Investigation Report

Investigation of a complaint against the Southern Health & Social Care Trust

NIPSO Reference: 201916356

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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: 201916356

Listed Authority: Southern Health & Social Care Trust

SUMMARY

This office received a complaint about the actions of the Southern Health and Social Care Trust (the Trust). It related to care and treatment the Trust provided to the complainant's mother (the patient) following her diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion[1] (SIADH) in September 2018.

The investigation examined the details of the complaint, the Trust's response, relevant records, and guidance. I also sought advice from a Consultant in General and Respiratory Medicine (G IPA), a Nephrology Consultant (NP IPA), and a Nurse Practitioner (N IPA). While I initially focused the investigation on treatment provided between December 2018 and February 2019, the investigation established the Trust should have put in place a plan to treat and monitor the patient's symptoms of SIADH from September 2018. However, it did not initiate such a plan until January 2019. I considered this a failure in the patient's care and treatment resulting in her experiencing uncertainty, anxiety, and a loss of opportunity to receive earlier treatment. The investigation found the Trust's care and treatment of the patient during her admissions to hospital from December 2018 to February 2019 appropriate.

The complainant also raised concerns with the Trust's complaints process. The investigation established the Trust failed to address all the complainant's concerns in its response to her complaint. It also found the Trust signposted the complainant to my office without making sufficient efforts to resolve the complaint at a local level. By failing to do so, I considered the Trust did not act in accordance with relevant guidance. I was satisfied this caused the complainant frustration, uncertainty, and the time and trouble of raising her complaint to my office. I recommended the Trust apologise to the complainant for the failings identified. I also recommended action for it to take to prevent the failures recurring. The Trust accepted my findings and recommendations.

[1] Antidiuretic hormone (ADH) controls water reabsorption via its effect on kidney nephrons, causing the retention of water (but not the retention of solutes). By increasing water retention, ADH assists in the dilution of the blood, decreasing the concentration of solutes such as sodium.

THE COMPLAINT

1. This complaint was about the actions of the Southern Health and Social Care Trust (the Trust). It related to care and treatment Daisy Hill Hospital (DHH) staff provided to the complainant's mother (the patient) following her diagnosis of Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH)[2]. It was also about how the Trust handled the subsequent complaint.

Background

2. The Trust diagnosed the patient with SIADH in September 2018. It admitted the patient on three occasions from December 2018. These admissions were from 14 to 19 December 2018, 13 to 14 January 2019, and 27 January to 15 February 2019. The complainant explained the patient's admissions related to her '*chronic and acute presentation of hyponatraemia*[3]'. The patient attended the Psychiatry of Old Age department for assessment and review in January 2019. The complainant said the Psychiatrist considered the patient's difficulties with sodium adversely impacted her mental health. She explained Trust staff failed to refer the patient to an endocrinologist[4] and it did not effectively treat her SIADH condition. The patient contracted hospital acquired pneumonia (HAP) and sepsis on 13 February 2019. She sadly passed away two days later.

3. The complainant raised concerns to the Trust on 31 March 2019. The Trust provided its first response on 6 August 2019. The complainant raised further queries on 6 November 2019. The Trust said it provided its final response on 7 February 2020.

Issues of complaint

4. I accepted the following issues of complaint for investigation:

Issue 1: Whether the Trust provided appropriate care and treatment to the patient between 15 December 2018 and 13 February 2019?

Issue 2: Whether the Trust handled the complaint in accordance with

[2] Antidiuretic hormone (ADH) controls water reabsorption via its effect on kidney nephrons, causing the retention of water (but not the retention of solutes). By increasing water retention, ADH assists in the dilution of the blood, decreasing the concentration of solutes such as sodium.
[3] A low blood sodium level.
[4] An Endocrinologist can diagnose and treat disorders of the endocrine glands and hormones.

appropriate 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 the complainant raised. This documentation included information relating to the Trust's complaints process.

Independent Professional Advice Sought

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

    - A Registered General Nurse with twenty years nursing and managerial experience across both primary and secondary care (N IPA);
    - A Consultant in General and Respiratory Medicine with over 25 years' experience in the field (G IPA); and
    - A Consultant in Nephrology[5] with 20 years' experience treating inpatients with complex health needs including electrolyte imbalance.

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

7. 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

8. 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 make reference to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[6]:

[5] Concerned with all aspects of kidney disease and renal medicine.
[6] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

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

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 Nursing and Midwifery Council Code: Professional standards of practice and behaviour for nurses and midwives, March 2015 (the NMC Code);
   - Guidelines and Audit Implementation Network's Hyponatraemia in Adults (on or after 16th birthday), February 2010 (GAIN Guidelines);
   - The Royal College of Physicians' National Early Warning Score (NEWS2) Standardising the assessment of acute illness severity in the NHS, 2017 (the RCP NEWS guidance); and
   - The Department of Health's Health and Social Care Complaints Procedure (revised April 2019) (DoH Complaints Procedure).

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

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

11. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. Both the complainant and the Trust provided comment on the draft report, the content of which I considered and reflected in changes where appropriate.

THE INVESTIGATION

Issue 1: Whether the Trust provided appropriate care and treatment to the patient between 15 December 2018 and 13 February 2019?

