnostic work-up for *'an unexplained exudative pleural effusion'*. However, she advised it would have been difficult to move the patient to a CT scanner given she was on high flow nasal oxygen. In relation to the timing of the CT scan, the R IPA advised, *'From the medical notes, it appears a CT scan was not considered by the Trust before that date [29 February 2020]. If it was considered, I would*

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<sup>32</sup> Clexane belongs to a group of drugs called anticoagulants. Clexane stops unwanted blood clots from forming and can stop any blood clots that have already formed from growing bigger. Clexane does not break down existing blood clots.

<sup>33</sup> The Wells score is a number that reflects your risk of developing deep vein thrombosis (DVT).

<sup>34</sup> A computerized tomography (CT) scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images (slices) of the bones, blood vessels and soft tissues inside your body.

<sup>35</sup> Partial collapsed lung.

*have expected this to be documented in the medical notes*'. She added, *'A CT scan should have been considered at an earlier date*'.

36. The R IPA advised the respiratory team performed an ultrasound and pleural aspiration on 25 February 2020. She advised the BTS Pleural Disease guidance recommends pleural aspiration as the first diagnostic step when investigating unilateral effusions. The R IPA referred to the colour and PH of the aspirated liquid. She advised *'A chest drain was therefore not definitely indicated at this stage*'.
37. The R IPA advised the Trust sent a sample of fluid to biochemistry for analysis. She referred to the results and advised *'Whilst it may not have changed the management of the patient or her outcome, the Trust should at least have considered the cause of this 'heavily blood-stained pleural fluid' at an earlier stage, and this thought process should have been recorded contemporaneously in the medical notes*'. The R IPA advised the *'cytology sample sent confirmed the diagnosis of metastatic adenocarcinoma in this patient*'.
38. In relation to the procedure to drain fluid from the patient's lung, the R IPA advised an ultrasound (echo-cardiogram) performed on 3 March 2020 showed a pleural effusion measuring four by eight centimetres. The R IPA advised that the BTS Pleural Disease guidelines suggest that a chest drain is appropriate if the patient's prognosis is greater than one month, and the patient is symptomatic. The R IPA advised that therefore, a chest drain was appropriate at this time.
39. In relation to the insertion of an indwelling pleural catheter (IPC), the R IPA advised, *'there was a high likelihood that the pleural fluid would reaccumulate*' and the Trust should have devised an action plan for if/when this would happen. She advised the patient's records do not document such a plan. The R IPA referred to the Trust's statement that it discussed a plan to insert an IPC with the Complainant. She advised the records do not document such a discussion. The R IPA advised the decision to insert an IPC during the patient's second admission was appropriate. She also referred to the Trust's



statement regarding its consideration of *'pleurodesis<sup>36</sup> using a sclerosing agent<sup>37</sup>'*. She advised it is *'conceivable that talc pleurodesis would have been appropriate in this case after [the patient] had completed her antibiotics prior to her discharge'*. However, the R IPA advised the records do not document the Trust's consideration of either of these treatment options for either admission.

40. The R IPA advised the Trust drained the pleural fluid *'at an appropriate time...to help the patient with her breathing'*. She advised *'This patient presented to hospital with a late diagnosis of lung cancer that had already sadly spread to her pleura (lining of the lungs) and pericardium (lining of the heart). By definition, metastatic cancer is incurable. The treatment the patient received did not cause the cancer to 'spread'*.

#### *Procedure to drain fluid from the pericardium*

41. The C IPA advised the Trust first recorded pericardial effusion during a CT pulmonary angiogram<sup>38</sup> performed and reported on 29 February 2020. She advised the effusion measured 1.3cm in depth. The C IPA advised the Trust performed this procedure *'to assess the possibility of pulmonary emboli (clots in the lungs)'*. She further advised *'the effusion was assessed by echocardiography<sup>39</sup>'* on 3 March 2020, which showed it increased in size to 1.7 cm. The C IPA advised that the cardiology team assessed the patient the next day and decided *'there was no indication for drainage.'* The C IPA agreed with this opinion.
42. The C IPA advised the Trust performed a follow up procedure on 10 March 2020, which showed an increase in the size of the effusion to 3cm. The C IPA advised *'There were minor signs that this was affecting cardiac function. [The*

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<sup>36</sup> Pleurodesis is a procedure which involves putting a mildly irritant drug into the space between your lung and chest wall (the pleural space), on one side of your chest. This is done to try to 'stick' your lung to the wall of your chest and prevent a further collection of fluid or air in this space.

