Investigation of a complaint against the Northern Health and Social Care Trust

Report Reference: 202001526

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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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Listed Authority: The Northern Health and Social care Trust

SUMMARY

I received a complaint about the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) in Antrim Area Hospital from 14 March 2021 to 11 April 2021. The complainant raised several concerns, including the management of discussions about 'Do Not Resuscitate'; the assessment of the patient's delirium/confusion; the decision not to give the patient a second Covid vaccination; the patient contracting Covid; communication with the patient's family regarding the patient's positive Covid test while in hospital; the ability to visit or engage with the patient; and the patient's nursing care. Sadly, the patient passed away in hospital as a result of Covid.

The investigation upheld a number of areas of the complaint and identified further areas where the care provided was not to the required standard. The Trust delayed in assessing the patient's capacity to make decisions and therefore denied the opportunity for either him or his family to be involved in decisions affecting his care and treatment for a period in the early stages of his care.

Of particular concern was the lack of documentation in support of the Trust meeting the patient's personal care and nutritional needs alongside the complainant's account of how she found the patient when she was permitted to visit and his development of a pressure ulcer. I consider the Trust failed to meet the patient's fundamental physical needs. I consider this constitutes a failure in care and treatment of the patient and indicates the Trust did not have appropriate regard to the patient's rights regarding dignity and autonomy. I therefore uphold this element of the complaint. In this area, the Trust failed to act in line with a range of guidance. This included national guidance and the Nursing and Midwifery Code in relation to the patient's personal care and nutrition; the patient's family experienced upset about his personal care and nutrition, especially in the context both of Covid, when he had no one to visit him, and his vulnerable state, when he may not have known the care was not appropriate. I also consider the patient's family experienced continuing uncertainty about whether appropriate nursing care would have made a difference to the patient's experience. I consider those public bodies which

provide care for elderly people have an enhanced responsibility to be vigilant in ensuring patients' needs are met when their vulnerability makes it more difficult for them to articulate their concerns and they have no one to speak on their behalf, as was the case due to restricted visiting and access for family members.

The Trust failed to follow good practice and the Nursing and Midwifery Code in relation to communicating with the patient's family about the patient's Covid-positive status; and the Department of Health's Covid Visiting Guidance during the patient's first week in hospital. The investigation also identified a failure to manage discussions about resuscitating the patient in line with good practice, as the discussion did not take place as soon as possible, whilst the patient was in the Emergency Department.

The investigation established, because of the failings identified, the patient experienced unnecessary discomfort; and the patient and his family experienced upset, uncertainty and lost the opportunity to ensure decisions about his care and treatment at first admission were in keeping with the patient's wishes.
I recommended the Trust apologises to the complainant and her family. I also recommended the Trust:

- ensures staff are reminded of the importance of relevant guidance and good practice;
- conducts a review of documentation and practice in nursing care, particularly in relation to personal care, nutritional monitoring and mobility assessments; and
- ensures relevant staff have the opportunity to reflect on the independent professional advisors' full advice.

I recommended the Trust should provide evidence of the implementation of these recommendations through the provision of records of information sharing and training and sample audits within six months.

I would also wish to convey my sincere condolences to the complainant and her family.

THE COMPLAINT

1. This complaint concerned the care and treatment the Northern Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) from 14 March to 11 April 2021.

Issues of complaint

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

Issue 1: Whether the care and treatment the Trust provided to the patient from 14 March to 11 April 2021 was appropriate and reasonable and in accordance with relevant standards and guidance.

In particular, this will consider:

i. The assessment of the patient's clarity of mind on admission and during his period of hospitalisation;
ii. Decisions about the administration of a second Covid vaccination to the patient;
iii. The patient's admission to a ward with Covid patients;
iv. Nursing care of the patient, including personal care;
v. Access to the patient from his family both in person and by telephone;
vi. Communication with the patient's family about the patient contracting Covid; and
vii. Management of 'do not resuscitate' discussions with the patient and his family.

INVESTIGATION METHODOLOGY

3. To investigate this complaint, the Investigating Officer obtained all relevant documentation from the Trust, 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

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

- A Consultant Physician/Geriatrician (MBChB MRCP(UK) DipPallMed); with 11 years' experience as a Consultant Physician/Geriatrician;

- A Consultant in Emergency Medicine (MB ChB FRCS FRCEM DIMC); with 18 years' experience as a Consultant in Emergency Medicine; and

- A nurse (MSc Advanced Clinical Practice, BSc (Hons) Nurse Practitioner, MA Health Service Management, Registered General Nurse (RGN), Diploma in Adult Nursing, Diploma in Asthma, Diploma in Chronic Obstructive Pulmonary Disease (COPD), V300 Non-medical prescriber); a senior nurse with 21 years' experience.

I enclose the Consultant Physician/Geriatrician's professional advice at Appendix three, the Consultant in Emergency Medicine's professional advice at Appendix four and the Nurse's professional advice at Appendix five to this report.

5. I included the information and advice that informed the findings and conclusions within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

6. To investigate complaints, I must establish a clear understanding of the standards, both of general application and of 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[1]:

- The Principles of Good Administration.