Detail of Complaint

12. The complainant raised the following concerns regarding care and treatment the Trust provided to the patient:

- The medical team did not put in place a suitable plan to treat the patient's symptoms of SIADH. It also did not listen to the family's and the Psychiatrist's view that the patient's low sodium levels caused her increased confusion;
- The medical team disregarded advice from a Renal Consultant, who recommended they seek input from an endocrinologist;
- The Trust did not appropriately monitor the patient's urea and electrolytes[7] (U&E) levels;
- The Trust did not prescribe demeclocycline[8] until 8 February 2019. Furthermore, the medical team did not refer the patient to an endocrinologist so they could prescribe tolvaptan[9];
- The Trust did not appropriately consider a diagnosis of reset osmostat[10] for the patient; and
- The Trust did not inform the patient's family of her HAP diagnosis within a reasonable timeframe.

Evidence Considered

Legislation/Policies/Guidance

18. I referred to the following policies and guidance, which were considered as part of investigation enquiries:

- The NMC Code;
- GAIN Guidelines; and
- The RCP NEWS guidance.

[7] This test checks for chemicals called electrolytes in the blood such as sodium (salt), potassium, and magnesium.
[8] Used to treat infections caused by bacteria including pneumonia and other respiratory tract infections.
[9] Used to treat hyponatremia associated with inappropriate antidiuretic hormone.
[10] A rare cause of hyponatraemia, characterised by a decrease of the threshold of plasma osmolality for the excretion of antidiuretic hormone.

Trust's response to investigation enquiries

Treatment plan

19. The Trust explained Doctor A '*thoroughly investigated'* underlying causes for the patient's hyponatraemia in September 2018.

20. The Trust referred to the patient's consultation with a Trust Grade Psychiatrist in January 2019, who did not consider the patient's symptoms related to a '*psychiatric element'*. It explained the Psychiatrist issued a letter detailing the outcome of her assessment to a '*Medical Consultant Female Medical Ward*'. However, Doctor A did not recall '*receiving or seeing this correspondence prior to [the patient's] subsequent admission under his care on 27 January 2019'*. The Trust said the patient's family provided the letter to Doctor A during this admission. It explained Doctor A '*duly noted*' the Psychiatrist's view. It also said the medical team treated the patient for a urinary tract infection and chronic hyponatraemia. The Trust explained this '*illustrates*' the team actively investigated and treated '*underlying medical complaints*', which may have contributed to the patient's symptoms.

21. The Trust explained Doctor A sought input from a Clinical Biochemist when managing the patient's care and treatment. It said the Clinical Biochemist explained that *'chronic and largely stable serum sodium levels would not have been the predominant cause of this lady's fluctuating cognition/confusion'.* He also explained that other factors would have contributed. The Clinical Biochemist said that *'in his experience, chronic hyponatraemia is highly unlikely to cause severe symptoms unless [sodium] is less than 120mmol/l. It is also rare to find significant symptoms in the 120-125mmol/l range'.*

Endocrine referral and input

22. The Trust said that in January 2019, a Renal Consultant advised the '*current treatment approach was appropriate*'. He also recommended that '*endocrinology be involved for ongoing outpatient*' treatment.

23. The Trust explained that Doctor A's practice has always been to *'involve Clinical Biochemistry in management of chronic hyponatraemia*'. It said that to assist him in the management of the patient's hyponatraemia, Doctor A decided

to take advice from Clinical Biochemistry rather than from endocrinology. The Trust explained Doctor A based this decision on *'their expertise in managing chronic hyponatraemia'* and Doctor A's *'experience of receiving an excellent level of service from the Clinical Biochemistry Department in similar cases in the past'.*

24. The Trust explained that Clinical Biochemistry regularly reviewed the patient's blood tests and provided advice regarding '*starting other agents for her low sodium*'. It said *'at no stage did [the Clinical Biochemist] indicate to [Doctor A] that the patient's chronic low sodium was a matter outside of his sphere of expertise'*. It also said the Clinical Biochemist did not indicate *'that Endocrinology should have been involved instead'.* The Trust explained the Clinical Biochemist *'was clear in his view that the aim of treatment of SIADH in this case (and in general) was to maintain safe serum sodium above 125 mmol/l'.* The Trust explained that Doctor A attempted to '*reassure*' the patient's family on '*several occasions'* that he sought expertise that was *'equivalent to that which would be given by an Endocrinologist'.*

25. The Trust explained that Doctor A informed the patient's family he put '*appropriate measures'* in place to treat the patient. This included *'fluid restriction and slow sodium treatment, Renal review and subsequently Clinical Biochemistry'*. It said the patient showed *'gradual improvements'* in her sodium levels *'with small fluctuations'.* The Trust said the patient's family did not accept this. It explained that Doctor A asked a Consultant Endocrinologist to review the patient in February 2019, and *'his opinion is noted in the medical notes and in the initial Trust complaint response'.*

Monitoring of U&E

26. The Trust explained the patient's family was '*very keen that her U&E be monitored more closely due to fluctuations in her symptoms*'. It further explained the family considered the patient's confusion worsened when staff delayed the administration of her slow sodium tablets. The Trust said Doctor A informed the family the tablets '*did not cause such a sudden improvement in sodium levels within several hours of ingestion (hence the name Slow Sodium)*'. Therefore, '*small delays*' in their administration '*would not have been*

detrimental to [the patient's] sodium levels'. The Trust explained the Clinical Biochemist indicated he did not feel '*more frequent blood tests would change the patient's management…given the slow improvement in sodium levels that was the aim of treatment*'.

27. The Trust said that given the family's concerns, Doctor A '*ultimately agreed to twice daily blood testing*'. However, it was not possible to take blood samples at exact times each day due to '*phlebotomy*[11] *provisions on the Ward*'. The Trust explained that Doctor A did not '*believe that the pattern of monitoring of blood biochemistry altered [the patient's] management plan*'. He also did not consider it would have resulted in a different outcome. The Trust said Doctor A committed to the family that he would take regular blood tests. However, it acknowledged that '*on several occasions this did not happen*'. It said Doctor A acknowledged '*this must have caused distress and upset during a difficult time and for that he can only apologise*'.