<sup>37</sup> Sclerosing agents are chemical compounds that act as irritants and are used to treat pleural effusions.

<sup>38</sup> A CT pulmonary angiogram (CTPA) is a medical diagnostic test that employs computed tomography (CT) angiography to obtain an image of the pulmonary arteries.

<sup>39</sup> An echocardiogram, or "echo", is a scan used to look at the heart and nearby blood vessels. It is a type of ultrasound scan, which means a small probe is used to send out high-frequency sound waves that create echoes when they bounce off different parts of the body.

*patient] was reviewed by the consultant cardiologist, who arranged to drain the effusion the following day’.*

43. The C IPA advised the Trust scheduled a pericardial tap<sup>40</sup> for the morning of 11 March 2020. She said the nursing notes document the patient was comfortable and stable until 13:00 that day. The C IPA advised the records evidence the patient experienced a *‘sudden deterioration with dizziness, light headedness and a drop in blood pressure at 2.15pm’*. The C IPA advised *‘the pericardial tap was therefore performed as a matter of urgency, at 2.30pm’*.
44. The C IPA advised *‘A pericardial tap is often undertaken in a cardiac catheterisation laboratory’*. She explained that laboratories run daily elective lists for procedures which take variable lengths of time to complete, and Trusts fit in urgent or emergency cases as required. The C IPA advised *‘it is therefore difficult to plan an exact time for an urgent procedure’*. The C IPA advised *‘The operation note describes the procedure, and it was carried out in the standard way’*.
45. The C IPA advised the Trust readmitted the patient on 13 April 2020 with breathlessness. She advised the Trust performed an echocardiogram on 14 April 2020, which *‘confirmed recurrence of the pericardial effusion, with a depth of 3.8cm’*. The C IPA advised that after reviewing the patient, the cardiology team *‘suggested a pericardial window to relieve the effusion, but also said they would do an urgent pericardiocentesis if she [the patient] became unstable’*.
46. The C IPA advised the patient *‘received usual care after the pericardiocentesis’*. She further advised staff performed *‘the usual observations, was seen regularly by medical and nursing staff, and the output from the pericardial drain was monitored. The drain was removed after a repeat echocardiogram had shown resolution of the effusion’*. The C IPA advised the Trust completed a ‘Video Assisted Thoracoscopic (VAT) Pericardial Window<sup>41</sup>’ on 23 April 2020.

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<sup>40</sup> A procedure in which a needle and catheter remove fluid from the pericardium, the sac around your heart.

<sup>41</sup> Video Assisted Thoracoscopic Pericardial Window refers to the surgical removal of a small section of the pericardium to allow drainage of fluid.

47. I referred the C IPA to the records relating to the patient's ischaemic foot. She advised the records first document the patient's right foot was '*cold and painful*' in the recovery room after the VAT assisted pericardial window on 23 April 2020. The C IPA advised this was due to a '*thrombus (clot)*<sup>42</sup> *in the popliteal artery*<sup>43</sup> *in the right leg, which might have occurred locally or might have travelled from the aorta*'. The C IPA also advised there was '*no obvious association between the VA[T] pericardial window and thrombosis (clotting)*'. The C IPA further advised there is '*no reasonable proposed mechanism to explain it, other than the thrombotic tendency associated with cancer.*' The C IPA advised the Trust '*treated [the patient] with subcutaneous heparin to reduce the likelihood of clots. This was appropriately stopped the day before the planned surgery*'. The C IPA advised the Trust could not have taken any additional action to prevent development of the ischaemic foot.