7. The specific standards and guidance referred to are those that 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:

- National Institute for Health and Care Excellence (NICE): Delirium: prevention, diagnosis and management in hospital and long-term care, Clinical Guideline (CG 103), March 2019 (NICE Delirium Guidance);
- Mental Capacity Act (Northern Ireland), 2016 (Mental Capacity Act);
- Nursing and Midwifery Council Code, October 2018 (NMC Code);

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

- National Institute for Health and Care Excellence (NICE): Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition Clinical Guideline (CG32), August 2017 (NICE Nutrition Guidance);
- Department of Health Covid-19: Regional Principles for Visiting in Care Settings in Northern Ireland, 26 February 2021 (DoH Covid Visiting Guidance);
- National Institute for Health and Care Excellence (NICE): Covid-19 Management, March 2020 (NICE Covid Management Guidance);
- National Institute for Health and Care Excellence (NICE): Covid-19 Rapid Guideline: Critical Care in Adults, March 2020 (NICE Covid-Adult Care Guidance); and
- Public Health/National Health Service: COVID-19: Guidance for maintaining services within health and care settings-Infection prevention and control recommendations, 21 January 2021 (PH/NHS Covid-Infection Control Guidance).

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

9. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Detail of Complaint

10. Each element of the complaint is addressed separately below, including the details of the complaint, the evidence considered and analysis and findings for each element of the complaint.

Trust's response to investigation enquiries

11. As part of investigation enquiries, the Trust had an opportunity to respond to the complaint. The Trust's response to my enquiries related to the complaint is at Appendix two to this report.

i. ***The assessment of the patient's clarity of mind on admission and during his period of hospitalisation***

12. The complainant said the patient's records indicate he was admitted to the Trust hospital with acute confusion but she believed he was not confused. In support of this view the complainant said she understood the family liaison officer concurred with her view, as the patient spoke about his family and was not confused.

Evidence Considered

Legislation/Policies/Guidance

13. I considered the NICE Delirium Guidance, the NMC Code, NICE Nutrition Guidance, the DoH Covid Visiting Guidance and the PH/NHS Covid-Infection Control Guidance. Key extracts from the relevant policies and guidance are included either within the Independent Professional Advisors' advice at Appendices three and five or at Appendix six, as appropriate.

Relevant Trust Records

14. I reviewed the patient's medical records for 14 to 16 March 2021.

Relevant Independent Professional Advice

Consultant in Emergency Medicine Advice (CED IPA)

15. The CED IPA advised, following triage it was recorded the patient had '*right sided abdominal pain, new onset confusion and delirium'* and this reflected the ambulance patient report which noted '*delirium early morning severe'.* The CED IPA advised the ED diagnosis included, *'Delirium secondary to urinary tract infection*'. The CED IPA further advised the receiving doctor at admission recorded at 02.29 on 15 March 2021, a *'fluctuating confusional state'* for the patient and, at 09.20, the receiving medical consultant reviewed the patient, at which point the patient knew his name, age and date of birth but did not know where he was. The CED IPA advised at 11.30, it was recorded that, following a conversation with the patient's daughter, the patient had *'new confusion over weekend, hallucinating.'*

16. The CED IPA advised it is common for elderly patients to develop acute confusional states due to urinary tract infections. He further advised, '*based on the records, the assessment of delirium appears appropriate'*. The CED IPA further advised, whilst in ED, the *'assessment of the patient's clarity of mind was reasonable and appropriate'.*

Consultant Physician/Geriatrician advice (CPG IPA)

17. The CPG IPA advised, the Emergency Department assessment records indicate a '*history was obtained from the patient's daughter which highlighted that the patient had had a few days of new onset confusion/delirium'.* The CPG IPA also advised delirium was detailed on the ambulance record. The CPG IPA advised, further to admission, there were daily assessments of the patient's orientation and alertness. The CPG IPA advised, based on both the assessments and history obtained, it was concluded the patient had delirium, and which the CPG IPA advised '*does seem likely … intermittently at least'.*

18. The CPG IPA further advised, it was not clear, however, if the patient had capacity to make decisions about his care. The CPG IPA advised, there were no records of the patient's capacity to make decisions about his medical care/treatment and which, she advised, in line with NICE Delirium Guidance should be undertaken when admitted. The CPG IPA advised this is important because if a patient lacks capacity to make decisions about their care, the Mental Capacity Act is relevant. The CPG IPA advised this requires that checks be made to identify who may hold legal powers for decision-making on the patient's welfare or who may have Power of Attorney and which may also involve others such as close family or carers to clarify a patient's wishes.

19. The CPG IPA advised, '*beyond initial emergency medical care on first presentation, further treatment needs to be based upon a patient's ability to decide on their treatment (or if they lack capacity to decide, this needs to be undertaken using the principles of the Mental Capacity Act with involvement of any welfare Power of Attorney, and/or close family/carers to help determine what the patient's likely wishes would be)'.* The CPG IPA advised, based on the records, she suspected

'*there were a significant number of days when the patient would have lacked decision-making capacity'.* The CPG IPA advised, an assessment of the patient's decision-making capacity should have been undertaken when admitted as an in-patient, with appropriate action taken in line with the Mental Capacity Act, as appropriate, and this should then have been reviewed daily.

Analysis and Findings

20. I note the CED IPA advised, '*the assessment of delirium appears appropriate'.* The CPG IPA advised, *'there were daily assessments of the patient's orientation and alertness … based on both the assessments and history obtained, it was concluded the patient had delirium'* and which the CPG IPA advised *'does seem likely … intermittently at least'.*

21. I accept the CED IPA and the CPG IPA's advice and am satisfied the assessment of the patient's confusion was appropriate. Therefore, I do not uphold this element of the complaint.