Failure to prescribe appropriate medication

28. The Trust explained it initially considered prescribing the patient Demeclocycline in September 2018. It said it only prescribes this medication following advice from Clinical Biochemistry or Endocrinology. The Trust referred to the clinical note from 3 September 2018, which documented, '*d/w (discuss with) clinical biochemistry, ?c/o (commence on) Democycline'*. It explained the note indicated that Doctor A required advice from '*an expert team as to whether this was an appropriate therapeutic option to consider'*. The Trust explained it consulted with Clinical Biochemistry between 3 and 7 September 2018 who did not advise prescription of Demeclocycline for the patient. It considered this appropriate and in accordance with the GAIN Guidelines.

29. The Trust explained the patient's sodium levels following her admission in January 2019 *'were 125, 121 and then 128mmol/l'.* It said the levels improved due to '*fluid restriction and salt supplementation alone'.* The Trust explained that Doctor A *'would not have considered starting Demeclocycline within the first 24-48 hours of admission'.* This is because he *'felt it more prudent to*

[11] When someone uses a needle to take blood from a vein.

observe the situation for 24-48 hours to see what progress was made with the sodium levels, with the conservative interventions mentioned'.

30. The Trust said the Clinical Biochemist agreed demeclocycline should not be prescribed unless the patient's sodium levels fell below 125mmol/l '*for a sustained period*'. It explained he was concerned that administering the medication could lead to *'severe brain damage*'. The Trust said the patient's sodium levels dropped to 125mmol/l on 8 February 2019, which '*led to a reconsideration of the situation*'. It said staff commenced democlocycline at that time.

31. The Trust said the Clinical Biochemist explained he only prescribes tolvaptan when demeclocycline fails '*with sodium remaining persistently less than 125mmol/l and in younger patients*'. He further explained tolvaptan '*can over-correct serum sodium too rapidly in the early stages and lead to significant morbidity and indeed mortality*'. The Clinical Biochemist said he did not '*feel it was suitable at all for this lady with her age, multiple health issues and morbidities*'.

Consideration of reset osmostat

32. The Trust explained staff queried a reset osmostat diagnosis during its morbidity and mortality (M&M) meeting. It said that as the patient *'had chronic hyponatraemia with symptoms which were considered (at least in part) to be attributable to this, then it was considered to be entirely appropriate to undertake treatment measures to attempt to slowly increase (but not necessarily normalise) the sodium level'.*

33. The Trust further explained that reset osmostat '*does not usually induce symptoms and it does not require treatment'.* It said that given the patient's symptoms, the medical team considered it '*appropriate that efforts were made to correct the low sodium i.e. treating this case as SiADH rather than reset osmostat'.* The Trust said this is especially as the patient's family were concerned *'the chronic hyponatraemia was having a detrimental effect and was primarily responsible for the symptoms'.*

Communication of HAP diagnosis

34. The Trust explained the patient *'was increasingly short of breath on 11 February 2019'.* It said chest x-rays on 11 and 12 February 2019 *'showed no evidence of pneumonia'.* However, given the patient's other symptoms and blood results, staff commenced antibiotics for a *'probable lower respiratory tract infection (there was no radiological evidence of pneumonia at that stage)'.*

35. The Trust explained the patient's antibiotic treatment was '*escalated to Tazocin*[12] *in the evening of 12 February 2019'.* However, staff did not perform a further chest x-ray at this time. Therefore, *'it is not possible to say whether pneumonia was present at that time or not'.* The Trust explained the patient's condition deteriorated in the early hours of 13 February 2019. It said *'a repeat [chest x-ray] showed pulmonary oedema (fluid on the lungs) and left-sided consolidation*[13]*'.* The Trust explained the symptoms and the x-ray were *'consistent with hospital acquired pneumonia'.* It said a doctor attended to the patient at 04:00 on 13 February 2019 and informed her family of the diagnosis. The Trust further explained High Dependency Unit (HDU) doctors also discussed the diagnosis with the patient's family upon her transfer. It said this *'indicates that [the] family were informed at the earliest opportunity'*.

Relevant Trust records

36. A summary of the relevant records is enclosed at Appendix five to this report.

Relevant Independent Professional Advice

General and respiratory consultant IPA (G IPA)

Treatment Plan

37. The G IPA advised the patient was '*hyponatraemic on 28 July 2018*'. However, staff did not diagnose SIADH at that time. He advised staff first arrived at a '*working diagnosis*' of the condition on 1 September 2018. The G IPA advised the medical team treated the patient *'appropriately for this with fluid restriction'.*

38. I referred the G IPA to the patient's admission on 14 December 2018. He advised she presented with anxiety, agitation, confusion, and increased urinary

[12] A medication active against bacteria which causes serious infections including chest infection.
[13] The alveolar airspaces are filled with fluid, cells, tissue, or other material.

frequency. The G IPA further advised the patient's sodium level was 126. He advised this was '*broadly similar*' to previous sodium levels. The G IPA advised doctors treated the patient with antibiotics for a possible urinary tract infection (UTI).