#### *Removal of Drapes*

48. The C IPA advised the doctor who inserted the chest drain on 3 March 2020 described the injury to the patient '*as a skin reaction to the dressing*' after they removed the drapes holding a chest drain. She further advised '*the nursing notes record that the top layer of skin was removed, and it appeared like a burn*'. The C IPA advised the dermatologist who reviewed it the next day described it as '*desquamation/sheered skin*<sup>44</sup>'. She advised this was '*a more likely explanation, as [the patient] had been on high dose steroids for about nine months, and this will have made her skin very fragile, and liable to damage*'.

49. The C IPA advised the Trust consulted dermatology, and they dressed the injury regularly based on their advice. The C IPA did not find any reference in the medical records to further injury caused to the patient, or to precautions the Trust took when it later removed the chest drains.

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<sup>42</sup> Blood clots are clumps that occur when blood hardens from a liquid to a solid. A blood clot that forms inside one of your veins or arteries is called a thrombus. A thrombus may also form in your heart.

<sup>43</sup> The popliteal artery is the direct continuation of the superficial femoral artery, at the point where it exits the adductor canal at the adductor hiatus, and passes into the popliteal fossa as the vessel courses posteriorly behind the knee.

<sup>44</sup> Desquamation or sheered skin refers to a condition where the outer layer of the skin starts to replace itself. Often, this happens when skin is damaged, either by diseases or injuries.

*Advice provided to the Complainant on 9 April 2020*

50. The R IPA advised the Complainant contacted the respiratory consultant on 9 April 2020 as the patient experienced a recurrence of her symptoms. The respiratory consultant referred the patient to her GP. The R IPA advised that had the consultant instead arranged for the patient to have an urgent x-ray, it would have established if her symptoms were due to recurrence of the pleural or pericardial infusion. She advised this would likely have led to the Trust readmitting the patient earlier.
51. She advised *'the respiratory consultants would have been aware that metastatic pleural (or pericardial) effusions often reaccumulate and for the above reasons I do think they could have done more to facilitate a timely return to hospital by at least suggesting the patient attends A+E for an urgent assessment. The R IPA further advised 'An earlier admission may have meant that the patient's symptoms of breathlessness were managed sooner. It would not have changed her prognosis'*.
52. The R IPA referred to the patient's discharge letter from her admission in February and March 2020. She advised the Trust should have provided additional information regarding what the patient should do in the event of a reoccurrence of symptoms.

*Complainant's Response to the Draft Report*

53. The complainant explained that the drainage procedure referred to took place over five days. He believed there was ample opportunity during this period to insert an IPC.
54. The complainant explained there was, in his opinion, *'poor communication between the respiratory team and the cardiology team'*. He stated he would have *"expected better liaison between the teams"*.
55. The complainant said he remained strongly of the view that the additional week during which the patient was restricted to lying in bed, increased the risk of blood clots during and after the procedure. He explained he is *'not convinced'*

by the C IPA's advice regarding the cause of the patient's ischaemic foot. He also wished to know if there was a delay in the Trust performing the VAD pericardial window for the patient. The complainant advised the delay was due to the Trust's decision to wait for a specialist anaesthetist. He asked if this cause for the delay was unreasonable.

*The Trust's response to the draft report*

56. The Trust explained that the patient's effusion occurred during the Covid-19 pandemic. It said that pre-pandemic, patients attended Belfast City Hospital (BCH) directly for assessment of worsening symptoms. It explained that patients had a clear pathway enabling them to access medical assessment if they suspected a recurrence. The Trust 'stood down' this facility during the pandemic to release respiratory staff to care for the high numbers of Covid-19 positive patients who required respiratory support. It explained that GPs assessed patients before attending the ED to avoid unnecessary exposure to Covid-19. The Trust said that as the pandemic subsides, it now books patients with suspected reoccurrence for an urgent appointment at the newly established Pleural Clinic at the BCH.