22. I note, however, the CPG IPA's advice about the failure to assess the patient's capacity to make decisions when admitted as an in-patient, in line with NICE Delirium Guidance. I refer to the NICE Delirium Guidance which states '*within 24 hours of admission, assess people at risk for clinical factors contributing to delirium*' and these include, *'Age 65 years or older. Cognitive impairment (past or present) and/or dementia (for guidance on diagnosing dementia, see the section on diagnosis in the NICE guideline on dementia). If cognitive impairment is suspected, confirm it using a standardised and validated cognitive impairment measure … Observe people at every opportunity for any changes in the risk factors for delirium.'* From review of the records the patient presented to ED at 20.44 on 14 March 2021 and was received on the ward as an admitted in-patient at 19.30 on 15 March 2021. The first record relating to the patient's decision-making capacity is dated 16 March 2021.

23. I accept the CPG IPA's advice. I also consider the records indicate there was no consideration of the patient's capacity before 16 March 2021. I therefore consider the Trust did not act in accordance with the NICE Delirium Guidance in failing to

conduct an appropriate capacity assessment in a timely manner. I consider this constitutes a failure in care and treatment.

Injustice

24. I considered carefully whether the failure caused an injustice to the patient and his family. I consider, because of the failure, the patient and his family lost the opportunity to ensure decisions about his care and treatment at first admission were in accordance with the patient's wishes.

Detail of Complaint

ii. *Decisions about the administration of a second Covid vaccination to the patient*

25. The complainant said the patient did not have Covid when he was admitted to hospital and was due to have his second Covid vaccination on 23 March 2021 but the patient was not given or offered his second vaccination at the hospital.

Evidence Considered

Relevant Trust Records

26. I considered the patient's medical records from the period 14 to 16 March 2021.

Relevant Independent Professional Advice

CPG IPA advice

27. The CPG IPA advised, the patient *'would not have been medically fit to receive a [vaccination/Covid booster] dose at the time due to his acute presentation with delirium and renal impairment.'* She further advised, there would have been no impact on the patient from not receiving a further Covid vaccination as, even if he was fit to receive this and was given it on admission, this would not have taken effect in time to reduce his chances of contracting Covid a week later as it effectiveness requires an average of two weeks. The CPG IPA concluded she had *'no concerns*' about the actions related to the Covid vaccination.

Responses to the Draft Investigation Report

28. Both the complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. Where appropriate, comments have been either reflected in changes to the report or are outlined in paragraphs 29 and 30 below.

The complainant's response

29. The complainant disputed the Trust's statement concerning the reason for the patient not being given a second covid vaccination at or during the early stage of his admission. The complainant said, when she asked about the patient getting his second covid vaccination, she was informed the hospital did not carry covid vaccinations and at no point was she told the patient was too frail to receive the vaccination.

Further Enquiries Following the Draft Investigation Report Responses

30. Following the complainant's comments in response to the Draft Investigation Report, described in paragraph 29 above, I made further enquiries of the Trust. Specifically, whether the Trust held Covid vaccinations at the hospital and to describe the process in place at that time for administering any necessary vaccinations to in-patients. The Trust stated it was recorded the complainant informed Family Liaison the patient was due to receive his second Covid vaccination. The Trust stated the process in place at that time for such circumstances was to provide the relevant site with vaccination stock if a patient required a vaccination and *'met the eligibility criteria'*. The Trust further stated, the patient was exposed to Covid on 21 March 2021 and, therefore, his second vaccination could not be administered for a period of 28 days. The Trust also stated there was no *'documentation to support the statement that [the complainant] was advised the hospital did not stock vaccinations'.*

Analysis and Findings

31. In reviewing the records referenced in paragraph 26 above, there are no records which indicate the Trust informed the complainant it did not carry Covid vaccinations.

32. Whilst there are no records of the Trust informing the complainant it did not have covid vaccinations, I refer to the Trust's response to further enquiries that the process at that time was when a patient required a vaccination and was eligible, a vaccination would be provided to the relevant site. In the absence of records, I cannot definitively determine if the Trust told the complainant this; however, I consider the process the Trust described indicates vaccinations were not necessarily held on site and which reflects the complainant's understanding of the situation. I also consider, however, this would not have prevented the Covid vaccination being obtained and administered if it was needed and it was appropriate to do so. I refer to the CPG IPA's advice. I note she advised, the patient was not medically fit to receive the Covid vaccination and, if he had been well enough, it would not have reduced his chance of contracting Covid a week later, on 21 March 2021, due to the timelines of the vaccine's efficacy. I accept the CPG IPA's advice and am satisfied it was reasonable and appropriate a second Covid vaccination was not administered to the patient during his admission. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

iii. ***The patient's admission to a ward with Covid patients***

33. The complainant said, although the patient was Covid-negative on admission to the hospital, he was admitted to a Covid ward on 16 March 2021 where he contracted Covid.

Evidence Considered

Legislation/Policies/Guidance

34. I considered the PH/NHS Covid-Infection Control Guidance.

Relevant Trust records

35. I reviewed the patient's records for the period 14 March to 26 March 2021. I also reviewed redacted records associated with Covid tests for other patients within the same bay as the patient.