39. I referred the G IPA to the patient's admission on 13 January 2019. The G IPA advised the medical team prescribed slow sodium medication. He said this was '*appropriate treatment for hyponatraemia'.*

40. I asked the G IPA if the Trust appropriately monitored the patient's SIADH symptoms each time staff discharged her from hospital. He advised the records indicate staff arranged for the patient's GP to check her sodium levels in the community. He advised that '*in this context, it was not appropriate because of the persistent and recurrent hyponatraemia.'*

41. I asked the G IPA to consider the complainant's view that the patient's low sodium level contributed to her confused state. He referred to the clinical records, which document occasions when the patient becomes '*more lucid as her sodium level increased to normal levels*'. However, he also advised '*there are occasions when she was reported as lucid despite low blood sodium levels*'. The G IPA referred to three potential reasons for the patient's increased confusion; small vessel ischaemia concern, urinary tract infection, and hyponatraemia. He advised that '*given the documented lack of a tight and consistent relationship between her serum sodium levels and the severity of the [patient's] confusion, it is difficult to not conclude that her confusion was multifactorial*'.

42. I asked the G IPA to consider the Psychiatrist's correspondence about the patient. He advised the Psychiatrist referred to the complainant's belief that hyponatraemia significantly contributed to the patient's mental state. However, he advised that *'neither of the letters from the psychiatrist offers the definitive opinion that the hyponatraemia was contributing to [the patient's] symptoms*'. The G IPA advised that while her opinion was not definitive, he considers the Psychiatrist's correspondence *'misled*' the complainant '*as to the principal cause of her mother's confusion*'. The G IPA also referred to the Psychiatrist's

letter dated 28 January 2019, which documents the patient was confused when her sodium level was 129. He advised he would not associate a level of 129 with confusion.

43. In relation to the overall plan of treatment for the patient, the G IPA advised staff failed *'to instigate a coordinated plan of investigation of the patient's hyponatraemia from the time of diagnosis*'. He further advised that if staff put in place '*a clear plan of monitoring*' from July 2018*, 'this complaint could have been avoided'.* The G IPA advised that staff's management of the patient's treatment from January 2019 was in accordance with the GAIN guidelines. However, this was six months after SIADH first presented. The G IPA advised*; 'it is hard to disagree with the family's assertion that [the patient's] hyponatraemia was not managed correctly'.*

44. I asked the G IPA to consider how the failings may have impacted the patient. He advised that '*even if earlier definitive treatment had been successful in maintaining higher levels of sodium, I do not think her terminal pneumonia, progression in her cerebrovascular*[14] *disease or her recurrent urinary tract infections would have been prevented*'.

Endocrine referral and input

45. The G IPA advised the medical team sought endocrine input on 12 February 2019. I asked if he considered this timely. The G IPA advised endocrinologists do not '*universally manage*' hyponatraemia. He advised it is '*more commonly the province of general physicians*'. The G IPA referred to the patient's experience and advised that '*advice had been sought from a renal physician and a clinical biochemist, both appropriate sources of expertise*'. He said for this reason, he considered the referral '*timely*'. He also advised the referral did not lead to any recommendation for alternative therapy.

Failure to prescribe appropriate medication

46. The G IPA advised staff prescribed demeclocycline for the patient on 11 February 2019. He advised it was appropriate for doctors to prescribe the medication at this time, and it is commonly used to treat SIADH. The G IPA

[14] A range of conditions that affect the flow of blood through the brain.

advised it was unlikely earlier administration of demeclocycline would have resulted in a different outcome.

47. I asked the G IPA if earlier involvement of an endocrinologist to prescribe tolvaptan for the patient was appropriate. He advised he remained of the opinion that '*earlier involvement of the endocrinologist would not have altered the outcome'*.

Consideration of reset osmostat

48. The G IPA advised reset osmostat is a '*hypothesis*' constructed to explain why some patients remain hyponatraemic despite efforts to maintain sodium within '*normal levels*'. He further advised it is unlikely a diagnosis of reset osmostat would have impacted the patient's condition or treatment, *'beyond cessation or relaxation of efforts to try and correct her sodium level'.*

Communication of HAP diagnosis

49. The G IPA referred to the care and treatment staff provided to the patient on 12 and 13 February 2019. He advised the medical team reviewed the patient at approximately 13:00 on 12 February 2019 and prescribed doxycycline[15]. He further advised that following a deterioration in the patient's condition, staff escalated the treatment to tazocin at 1830.

50. The G IPA advised staff informed the patient's family of the HAP diagnosis at approximately 04:00 on 13 February 2019. He considered this appropriate.

Nursing IPA (N IPA)

Monitoring of U&E

51. The N IPA advised that nursing staff took blood samples for the patient in accordance with the NMC Code for the patient's admissions in December 2018, and from 13 to 14 January 2019.

52. The N IPA advised nursing staff took morning U&E bloods from the patient following the Renal Consultant's instruction given on 28 January 2019. This continued until 1 February 2019. The medical team's instruction then changed

[15] An antibiotic used to treat bacterial infections.

to a request for daily U&E bloods until 5 February 2019. She advised staff took bloods a second time that day following a request from the complainant. The N IPA advised daily bloods were again taken until 8 February 2019. From this date, staff took blood samples from the patient twice daily due to administration of demecocycline.

53. The N IPA advised it is not possible to establish the exact time staff took the blood samples as the records only document when they reviewed the results. However, she advised nursing staff took blood samples '*either once daily or twice daily as directed by the medical team'*. The N IPA further advised it is not always possible to document events *'as they happen'*, as it takes time away from the delivery of patient care. She advised staff therefore use charts to simplify documentation. The N IPA advised the NMC Code requires staff to record notes as soon as possible after the event, which is what occurred in this instance.

54. The N IPA advised that on 12 to 13 February 2019, nursing staff's actions were *'timely and appropriate'.* She advised the staff's *'NEWS response times were in line with RCP (2017)*[16] *and the patient was escalated to the medical team and physio as per national standards (NMC Code)'*.