*Further advice from the C IPA*

57. I sought additional C IPA following consideration of the Complainant's response to the draft report. The C IPA advised it took over a week to arrange the VAD pericardial window. She advised that the reason the Complainant outlined (the preference for a specialist anaesthetist) is not documented in the patient's medical notes. She further advised the Trust did not document any reason for the delay in the patient's medical records. The C IPA advised the records indicate that the patient remained stable during the week in which she awaited the procedure.

58. The C IPA advised it is recognised that general anaesthesia, which is usually recommended in patients undergoing surgical (rather than needle) pericardial drainage, has significant risks in patients with pericardial effusion, causing

cardiac compression<sup>45</sup>. The C IPA referred to a general review<sup>46</sup>, which states, '*patients requiring general anaesthesia should preferentially be induced in the operating theatre with the surgeon scrubbed, sterile drapes applied and the surgical equipment ready.*' The CIPA advised it may have been for this reason that the Trust requested a specialist cardiothoracic anaesthetist.

59. The C IPA advised that on 14 April 2020, the patient displayed minor signs of echo of haemodynamic compromise<sup>47</sup>. However, it was '*not sufficient to make a diagnosis of tamponade<sup>48</sup> (in which the pressure on the heart should be treated urgently by pericardial drainage).*' The C IPA advised that as the patient remained stable and was monitored, '*it was reasonable to wait for a specialist anaesthetist to become available.*' She further advised that while the time the patient waited for the procedure was '*disappointing*', she did not identify a clinical failure.

## **Analysis and Findings**

### *Drainage of fluid from the patient's lung*

60. The complainant believed the Trust should have drained the patient's pleural effusion earlier. He said this would have allowed the Trust to diagnose the patient's cancer earlier and start appropriate treatment. The Trust explained the patient presented on 23 February 2020 with symptoms of pneumonia. It said it had '*no reason*' to drain the effusion earlier, and it treated the pneumonia with antibiotics. The R IPA advised the Trust treated the symptoms of pneumonia in accordance with CAP Guidelines. I accept her advice.
61. I considered the investigative tests the Trust performed for the patient following her admission. I note the R IPA advised that the tests showed the patient's D-dimer score was elevated, which may indicate PE. NICE NG158 states that where PE is suspected, clinicians should conduct a Wells assessment.

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<sup>45</sup> This can limit the cardiac output, which is the amount of blood your heart can pump.

<sup>46</sup> Perioperative implications of pericardial effusions and cardiac tamponade (Madhivathanan, Corredor and Smith, BJA Education, 20(7): 226e234 (2020) doi: 10.1016/j.bjae.2020.03.006  
<https://www.bjaed.org/action/showPdf?pii=S2058-5349%2820%2930047-0>

<sup>47</sup> This may occur when there is abnormal or unstable blood pressure, which can cause inadequate blood flow to the organs.

<sup>48</sup> When the fluid sac around the heart fills with blood or other fluid, putting pressure on the heart.

However, the medical records did not evidence the Trust did so. In response to my enquiries, the Trust explained it did not consider it necessary to perform a Wells assessment as it did not suspect PE. However, the R IPA advised that the records clearly document that doctors did suspect PE and commenced treatment for it following the patient's admission. Therefore, I would have expected the records to outline the reasons why the Trust did not consider a Wells assessment necessary.