Relevant Independent Professional Advice

CED IPA advice

36. The CED IPA advised the patient was tested for Covid whilst in ED, the result of which was negative. The CED IPA advised, as the patient was Covid-negative, he was admitted to a bay on a ward with other patients with negative tests. He advised, *'this was reasonable and appropriate'.*

CPG IPA advice

37. The CPG IPA advised, patients were admitted to '*separate COVID positive (+) and negative (-) bays … with separate staff for COVID + and COVID – patients'.* The CPG IPA advised *'this was appropriate and in line with guidance at the time'.* The CPG IPA advised, the patient was *'appropriately placed in a COVID negative bay',* where another patient *'who had initially tested negative, subsequently tested positive'*. The CPG IPA advised the Trust could not have prevented this because of the incubation period of Covid and its ability to spread prior to symptoms developing. She advised, patients were therefore still at risk of exposure. The CPG IPA advised without the capacity to care for all patients in single rooms, and which was not possible due to the number of patients needing inpatient care, the risk of transmission between patients remained. She advised, '*all of the appropriate precautions were taken, in line with guidance at the time'. T*he CPG IPA concluded she had *'no concerns about the decisions around the patient's placement on the ward'.*

Analysis and Findings

38. I refer to the PH/NHS Covid-Infection Control Guidance which refers to the designation of self-contained care areas, including within wards. I note from the review of the records detailed in paragraph 32, the patient tested Covid-negative in ED on 14/15 March 2021. Of those patients who tested positive for Covid, following the patient's first admission from 14 to 26 March 2021, Patient A tested Covid-negative on 14, 16 and 19 March 2021 but then tested Covid-positive on 23 March 2021; Patient B tested Covid-negative on 15 March 2021 and then Covid-positive on 18 March 2021; Patient C tested Covid-negative on 9 March 2021 and Covid-positive on 18 March 2021; and Patient D tested Covid-negative on 11 March 2021 and Covid-positive on 18 March 2021. I consider this indicates the patient was

placed in a bay which contained only Covid-negative patients at the time of admission.

39. The ED and CPG IPAs advised admission to a ward bay with Covid-negative patients was appropriate. I note the CPG IPA advised this was in line with guidance at the time, as were the precautions taken by the Trust.

40. I accept the IPAs' advice. I also consider the records demonstrate the other patients in the bay had Covid-negative status for a minimum of two days from the time the patient was placed in the bay. I consider the PH/NHS Covid-Infection Control Guidance indicates it was appropriate to house different categories of patients in designated areas within wards. Therefore, I do not uphold this element of the complaint.

Detail of Complaint

iv. *Nursing care of the patient, including personal care*

41. The complainant said she was denied access to the patient until she '*pushed'* and when she visited the patient, he was in a '*neglected state*' and she had to complete his personal care. This included having to feed the patient.

Evidence Considered

Legislation/Policies/Guidance

42. I considered the NICE Nutrition Guidance and the NMC Code.

Relevant Trust records

43. I reviewed the patient's records from 14 to 26 March 2021 and 28 March to 11 April 2021.

Relevant Independent Professional Advice

Nurse IPA advice

44. The Nurse IPA advised, all patients should have a nursing assessment which informs a person-centred plan of care. The Nurse IPA advised this should include all aspects of fundamental care, including personal care. She advised, if a patient needs assistance with hygiene needs, it should be clearly documented. The Nurse IPA referenced the NMC Code.

45. The Nurse IPA advised, the record of 14 March 2021 indicates *'the patient was independent with mobility and did not use any mobility aids'* but that this was *'inaccurate because the patient used a zimmer frame to mobilise'*. She further advised, the update on 15 March 2021 indicated he needed the assistance of two people and used a zimmer frame but on 20 March 2021, this was further updated to indicate he did not require a mobility aid.

46. The Nurse IPA also advised the continence assessment was '*confusing'* as it stated the patient had no difficulties with his bladder and did not use incontinence products but a urinalysis was not possible as he was incontinent of urine. The Nurse IPA advised the patient was suffering from confusion from admission and, on 15 March 2021, the records indicate he was incontinent but refused to wear continence pads. The Nurse IPA advised the nursing evaluations indicate he did have incontinence, *"incontinence needs met"*, but how his needs were met was not documented. The Nurse IPA also referenced medication administration charts and the personal care assessment as indicating the patient needed assistance with personal and oral hygiene. The Nurse IPA advised that *'the evidence'* indicates, therefore, '*the patient was incontinent of urine and faeces and he needed the help of two staff members to mobilise and for his personal hygiene.'*

47. The Nurse IPA advised there were daily SKIN bundles which indicate attention to continence needs every two to four hours except for 19 to 22 March 2021, for which period of four days there were no SKIN charts.

48. The Nurse IPA advised the '*patient's assessments give a confusing picture of the support he needed to maintain his hygiene needs'.* She advised, although the nursing evaluations refer to daily support of personal hygiene and incontinence, *'it is not clear how these were met (bed bath, wash by bedside, shower, bath for*

example and with pads or without pads)' and there were four days when there was no record of how his continence needs were met. The Nurse IPA advised, *'personal care was not in line with national guidance'.* She advised this was because the way in which his personal care needs were met, his preferences for personal care and the frequency of personal care were not documented.

49. The Nurse IPA advised, from 23 March 2021 the patient had a *'grade 2 pressure ulcer to his sacrum'.* She advised this was *'immediately after the four days of missing [SKIN] charts'.* The Nurse IPA advised, a lack of personal care, including being left to sit in moisture, can contribute to skin damage. The Nurse IPA also advised the patient should have had a continence care plan which outlined his preferences. She advised '*it is not clear if his preferences were met, and if they were not, this would have increased his agitation'* as he was '*suffering from confusion*'.

50. The Nurse IPA advised SKIN charts should have been maintained daily which ensures the patient receives regular prevention measures such as continence care and positional changes. She also advised when patients rely on nursing staff to meet personal care needs, it is important to document their preferences for personal care.