Nephrology IPA (NP IPA)

Monitoring of U&E

55. The NP IPA advised that clinicians request early morning blood testing for two main reasons. The first is because they require the results early for clinical decision making. The second is to measure something that changes rapidly after medication. The NP IPA advised that in the patient's case the medication was slow sodium, which is absorbed over a number of hours.

56. The NP IPA advised the intra-day variation of sodium is '*not clinically relevant'* for patients with chronic hyponatraemia. He advised the most useful data is from the '*longer term trends on daily blood tests'*. The NP IPA further advised

[16] Royal College of Physicians (2017) National Early Warning Score (NEWS2) Standardising the assessment of acute illness severity in the NHS. The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements such as oxygen saturation, pulse rate and temperature.

that taking bloods to monitor U&E levels at different times of the day, regardless of medication taken, will not affect the outcome.

Medication

57. The NP IPA advised that demeclocycline is a second line treatment. Therefore, medical staff should only consider it if a patient's levels do not improve following fluid restriction and administration of slow sodium tablets (first line treatment).

58. The NP IPA referred to the decision not to prescribe the patient demeclocycline in September 2018. He advised that the patient's improved blood tests and clinical condition demonstrated that she responded to interventions made at that time (other than demeclocycline). He further advised that the GAIN Guidelines do not recommend demeclocycline as treatment for hyponatraemia, and it is also '*associated with significant potential side effects'*. Therefore, the NP IPA advised the decision not to prescribe the patient demeclocycline in September 2018 was '*appropriate*'.

59. The NP IPA advised the medical team's decision to start demeclocycline from 8 February 2019 was appropriate as it was apparent the first line treatment stopped working.

60. The NP IPA advised that tolvaptan is a third line treatment and doctors should only introduce it when all other medications fail. He further advised the medical team prescribed appropriate medication for the patient during her admission.

Consideration of reset osmostat

61. The NP IPA advised that to confirm a diagnosis of reset osmostat, the medical team would first have had to rule out a diagnosis of SIADH. He further advised in this situation, the medical team would not have been able to treat the patient as they did. The NP IPA advised that given the patient's symptoms, it was '*unlikely*' the medical team would have stopped treatment to make this diagnosis.

The complainant's response to the draft report

Treatment plan

62. The complainant considered that if clinicians treated the patient appropriately and earlier, she would not have needed to remain in hospital, and therefore would not have contracted hospital acquired pneumonia. She also disagreed with the view that the outcome would not differ even if the patient received earlier treatment. The complainant also referred to the view that earlier involvement of Dr A would have meant earlier drug administration, which she considered would have resulted in a different outcome.

63. The complainant referred to the biochemist's view that patients do not usually display symptoms unless their sodium level is under 120. She disagreed with this view and explained it is not just the level that causes symptoms but also the fluctuations.

64. The complainant explained the investigation should consider the link between low sodium levels and the patient's confusion. This is because of the multi-factorial element as it led to a '*compounding*' of the patient's symptoms. She said it is unreasonable to disregard its relevance and dismiss it entirely.

Endocrine referral and input

65. The complainant disagreed with the Trust's view that Dr A sought expertise that was '*equivalent to that which would be given by an Endocrinologist'*. She explained the Endocrinologist suggested different medication. She also said the Trust later recommended obtaining advice from an Endocrinologist for all hyponatraemia cases going forward.

66. The complainant also disagreed with the finding that referral to an Endocrinologist was timely. She said the Renal Consultant recommended referral to an Endocrinologist on 31 January 2019 but staff did not refer the patient until 12 days later.

67. The complainant disagreed with the finding that earlier referral would not have altered the patient's course of treatment. She explained that if staff referred the

patient to an Endocrinologist earlier, she would have received tolvaptan earlier, and the outcome may have been different.

Monitoring of U&E

68. The complainant clarified the family was concerned about staff's monitoring of the patient's sodium levels throughout the day. They were also concerned about the patient's rapid drop in sodium, which they believed caused her fluctuating symptoms.

69. The complainant explained the Renal Consultant requested '*early AM'* blood tests to measure U&E levels. However, staff instead took bloods throughout the day and after the patient took sodium medication. She believed this impacted the U&E results, which then affected the treatment provided. The complainant considered that taking early morning blood tests would have generated different results, and the outcome would have been different.

70. The complainant referred to the N IPA's advice that it was not possible to establish when staff took the patient's bloods as the records only document the time staff reviewed the results. They said this was not in accordance with the NMC Code, which states that staff must time their records.

71. The complainant disagreed with the Trust's view that the patient's sodium levels showed a gradual improvement.

Medication

72. The complainant disputed the suggestion that doctors commenced treatment with demeclocycline appropriately. She said the Trust considered prescribing the patient demeclocycline as early as September 2018. However, it did not do so for further a further five months.

73. The complainant explained that on 5 February 2019 the patient's blood results showed a significant drop in sodium levels compared to the previous day, despite several doses of sodium administered. The complainant said the medical team still delayed appropriate treatment, and instead, the patient received fewer blood tests and more doses of slow sodium.

74. The complainant also questioned if prescribing and administering tolvaptan earlier would have altered the patient's pathway.

Communication of HAP to the family

75. The complainant said staff administered medication for HAP at 18:30 on 12 February 2019. She considered it was more appropriate for doctors to communicate the working diagnosis to family at that time rather than early the next morning.