62. I note the R IPA did not consider the absence of a Wells assessment a failure in the patient's care and treatment. I accept her advice. However, standards 19 to 21 of the GMC Guidance require doctors to keep full and accurate clinical records. These records should include '*decisions made and actions agreed*'. Therefore, I consider the absence of a record of the Trust's reasons explaining why it did not consider a Wells assessment necessary a service failure.
63. I note that NICE NG158 also states that clinicians should perform a CT scan immediately when they suspect a PE. The records document that the Trust performed a CT scan for the patient on 29 February 2020 following her admission to ICU; six days after her admission to hospital. The R IPA acknowledged it may have been difficult for the Trust to perform a CT scan given the patient was on high-flow nasal oxygen. However, she advised that the records do not evidence that the Trust *considered* [my emphasis] an earlier CT scan in accordance with NICE NG158.
64. The R IPA advised that while the delay in performing a CT scan did not impact the patient's prognosis, it would have confirmed the patient's pathology sooner. It also would have led to '*earlier initiation of anticoagulation and might have led to a suspicion of malignancy*'. Based on the evidence available to me, I consider the delay in arranging a CT scan for the patient a failure in her care and treatment. I consider this would have led both her and the Complainant to experience uncertainty regarding her diagnosis. I uphold this element of the complaint.
65. While I identified failings in the Trust's consideration of investigative tests, the R IPA advised that these tests did not indicate a need for the Trust to insert a

chest drain before 3 March 2020. I accept her advice. The R IPA also advised that by the time the patient attended hospital in February 2020, the cancer had sadly already spread to her pleura and pericardium. Therefore, the treatment the patient received did not cause the cancer to spread. I accept her advice and am satisfied the Trust inserted the chest drain at an appropriate time.

66. The complainant also believed the Trust should have inserted an IPC when it initially drained the pleural effusion to prevent recurrence. I note the BTS Pleural Effusion Guidelines refer to IPC as a means to drain fluid for those patients with pleural malignancy. The Trust explained it could not insert an IPC, as following drainage, there was no fluid for it to drain. I note the R IPA questioned in this case if the Trust considered talc pleurodesis as an alternative. The Trust explained it did consider this as an option. However, the medical records do not evidence its consideration or any other plan to put in place if/when pleural fluid reaccumulated. The R IPA advised the Trust should have included such a plan in the patient's medical records.
67. I again refer to standards 19 to 21 of the GMC Guidance, which outline the requirement for doctors to keep full and accurate records. I consider the absence of this plan would have limited the availability of clinical information for staff who became involved in the patient's ongoing care. I am satisfied this represents a failure in the Trust's provision of care and treatment for the patient. I am satisfied this failure led to the patient experiencing a loss of opportunity for staff to consider these records when deciding on her future care and treatment. I uphold this element of the complaint.

*Procedure to drain fluid from the pericardium*

68. The complainant said the Trust recommended the patient have '*an urgent procedure*' to drain fluid from her pericardium on 11 March 2020. He explained the patient became very stressed when the procedure did not take place that morning. The complainant said the Trust later rushed the patient to cardiology to complete the procedure.
69. The records document that an echocardiogram performed on 3 March 2020 identified pericardial effusion. The Trust explained there was an insufficient



level of fluid to perform a pericardial tap at that time. The C IPA advised the records provide evidence that the effusion did not affect the patient's cardiac function. Therefore, she agreed with the Trust's explanation. Having considered the ESC Guidance, I accept her advice.

70. The records document the Trust performed a second echocardiogram on 10 March 2020. It showed an increase in the level of fluid. The C IPA advised the cardiology team identified '*minor signs*' that the fluid affected the patient's cardiac function. Therefore, the team decided to drain the effusion the following morning (11 March 2020). However, I note the Trust did not perform the procedure until 14:30, and only after the patient's condition deteriorated.
71. I considered if this delay was appropriate. The C IPA advised it is difficult to plan an exact time for a procedure in the cardiac catheter laboratory. This is because procedures can take longer than the time allocated to them, and emergency procedures should take precedence. I note that once the patient's condition deteriorated, the Trust performed the procedure urgently.
72. I recognise the stress the delay likely caused the patient. However, I have not identified any evidence to suggest that the Trust failed in its care and treatment of the patient regarding the timing of this procedure. I acknowledge that delays such as this may be unavoidable. However, I consider the Trust can minimise the impact this has on patients by notifying them of the delay and when it expects to perform the procedure. I would ask the Trust to reflect on this and the impact this type of uncertainty has on patients waiting for procedures.
73. The C IPA advised that an echocardiogram on 14 April 2020 following the patient's readmission, confirmed a recurrence of the pericardial effusion. The effusion was associated with minor changes suggesting pressure on the heart. The cardiology team reviewed the patient and suggested a pericardial window to relieve the effusion. However, the team also said they would perform an urgent pericardiocentesis if the patient became unstable. As the patient was stable during the time the Complainant believes there was a delay, the C IPA advised there was no urgency to perform the procedure earlier.