51. The Nurse IPA referred to the NICE Nutrition Guidance. She advised all hospital in-patients should be assessed for malnutrition or risk of malnutrition on admission and then weekly, or when there is cause for clinical concern. The Nurse IPA advised nutrition support should be considered for those who have eaten little or nothing for more than five days and /or are likely to eat little or nothing for the next five days or more. The Nurse IPA also referred to the Trust's Malnutrition Universal Screening Tool (MUST). She advised this should be completed within 24 hours of admission. The Nurse IPA advised the MUST was not completed on admission and was only completed on 20 March 2021 and again in April. The specific date in April is unclear but the Nurse IPA suggested it was likely to be 1 April 2021 because there was a referral to a dietician on the same day. The Nurse IPA advised that, on both 20 March and 1 April 2021, the patient's nutrition score was one, due to a weight loss of between 5-10%, and which the Nurse IPA advised indicates a medium risk of malnutrition. The Nurse IPA advised food intake charts are only

documented between 21 and 28 March 2021. She advised, from 21 to 23 March 2021, the intake is noted as variable/ poor and from 24 to 28 March 2021 as poor. The Nurse IPA advised the April MUST is *'therefore inaccurate as his risk of malnutrition by this stage should have been documented as 'high' and not 'medium'. High risk due to him eating little or nothing from 24th.'*

52. The Nurse IPA advised the patient was referred to a dietitian on 1 April 2021. The Nurse IPA advised the patient was also reviewed by a Speech and Language Therapist due to poor swallow which was identified on 29 March 2021. The Nurse IPA advised a nasogastric (NG) tube was positioned on 31 March 2021 with 100ml of enteral feed given but no further NG feeds were documented on fluid balance charts. She advised there were oral nutritional supplements given but only on 29 and 30 March 2021 and 7 and 9 April 2021.

53. The Nurse IPA advised, fluid intake was monitored regularly and intravenous (IV) fluids were given as prescribed, which was daily from 28 March 2021. She advised, although fluid balance was not always accurately maintained, there are no concerns with fluid intake as fluids intake was reasonable up until the patient's readmission and then IV fluids were administered as prescribed.

54. The Nurse IPA concluded the Trust failed to act in line with NICE Nutrition Guidance by failing to complete MUST assessments on admission, weekly, or when there was a decline in the patient's condition. She advised the April MUST assessment was *'inaccurate, giving a medium rather than a high score'.* The Nurse IPA advised food charts were only maintained from 21 to 28 March 2021, even though there was possibly poor nutritional intake prior to 21 March and *'definite[ly] poor intake after 28 March'.* The Nurse IPA further advised, on 31 March 2021, the NG tube was sited but only 100ml of feed was given. She also advised, as the patient *'could not tolerate this'* it was removed but food charts were not restarted although oral intake was still poor. The Nurse IPA advised supplements were prescribed but these were given '*infrequently.'* The Nurse IPA advised, the monitoring of food intake was therefore *'poor'.*

55. The Nurse IPA advised she could not find any reference to the patient's family being asked to feed the patient; however, if discussed and agreed with the patient

and family this is not inappropriate as it can be an intervention for confused patients, who may be more comfortable with people they know and trust. She also referred, however, to her advice about the patient's nutrition and the requirements for nursing staff in relation to this.

CPG IPA's advice

56. The CPG IPA provided advice about the impact on the patient of poor nutritional intake. The CPG IPA advised, '*whilst appropriate nutrition and fluid are important in terms of recovery from acute illness, I think in the wider picture of this patient's situation there was nothing more that could have been done to change the overall outcome (due to his frailty and general condition)'.* She further advised, *'it would not have been appropriate to sedate'* the patient to enable the drip or NG feed *'because sedation would have been harmful in terms of his chest problems related to COVID, and would have put him at high risk of aspiration/further pneumonia'.*

Responses to the Draft Investigation Report

The complainant's response

57. The complainant said the Trust did not inform the patient's family about the patient's grade two pressure sore. The complainant said it was '*shocking*' this was allowed to happen '*and … would have contributed to his agitated state and discomfort'.* The complainant also said, the patient's *'skin was intact as [she was] (a nurse and his main carer) [and had] showered him on 13th March a day before he was admitted'.* The complainant also said she informed the staff on the ward *'numerous times … if they had any issues with managing [the patient the complainant] would come in and care for him'.*

Analysis and Findings

58. I note the Trust stated regular skin checks and personal care were documented for the patient throughout his admission.

59. I note the Nurse IPA advised, the patient's '*personal care was not in line with national guidance'* and the *'patient's assessments give a confusing picture of the support he needed to maintain his hygiene needs.'* The Nurse IPA advised there were four days of missing SKIN charts, *'immediately'* after which the patient had a

'grade 2 pressure ulcer to his sacrum'. She further advised a lack of personal care, including being left to sit in moisture, can contribute to skin damage. The Nurse IPA also advised if the patient's preferences were not met, and which is unclear as these were not documented, '*this would have increased his agitation'* as he was '*suffering from confusion'*. The Nurse IPA advised SKIN charts should have been maintained daily and when patients rely on nursing staff for personal care needs, it is important to document their preferences.

60. I note the initial nursing care records, in relation to the patient's mobility and continence at the time of the patient's presentation to ED, do not correlate to the patient's condition and needs as identified in later records.

61. The Nurse IPA advised the Trust failed to act in line with NICE Nutrition Guidance by failing to complete MUST assessments on admission, weekly, or when there was a decline in the patient's condition. The Nurse IPA also advised the April MUST assessment was *'inaccurate, giving a medium rather than a high score'.* I note the Nurse IPA advised food charts were only maintained for seven of the days of the patient's admission, although there was poor nutritional intake during the period and the oral supplements prescribed were given '*infrequently.'*

62. Whilst the initial information, documented in ED, about the patient's mobility and continence needs may have been drawn from the patient, as he was assessed as presenting with some confusion from the onset, I consider the Trust failed to take appropriate steps to ensure an accurate assessment of the patient's nursing care needs. I also accept the Nurse IPA's advice concerning the patient's nutrition and skin care needs and which accords with the review of the relevant records. I consider this is contrary to the Trust's statement that skin checks and personal care were documented throughout the patient's admission, which I find concerning. I consider the Trust failed to act in accordance with national guidance and the NMC Code in relation to the patient's personal care and nutrition. There is a lack of documentation in support of the Trust meeting the patient's personal care and nutritional needs; therefore, I consider the Trust failed to meet the patient's fundamental physical needs. I consider this constitutes a failure in care and treatment and therefore uphold this element of the complaint.