Analysis and Findings

Treatment Plan

76. The complainant raised concerns about the Trust's failure to establish a suitable plan to treat the patient's SIADH. I note the complainant specifically referred to the Trust's failure to consider the Psychiatrist's belief that low sodium levels caused the patient increased confusion. The records document the patient attended the Psychiatrist in January 2019. I also note that in her correspondence to the medical team, the Psychiatrist said she did not feel they were '*dealing with a psychiatric illness, but a physical illness'*. However, I accept the G IPA's advice that the Psychiatrist did not definitively relate the two issues.

77. I note Doctor A explained he did not have sight of the Psychiatrist's letter prior to meeting with the family in late January 2019. However, he considered the opinion alongside other possible underlying factors. He also consulted a Clinical Biochemist who did not consider the patient's sodium levels caused her confusion. I note from the records there were occasions when the patient appeared lucid despite low sodium levels. I also note the G IPA advised medical staff treated the patient for a UTI and a small vessel ischaemia concern, both of which could have contributed to her increased confusion. He also advised the confusion may be multifactorial. This suggests low sodium could be a contributory factor but not the sole cause. I note the complainant's view that the multi-factorial element led to a '*compounding*' of the patient's symptoms. However, I do not consider there is sufficient evidence to establish a link between the patient's low sodium levels and her confused mental state.

78. To identify if the Trust established an appropriate treatment plan for the patient, I considered her clinical records. The records document the Trust first treated the patient for hyponatraemia in July 2018. However, doctors did not diagnose SIADH until September 2018. While my investigation focused on the period between December 2018 and February 2019, I note the G IPA's advice that the records do not provide evidence the Trust put in place a plan to treat the patient following its diagnosis up until January 2019. I accept the G IPA's advice that by failing to do so, the medical team did not appropriately manage the patient's condition as an outpatient during this time.

79. I also considered if the Trust appropriately monitored the patient's condition. I note that upon her discharge from hospital in both December 2018 and January 2019, the medical team expected the patient's GP Practice to monitor her sodium levels within the community. However, I note the G IPA's advice that by January 2019, the patient experienced *'persistent and recurrent hyponatraemia'.* Therefore, I accept his advice that in this context, it was inappropriate for Trust staff to expect the GP to monitor the condition in the community.

80. Based on the evidence available to me, I consider the Trust failed to put in place an appropriate plan to monitor and treat the patient's condition until January 2019. I also note the G IPA's advice that Trust staff acted in accordance with its GAIN Guidelines from this date. However, it only did so six months after staff first suspected SIADH. I consider this a failure in the patient's care and treatment resulting in a loss of opportunity for her to receive earlier treatment. I also recognise the uncertainty and anxiety the complainant and her family would have experienced as a result of this failure.

81. While I identified this failure, I note the G IPA's advice that it is unlikely earlier treatment would have prevented the progression of the patient's cerebrovascular disease, or the infections that ultimately caused her death in February 2019. I accept his advice. I also note the G IPA's opinion that an earlier treatment plan would have avoided the need for a complaint. However, I

consider this a hypothetical postulation, and there is no way to know whether or not earlier action would have alleviated the complainant's concerns.

82. I appreciate the complainant's view that had medical staff established an appropriate treatment plan earlier for the patient, she would not have had to attend hospital where she contracted HAP. However, having considered the hypothetical scenario posed by the complainant, I do not believe given the range of variables involved it is possible to make a finding on what may have happened had staff acted differently.

Endocrine referral and input

83. The complainant raised concerns with the Trust's failure to refer the patient to endocrinology earlier than February 2019, despite a Renal Consultant's recommendation. I note the records document that a Renal Consultant recommended endocrine input on 29 January 2019. However, he recommended '*long term follow up as an outpatient'* rather than immediate treatment as an inpatient. The outpatient referral did not occur as the patient sadly passed away while in hospital.

84. The G IPA advised it is common for general physicians to treat patients with hyponatraemia. I also note Doctor A sought input from a Renal Consultant and a Clinical Biochemist, which the G IPA considered '*appropriate*'. The clinical records document Doctor A eventually sought endocrine input on 12 February 2019. However, the records evidence the Endocrinologist considered the medical team's actions up until the referral '*appropriate*'. Based on the evidence available, I consider Doctor A's decision not to initially refer the patient to endocrinology appropriate. I do not uphold this element of the complaint.

85. I acknowledge the complainant's view that had staff referred the patient earlier, the Endocrinologist would have prescribed tolvaptan earlier. However, I note the NP IPA's advice regarding tolvaptan, which he said doctors usually only consider if they identify that demeclocycline is no longer effective. Therefore, I do not consider it likely, in that scenario, that the Endocrinologist would have prescribed tolvaptan earlier.

Monitoring of U&E

86. The complainant said the Trust failed to appropriately monitor the patient's U&E levels during her admission in February 2019. She explained that despite the Renal Consultant's instruction to take '*early AM'* blood tests, nursing staff took them at various times throughout the day, and after administering slow sodium tablets.

87. The records document the Renal Consultant gave this instruction to staff on 28 January 2019. The N IPA advised nursing staff took morning blood samples until 1 February 2019, after which medical staff requested '*daily U&E'*. The N IPA further advised that nursing staff again appropriately followed this instruction. I accept her advice.

88. In her response to the draft report, the complainant also questioned nursing staff's failure to document the exact time they took the patient's bloods. The N IPA advised it is not always possible to document events in the records as soon they happen. I note the NMC Code requires staff to document records '*as soon as it is possible after the event'*. Having reviewed the records, I note that while staff did not document the exact time they took the samples, they did document their actions and time stamped that record. I accept the N IPA's advice that in that case, nursing staff acted in accordance with the NMC Code.