74. In relation to the VAD pericardial window procedure performed on 23 April 2020, the C IPA advised the patient waited more than a week for the procedure. I note that while she considered this '*disappointing*', she did not identify a clinical failure. The C IPA could not establish a definitive reason for the wait. However, she considered the Complainant's statement that the Trust informed him it wanted to wait until a specialist anaesthetist became available. The C IPA considered this reasonable. I accept her advice and do not consider the patient's wait for the procedure a failure in care and treatment. I do not uphold this element of the complaint.
75. I note the C IPA's advice that the Trust did not document the reason for the wait in the patient's records. Standard 21b of the GMC Guidance states that clinical records should include '*the decisions made and actions agreed, and who is making the decisions and agreeing the actions.*' I consider a failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided to patients. I also consider that maintaining accurate and appropriate records affords protection to staff involved in patient care by providing a clear record of their actions and the treatment provided. I note the C IPA did not identify a failure in the patient's care and treatment regarding this issue. Therefore, I consider the absence of this record a service failure. I would ask the Trust to remind doctors of the importance of documenting their decisions and the reasons for them.
76. The complainant also raised concern about the aftercare the patient received following the procedure on 23 April 2020. He said this contributed to the patient developing an ischaemic foot. The Trust explained it administered the patient blood-thinning injections to prevent the formation of clots. It also explained it is not '*standard protocol*' to offer physiotherapy in this situation. I note NICE NG89 does not refer to physiotherapy as treatment for the prevention of clots.

77. The C IPA advised that the patient's ischaemic foot was due to a '*thrombus (clot) in the popliteal artery<sup>49</sup> in the right leg*'. She said it may have occurred locally or travelled from the patient's aorta. The C IPA did not identify an '*obvious association*' between the procedure and the clotting. I accept her advice and consider there is insufficient evidence to suggest the procedure, or aftercare provided, caused the patient to develop an ischaemic foot.
78. The C IPA advised the Trust treated the patient with heparin delivered subcutaneously to reduce the likelihood of clots. It then stopped the injections the day before the procedure, which the C IPA considered appropriate. She also advised the Trust could not have done anything more to prevent the patient's ischaemic foot. I accept her advice and have not identified a failure in the Trust's care and treatment that would have led the patient to develop ischaemic foot. I do not uphold this element of the complaint.

#### *Removal of Drapes*

79. The complainant said the Trust tore the patient's skin when removing drapes holding chest drains in place. He said the patient required treatment for the injury until she died.
80. The Trust explained its dermatology team treated the patient for '*desquamation*' of the skin rather than a skin tear. The C IPA considered this more likely given the patient had been on high dose steroids for a long period of time, which would have caused her skin to become fragile and liable to damage.
81. The complainant said the patient experienced another injury when the Trust removed the drapes a second time in April 2020. However, I note the C IPA advised that she could not find any evidence of an injury in the records referring to this date.
82. I recognise the pain and discomfort the patient experienced because of the trauma to her skin. I also recognise how difficult it would have been for the Complainant to witness his wife experiencing such pain and discomfort.

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<sup>49</sup> The popliteal artery is the primary vascular supply in the region of the knee and lower leg.

Therefore, I have not identified any failure in the care and treatment the Trust provided to the patient when it removed the drapes. I do not uphold this element of the complaint. I note the Trust offered the Complainant an unreserved apology for any pain and discomfort the patient suffered.