Overall including injustice

63. I considered carefully whether the failure in care and treatment caused an injustice to the patient and his family. I note the complainant described when she was allowed to visit the patient, *'he was in a neglected state, his hands, face and general appearance was awful'* and the grade two pressure ulcer '*would have contributed to his agitated state and discomfort'.* In relation to nutrition, I accept the CPG IPA's advice this did not affect the '*overall outcome*' and sedation was not appropriate because of the patient's condition with Covid. However, I consider the patient experienced unnecessary discomfort and, in consideration of the Nurse IPA's advice, upset, arising from the failings in personal care. I also consider the patient may have experienced unnecessary discomfort from the failings related to nutrition. I consider the patient's family experienced upset about his personal care and nutrition, especially in the context both of Covid, when he had no one to visit him, and his vulnerable state, when he may not have known the care was not appropriate. I also consider the patient's family experienced continuing uncertainty about whether appropriate nursing care would have made a difference to the patient's experience.

64. I consider the failure to engage with the patient to identify his personal care preferences indicates the Trust failed to demonstrate appropriate consideration of the patient's autonomy. Further, the absence of documentation about how the patient's personal care was met, with particular reference to the four days when there were no SKIN records which preceded the grade two pressure ulcer indicates the Trust did not demonstrate appropriate consideration for the patient's dignity.

65. I consider those public bodies which provide care for elderly people have an enhanced responsibility to be vigilant to ensure their needs are met when their vulnerability makes it more difficult for them to articulate their concerns. This is even more important, when those who often speak out for those who are vulnerable, such as their family, are denied access such as was the case during the Covid pandemic.

Detail of Complaint

v. *Access to the patient from his family both in person and by telephone*

66. The complainant said she was denied access to the patient until she '*pushed*'. The complainant also said she did not receive any FaceTime or personal calls from the patient during his time in hospital.

Evidence Considered

Legislation/Policies/Guidance

67. I considered the DoH Covid Visiting Guidance.

Relevant Trust records

68. I reviewed the patient's records from 14 March to 26 March and 28 March to 11 April 2021.

Relevant Independent Professional Advice

CPG IPA advice

69. The CPG IPA advised there were '*a number of occasions when the patient was able to have video/telephone calls with family, but that on some occasions the patient felt too tired and did not want to do so. According to the notes, this was explained to family'.* The CPG IPA also advised, however, the guidance at the time indicated the patient could have been permitted one visitor for one hour per week until the patient tested Covid-positive. The CPG IPA advised *'it was difficult to comment'* about the potential impact of not having a single short visit for the patient and his family but '*potentially even a short visit could have reduced stress and distress at the time'.* The CPG IPA advised, following the positive Covid test, the '*arrangements were in accordance with the guidance at the time – with virtual visiting being offered'.* She further advised in-person visits were also allowed later.

70. The Nurse IPA referenced the DoH Covid Visiting Guidance, in particular that virtual visiting was preferable but this should be balanced with support for visits when patients are nearing end of life and to alleviate anxiety. The Nurse IPA advised the patient spoke with his daughter on 15 March 2021 and there were visits from his

daughter on 31 March 2021 and 5 April 2021 and from a family member on another two occasions. The Nurse IPA advised, family liaison were involved, which *'was common during the Covid19 pandemic and therefore were the main communication channel*'. The Nurse IPA advised family were also updated on eight separate occasions by family liaison. The Nurse IPA concluded, staff are responsible for '*communicating with family when they are not able to visit due to matters that they cannot control (covid). The preferred method of communication is virtual in these cases'* and which the Nurse IPA advised was '*offered/facilitated but was not always successful because the patient was unable to or did not want to'*. The Nurse IPA advised *'from a nursing perspective, communication with family appears to be appropriate*'.

Responses to the Draft Investigation Report

The complainant's response

71. The complainant said both the family liaison officers, known to the complainant both professionally and personally, told her of conversations they had with the patient; however, the family were not given the opportunity to speak to him directly. She said the patient was able to hold conversations with these staff but the family did not get to speak with him.

Analysis and Findings

72. I identified the following records from review of those referenced in paragraph 68 above: -

- On 15 March 2021 at 2:05, the complainant spoke with the patient;
- On 20 March 2021 the Trust arranged a call but the records indicate the patient was *'too tired*' and did not want to be involved in the call;
- On 24 March 2021 the Trust arranged a facetime call but the patient again '*refused'* as he was *'too tired and unsettled';*
- On 26 March 2021 at 12:30 the Trust facilitated a call with the patient's wife with the records indicating the patient was '*speaking to [his] wife at present';*
- On 31 March 2021 at 19:20 the complainant was allowed to visit the patient;
- On 4 and 5 April 2021 the complainant was allowed to visit the patient; and thereafter

- End of life visits were allowed in recognition of the patient's deterioration.