89. In consideration of the complainant's comments, I asked the NP IPA if taking early morning blood tests would have generated different results. He advised that taking bloods at different times of the day, regardless of medication taken, will not affect U&E levels. I accept his advice. I hope this reassures the complainant that taking blood samples at various times during the day did not impact the results.

90. The complainant also raised a concern about staff's failure to check the patient's U&E levels twice daily. I note Doctor A agreed with the complainant to conduct twice daily checks from 5 February 2019. However, staff took bloods only once daily on 6 and 7 February 2019.

91. I considered the patient's clinical records and the 'blood book', which documents requests for blood tests. I am unable to find any evidence to suggest the medical team requested nursing staff to take samples of the patient's blood twice daily on 6 and 7 February 2019. Therefore, I accept the N IPA's advice that nursing staff took the patient's blood samples as '*directed by the medical team'*.

92. I note that while Doctor A did not consider it necessary to monitor U&E levels more frequently, he assured the complainant he would arrange for twice daily blood tests. This is despite the GAIN Guidelines recommending only daily checks of U&E levels. Although he set this expectation, Doctor A failed to pass the instruction to nursing staff. I note he acknowledged this failing and apologised for it. I would ask the Trust to remind staff to consider this when managing the expectations of those close to patients, and to follow through on agreements made.

Medication

93. The complainant was concerned the Trust initially considered prescribing demeclocycline for the patient in September 2018. However, it did not do so until 8 February 2019.

94. The Trust explained that following advice from the Clinical Biochemist in September 2018, it decided not to prescribe demeclocycline at that time. I note the GAIN Guidelines do not recommend this medication for treatment of hyponatraemia. I also note the NP IPA's advice that as the patient responded to other treatment, and given the risk of side effects, the decision not to prescribe demeclocycline at that time was appropriate. I accept his advice. I appreciate the complainant's concern that the Trust first considered prescribing demeclocycline as early as September 2018. However, based on the evidence available, I am satisfied its decision not to do so at that time appropriate. I do not consider its decision a failure in the patient's care and treatment.

95. I note that based on advice from the Clinical Biochemist, the medical team decided not to prescribe demeclocycline until the patient's sodium levels remained below 125 mmol/l even with other treatment. I note the patient's

levels dropped on 8 February 2019, and it was at that time Doctor A commenced demeclocycline.

96. I appreciate the complainant's concern that the patient's levels dropped from 132mmol/l to 127mmol/l between 5 and 6 February 2019. However, the level remained above 125mmol/l. Furthermore, the records evidence the patient's level increased the following day to 129mmol/l. I also considered the NP IPA's advice that demeclocycline is a second line treatment and the medical team were correct to introduce it only after failure of the first line treatment. Therefore, based on the evidence available to me, I accept the G IPA's advice that the decision not to prescribe this medication before 8 February 2019 was appropriate.

97. The complainant also said staff did not seek endocrinology input to allow them to prescribe tolvaptan to treat hyponatraemia. I note her comments regarding the decision not to prescribe tolvaptan until late in the patient's treatment, and only after involvement of an Endocrinologist. The records evidence that Doctor A initially consulted a Clinical Biochemist rather than an Endocrinologist when deciding on treatment for the patient. As I outlined previously in this report, I considered his decision appropriate.

98. The NP IPA advised that tolvaptan is a third line treatment and doctors should only consider it when all other treatments fail. The records evidence the medical team introduced the medication only after attempting fluid restriction and slow sodium medication (as first line treatment), and demeclocycline (as second line treatment). I accept his advice that the medical team's decision to follow this treatment plan was appropriate. I do not uphold this element of the complaint.

Consideration of reset osmostat

99. The medical team first raised the question of this diagnosis during its M&M[17] meeting on 20 February 2019. However, the complainant said staff did not consider it a cause for the patient's hyponatraemia.

[17] Morbidity and mortality meetings provide a rigorous, systematic, open, collaborative and transparent review process for clinicians to examine areas of improvement.

100. I note both the Trust's comments and the NP IPA's advice that to confirm a diagnosis of reset osmostat, the medical team would have had to cease treatment of the patient. The Trust explained that given the patient's symptoms and the family's views, the medical team did not consider this action appropriate. I note the NP IPA also did not consider the option of stopping treatment a possibility. Based on the evidence available, I consider the medical team's decision not to consider a reset osmostat diagnosis appropriate. I do not uphold this element of the complaint.

Communication of HAP with the family

101. The complainant said the Trust failed to inform the patient's family of her HAP diagnosis within a reasonable timeframe. I note from the records the patient's condition started to deteriorate on 12 February 2019. However, chest x-rays performed that day and the following day did not support a HAP diagnosis. The records also document staff prescribed and administered antibiotics at 18:30 that day. However, the records evidence they did so as a precaution in the absence of a confirmed diagnosis.

102. The records document the patient became distressed at 03.30, and very distressed at 04.00. Staff then performed an urgent ECG and chest x-ray, which confirmed a HAP diagnosis. I note it was at this time staff communicated the diagnosis to the patient's family. I accept the G IPA's advice, and consider it appropriate that staff waited until tests confirmed the diagnosis before they informed the family. I do not uphold this element of the complaint.

Issue 2: Whether the Trust handled the complaint in accordance with appropriate standards?

Detail of Complaint

103. The complainant said staff identified learning '*with respect to patient care*' at its M&M meeting on 20 February 2019. She raised concerns the Trust failed to clarify the learning identified despite her requests for it to do so. The complainant was also concerned the Trust failed to respond to specific

questions she raised regarding the patient's care and treatment in her complaint.

Evidence Considered

Legislation/Policies/Guidance

104. I referred to the following guidance, which I considered as part of investigation enquiries:

- The DoH Complaints Procedure.