*Advice provided to the Complainant on 9 April 2020*

83. The complainant said the Trust should have assessed and readmitted the patient following his telephone conversation with a consultant on 9 April 2020. The Trust said it was aware the patient's GP diagnosed a chest infection and prescribed antibiotics. Also, that due to the Covid-19 pandemic, it wanted to avoid readmitting the patient to hospital.
84. I recognise that in providing this advice, the Trust considered the risk to the patient of contracting the virus. However, I note the R IPA advised there was an increased risk to the patient that the pleural effusion would reaccumulate and require hospital treatment. I am concerned the Trust did not consider this and take appropriate action when the Complainant notified it of the patient's symptoms on 9 April 2020. I accept the R IPA advice that the Trust ought to have arranged for an urgent chest x-ray for the patient to establish if she required treatment for pleural effusion. I consider the Trust's inaction represents a failure in the patient's care and treatment.
85. In her consideration of the patient's discharge records (from her admission in March 2020), the R IPA identified that the Trust did not provide documented advice to the patient or complainant regarding action they should take if the effusions reaccumulated while at home. I consider this a failure in the patient's care and treatment. I accept the R IPA's advice that had the Trust outlined such advice, it would likely have facilitated a more *'timely return to hospital'*.
86. I note the R IPA advised these failures did not impact the patient's prognosis. However, I consider they led to a loss of opportunity for the patient to access earlier treatment. I also consider they caused both the patient and the Complainant anxiety and uncertainty. I uphold this element of the complaint.

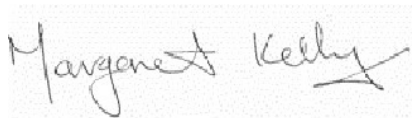
## CONCLUSION

87. This complaint is about care and treatment the Trust provided to the patient from February 2020 to April 2020. I upheld elements of the complaint for the reasons outlined in this report. My investigation identified that the Trust failed to consider and arrange an earlier CT scan for the patient. It also identified that the Trust failed to document its consideration of using talc pleurodesis, or any other plan, to manage the recurrence of fluid. It established that the Trust ought to have arranged an urgent chest x-ray for the patient following its telephone conversation with the Complainant on 9 April 2020. Furthermore, it did not provide advice to the patient or complainant regarding what action they should take if the pleural or pericardial effusion reaccumulated at home.
88. I recognise the impact these failures had on both the patient and the Complainant. I consider they led to a loss of opportunity for the patient to receive an earlier diagnosis and access earlier treatment. I also consider they caused both the patient and the Complainant anxiety and uncertainty.
89. My investigation also identified that the Trust failed to document the reason for the wait the patient experienced for the VAD pericardial window procedure. I consider this a service failure.
90. It is evident from my reading of the records how involved the Complainant was in the patient's care. I recognise the loss and grief he has felt since losing his wife in May 2020, and I do not doubt how difficult it has been for him to progress through this complaints process. I wish to offer through this report my condolences to the Complainant for the sad loss of his wife.

## Recommendations

91. I recommend within **one month** of the date of this report:
- i. The Trust provides to the Complainant a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to him as a result of the failures identified; and

- ii. The Trust shares this report with staff involved in the patient's care and asks them to reflect on the failures identified.
92. I further recommend the Trust provides training to relevant staff within **three months** of the date of my final report. It should provide evidence to confirm completion of the training and that it used the findings in this report as a training tool for staff. The training should incorporate:
- i. Completing and retaining full and accurate records in accordance with standards 19 to 21 of the GMC Guidance (to include documenting their consideration of investigative tests);
  - ii. Performing CT scans for patients they suspect of having pulmonary embolism, in accordance with NICE NG158;
  - iii. The importance of documenting in patients' clinical records a plan to manage recurrence of pleural effusion where this is considered a risk;
  - iv. When to arrange urgent chest x-rays for those patients recently discharged from hospital who are at increased risk of a recurrence of pleural effusion; and
  - v. The provision of advice to patients who are at risk of pleural and/or pericardial effusion, including what action to take should they suspect recurrence following discharge from hospital.



**MARGARET KELLY**  
Ombudsman

**21 February 2023**

## 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.