73. The records detailed in paragraph 68 above indicate the Trust attempted to offer virtual visiting and telephone contact between the patient and his family but on some of these occasions the patient was not willing or able to engage with these. The records also indicate a member of the family was able to speak with the patient, in some form, on five occasions prior to the arrangements for visiting towards the end of the period of care. I note both the CPG and Nurse IPAs' advice confirms this. The CPG and Nurse IPA also advised the virtual visiting was in line with guidance at that time. The CPG IPA also advised, following the patient's Covid-positive test, the arrangements were in keeping with guidance. The Nurse IPA advised, family liaison provided a number of updates to the family and *'communication with the family was appropriate'.*

74. The CPG IPA also advised, however, during the patient's first week of admission, until he tested positive for Covid, one member of the family should have been permitted to visit for one hour in that week. I note this accords with the DoH Covid Visiting Guidance related to Medium Alert Level four which was the status of the period to which the DoH Visiting Guidance relates.

75. I consider the records evidence the Trust offered and facilitated virtual communication with the family, although in line with the patient's wishes, this was not always successful. I accept the CPG IPA's advice that this was also explained to the family. I also accept the Nurse IPA's advice updates provided to the family were appropriate. I also consider, however, the DoH Covid Visiting Guidance indicates the patient should have been allowed a single visit from one person during his first week of admission and there is no evidence this was offered. I consider while the patient was Covid-positive, the DoH Covid Visiting Guidance indicates the patient should not have received in-person visits. I consider the CPG IPA's advice supports this. I note the Trust facilitated visits towards the end of the patient's life.

76. Therefore, I partially uphold this element of the complaint. Specifically, I consider the Trust failed to act in accordance with the DoH Covid Visiting Guidance during the first week of the patient's admission and which constitutes a failure in care and treatment; however, I also consider the Trust facilitated virtual visiting in line with

the DoH Covid Visiting Guidance, appropriately updated the family and acted in accordance with the DoH Visiting Guidance in not allowing visits whilst the patient was Covid-positive and in permitting in-person visits towards the end of the patient's life.

Injustice

77. I considered carefully whether the failure in care and treatment caused an injustice to the patient and his family. I consider this would have caused the patient and his family upset and uncertainty.

Detail of Complaint

vi. Communication with the patient's family about the patient contracting Covid

78. The complainant said it was the Public Health Agency (PHA) which informed the family of the patient's Covid positive status, rather than the Trust hospital staff.

Evidence Considered

Relevant Trust records

79. I considered the patient's records for the period 14 to 26 March 2021.

Relevant Independent Professional Advice

CPG IPA advice

80. The CPG IPA advised she could not find any evidence the Trust informed the family about the patient contracting Covid but there were updates provided on the patient's condition thereafter. The CPG IPA advised, normally it would be the hospital staff who would communicate with the family about a patient's condition, with the patient's consent; however, during Covid, the PHA handled much of the work associated with positive results and there was no specific guidance available about this. She further advised, however, it *'would have been good practice' f*or the team involved with the patient to have updated the family as soon as the result was available but she could not determine if or when this was done from the records.

The CPG IPA advised *'it would have been upsetting/distressing for the family'* to hear from the PHA, particularly as the PHA could not answer any questions or concerns about the patient's condition. The CPG IPA also advised, however, the family were informed swab results were pending, following a positive contact, and therefore the news *'would not have been completely out of the blue'*. The CPG IPA concluded the member of hospital staff in receipt of the positive result should have contacted the family as soon as possible, with the patient's consent; however, the PHA's role in informing the family was appropriate during Covid.

81. The Nurse IPA referenced the NMC Code and advised nurses should inform the family if a patient tests positive, as soon as the result is received. The Nurse IPA advised the patient's Covid-positive result was documented at 11:20 on 22 March 2021 and at this point the nurses should have updated the family but there is no evidence to suggest this happened. The Nurse IPA advised, as the staff were aware of the patient's Covid status, this did not impact on the patient; however, if the PHA contacted the family after 22 March 2021, there would have been a delay in updating the family of the patient's condition.

Analysis and Findings

82. The CPG IPA advised the PHA managed much of the work related to Covid results and, therefore, at that time, it was appropriate the PHA informed the family. I note, however, both the CPG and Nurse IPAs advised, once the staff involved with the patient were aware of the Covid-positive result, which appears to be on the morning of 22 March 2021, they should have informed the family, with the patient's consent but there is no evidence this happened. I accept the IPAs' advice. I consider it was appropriate for the PHA to inform the family but the Trust's failure to update the family with the result from 22 March 2021 did not accord with the NMC Code, or '*good practice*'. I consider this constitutes a failure in care and treatment and therefore, I uphold this element of the complaint.

Injustice

83. I considered carefully whether the failure caused an injustice to the patient and his family. I refer to the Nurse IPA's advice this would not have impacted on the patient; however, I consider the patient's family experienced upset and uncertainty.

This is because, when they were informed by the PHA, they would not have had the opportunity to raise any concerns or questions about the patient.

Detail of Complaint

vii. ***Management of 'do not resuscitate' discussions with the patient and his family***

84. The complainant said the Trust discussed decisions about resuscitation (DNAR) within the first few days of the patient's admission but which the complainant believed was too soon.

Evidence Considered

Relevant Trust records

85. I considered the patient's records for the period 14 March to 26 March and 28 March to 11 April 2021.

Relevant Independent Professional Advice

CPG IPA's Advice

86. The CPG IPA advised there were a number of discussions about DNAR with the patient's daughter during the patient's admission. The CPG IPA advised these discussions included explanations about how the patient's physical frailty meant cardiopulmonary resuscitation, ventilation and intensive care would not be appropriate. The CPG IPA advised the DNAR decision was made on 31 March 2021, following further discussion with the patient's daughter. The CPG IPA advised the Trust's actions and decisions were '*appropriate*'.