Relevant extracts of the guidance is enclosed at Appendix four to this report.

The Trust's response to investigation enquiries

Clarification request following the morbidity and mortality meeting

105. The Trust explained staff discussed the patient's case at the M&M meeting so that *'education and learning could take place around what was a very difficult case'*. It said the meeting focused on the management of hyponatraemia, the involvement of other specialists, the contribution of hyponatraemia to the patient's decline and subsequent death, and concerns the family raised.

106. The Trust explained the meeting concluded that staff sought appropriate specialist input and managed the case appropriately. It said the meeting identified learning that '*COULD [its emphasis] be improved'*. However, it established *'the patient's eventual outcome was not affected'*. The Trust explained staff identified *'that in future cases, the managing physician can formally request a joint MDT [multi-disciplinary team] discussion between Clinical Chemistry, Endocrinology and Renal to provide ongoing advice in the management of chronic hyponatraemia.'*

Responses to the complainant's outstanding concerns

107. The Trust explained it received correspondence from the complainant on 6 November 2019. It said the complainant sought clarification for questions she felt the Trust did not fully address.

108. The Trust said it wrote to the complainant on 7 February 2020. The letter documented, *'after thorough consideration of the additional questions and*

issues raised in your email, it was agreed that the best way forward for you and your [family], in order to gain the most impartial, independent response to your concerns, would be for you to refer your complaint to the Northern Ireland Public Services Ombudsman'.

Analysis and Findings

109. The complainant said the Trust failed to respond to questions she raised in her letter sent to the Trust in November 2019. In particular, it failed to clarify the learning staff identified in an M&M meeting held on 20 February 2019.

110. I refer to the Trust's first response to the complaint, issued on 9 August 2019. I note in this letter the Trust advised the complainant to '*contact a member of the Clinical and Social Care Governance Team'* if she had any queries regarding its response. This was so the Trust could *'attempt to resolve any outstanding issues'*. I note the complainant did so in her letter dated 6 November 2019. However, in its second response to the complainant, dated 7 February 2020, instead of responding to any of her queries as was originally offered, the Trust signposted her to my office.

111. I note in its response to my enquiries, the Trust explained it considered this '*the best way forward*'. I refer to Section 3.45 of the DoH Complaints Procedure, which states the *'HSC organisation should offer every opportunity to exhaust local resolution'*. I also refer to Section 25 of the 2016 Act, which places an obligation on a statutory body to signpost a complainant to NIPSO when the complaints procedure is exhausted. I consider it clear from the Trust's first response to the complainant (August 2019), that it did not consider the complaints process exhausted at that time. I also consider it set an expectation in its letter that it would respond to the complainant's additional queries. I consider the Trust directed the complainant to NIPSO without making sufficient effort to address the considerable number of issues she raised. In failing to do so, I consider the Trust did not act in accordance with the DoH Complaints Procedure. I also consider that in failing to fully consider and respond to the complainant's queries, the Trust failed to act in accordance with Standard 6 and paragraph 3.44 of the DoH Complaints Procedure

112. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned*'. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with complaints promptly and avoid unnecessary delays. Furthermore, the Third Principle of Good Complaint Handling requires bodies to provide full, clear and evidence based explanations for their decisions. I consider the Trust failed to act in accordance with these Principles in its handling of the complaint. I uphold this issue of complaint.

113. I consider that had the Trust fully and appropriately responded to the complaint, the complainant may not have gone to the trouble of raising her concerns to my office. I also consider the Trust's failure caused her frustration and uncertainty.

CONCLUSION

114. I received a complaint about the actions of the Trust regarding the care and treatment it provided to the patient between 15 December 2018 and 15 February 2019. It was also about the Trust's handling of the complaint. I uphold one element of the complaint for the reasons outlined previously in this report.

Recommendations

115. 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 as a result of the failures and maladministration identified;

    ii. The Trust discusses the findings of this report with the staff involved in the patient's care at their next staff appraisal, and reminds them of the importance of putting in place a suitable treatment plan following diagnosis of SIADH; and

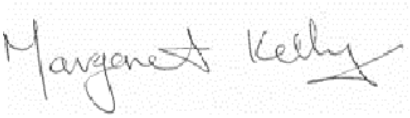
    iii. The Trust's Chief Executive reminds staff charged with the responsibility of investigating complaints of the need to address all elements of the complaint in its written response, in accordance with the DoH Complaints Procedure. Furthermore, the Chief Executive should remind relevant staff of the importance of making sufficient

efforts to resolve complaints in a timely manner at a local level before signposting the complainant to my office.

116. I recommend the Trust undertake an audit of record keeping to include a review of a random sample of records relating to the treatment of patients diagnosed with SIADH in the past three years. The Trust should ensure staff have put in place an appropriate treatment and monitoring plan for the patients. It should provide my office with an update on its audit within **three months** of the date of my final report.

117. I note the G IPA's comment regarding the quality of the patient's clinical records. Having reviewed the records, I agree they were, at times, unclear and difficult to follow. I acknowledge staff often have a short space of time to record and file their notes. However, I also recognise the importance of clear records, especially for those who become involved in the patient's ongoing care. While not a formal recommendation, I would ask the Trust to remind relevant staff to make sufficient efforts to ensure their notes are clear and retained in an order that is easy to follow.

118. I wish to offer my condolences to the complainant and her family on the loss of their mother. It is clear the complainant was keen to ensure her mother received the highest level of care and treatment available. I hope the information contained in this report answers some of the remaining questions she had in relation to the care provided to her mother.



MARGARET KELLY
Ombudsman **February 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 relevant guidance 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.