87. The CPG IPA advised the patient was very frail and was not '*doing well'* despite active treatments and therefore, more intensive treatments, including ventilation and CPR if required, would not have been successful and would have *'prolonged suffering'.* The CPG IPA also advised, based on the records this decision was in

keeping with the patient's *'prior wishes, as his daughter stated that he would not have wanted to go to Intensive Care or for his quality of life to be negatively impacted'.* The CPG IPA advised there was '*appropriate consultation with family*' and '*the conversation was not undertaken too soon'.* She further advised, '*it is best practice to try to ascertain a patient's wishes regarding escalation of treatment (including CPR/DNACPR) as soon as possible during an episode of care'.* The CPG IPA concluded, she had *'no concerns about the handling of the DNACPR discussions, or the decision making regarding end of life care'.*

CED IPA's Advice

88. The CED IPA advised there were no records of the patient's resuscitation status being discussed whilst in ED. The CED IPA advised, on 15 March 2021 at 02.29, the record indicates *'resuscitation status 'not discussed''.* The CED IPA advised, however, this *'should have been discussed with the patient's family on 14/15 March 2021'* during his time in ED and '*the failure to do so was not reasonable'.* He further advised, there would have been no impact on the patient or his family as it was carried out later and this delay, therefore, had no impact in this case. The CED IPA concluded the patient's '*resuscitation status should have been decided upon and recorded as soon as possible after his admission'.* He also advised the Trust ED staff should *'reflect on actions with regard to assessing and discussing resuscitation status'.*

Analysis and Findings

89. I recognise the complainant said the discussion about resuscitation was undertaken too soon; however, I note both the CPG and CED IPAs advised resuscitation decisions should be discussed *'as soon as possible'.* The CPG IPA advised she had *'no concerns about the handling of the DNACPR discussions'.* I accept the IPAs' advice and therefore do not uphold this element of the complaint that the resuscitation discussions were undertaken too soon.

90. I further refer, however, to the CED IPA's advice that the resuscitation status should have been discussed in ED on 14/15 March 2021 and *'the failure to do so was not reasonable'.* I consider the Trust's failure to do so constitutes a failure in care and

treatment. I refer, however, to the CED IPA's advice the delay did not impact on the patient or his family in this case.

CONCLUSION

91. I received a complaint about the care and treatment the Trust provided to the patient from 14 March to 11 April 2021. I upheld two and partially upheld one of the seven elements of the complaint for the reasons outlined in this report. I also identified two additional failures in care and treatment. I recognise this may be distressing for the family to read, in particular the nursing care failings, and wish to offer my sincere condolences to the complainant and her family.

- The Trust failed to act in accordance with NICE Delirium Guidance because it failed to assess the patient's capacity to make decisions in a timely manner.
    - I recognise, because of the failure, the patient and his family lost the opportunity to ensure decisions about his care and treatment at first admission were in keeping with the patient's wishes.

- The Trust failed to act in accordance with national guidance and the NMC Code in relation to the patient's personal care, nutrition and mobility.
    - I recognise, because of the failures, the patient experienced unnecessary discomfort and upset arising from the failings in personal care. I also consider the patient may have experienced unnecessary discomfort from the failings related to nutrition. I consider the patient's family experienced upset about his personal care and nutrition.

- The Trust failed to act in accordance with the DoH Covid Visiting Guidance during the first week of the patient's admission.
    - I recognise the failure would have caused the patient and his family upset and uncertainty.

- The Trust failed to act in accordance with *'good practice*' and the NMC Code by not informing the family of the patient's Covid-positive test as soon as it was known.

    - I recognise, because of the failure, the patient's family experienced upset and uncertainty because, when they were informed by the PHA of the Covid-positive result, they would not have had the opportunity to raise any concerns or questions about the patient.

- The Trust failed to discuss resuscitation during the patient's time in ED.

Trust's response to the Draft Investigation Report

92. The Trust provided a response to the draft investigation report in which it accepted the report's findings and recommendations. The Trust stated, following the investigation, it developed an action plan to improve service delivery, patient experience and outcomes with learning to be disseminated to the relevant teams. The Trust also extended sincere apologies to the complainant for the failures identified and for the resulting upset.

Recommendations

1. I recommend, within **one** month of the date of the final report, the Trust provides the complainant and his family with a written apology in accordance with the NIPSO 'Guidance on issuing an apology' for the failings identified and for the loss of opportunity, frustration, anxiety, uncertainty, additional time and trouble and the inability to move on arising from these failures.

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

- The Trust should ensure relevant medical staff are reminded of the importance of relevant guidance, including the NICE Delirium Guidance, the Mental Capacity Act and the current DoH Covid Visiting Guidance. This should be evidenced by information sharing and/or training records.

- The Trust should ensure relevant nursing staff are reminded of the importance of the NMC Code, NICE Nutrition Guidance and the requirements of MUST. These should be evidenced through information sharing and/or training records.

- The Trust should also review documentation and practice on the ward in nursing care, particularly in relation to patients' personal care, monitoring of nutritional intake and mobility. This should be evidenced through sample audits of records with a particular emphasis on completion of records associated with MUST, nutrition, skincare, continence and mobility. This audit should also review how the human rights of dignity and autonomy are considered in the provision of care and how they are respected. The Trust should take action to address any identified trends or shortcomings and provide this Office with an update of findings and corrective actions.

- The Trust should give relevant staff the opportunity to reflect on the full advice provided by the CED, CPG and Nurse IPAs. This should be evidenced by records of information sharing.

MARGARET KELLY
Ombudsman **July 2023**

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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