Investigation Report

Investigation of a complaint against

NIPSO Reference:

The Northern Ireland Public Services Ombudsman
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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: 202000973
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

This complaint was about care and treatment the Belfast Health and Social Care Trust (the Trust) provided, during 2020 and until 27 September 2021, to the complainants' daughter as a resident of a Trust run Residential Care Home (the Home). The complainants raised concerns about care and treatment the Trust provided to the resident, in particular for her epilepsy. They were also concerned about assessments the Trust undertook for the resident. The complainants felt a Nursing Home (rather than a Residential Home) would best meet the resident's needs.

The investigation considered information from the complainants, the Home, the Trust, their relevant records, and relevant local and national legislation and guidance. I also sought advice from an independent Registered General Nurse with experience of working in care homes. The investigation found the Trust provided appropriate care and treatment to the resident during the relevant period. It also found the Trust appropriately assessed and met the needs of the resident at the Home. Therefore, I did not uphold the complaint.

The investigation recognised that the resident's condition deteriorated in recent years, mainly in relation to her mobility and epileptic seizures. I appreciate the resident's needs will require continual review and assessment. While the investigation did not identify any failings, I hope it brings some reassurance to the complainants knowing that the Trust acted in accordance with relevant legislation and guidelines to meet the resident's needs during the period investigated.

THE COMPLAINT

1. This complaint was about the care and treatment Belfast Health and Social Care Trust (the Trust) provided, during 2020 and until 27 September 2021, to the complainants' daughter as a resident of a Trust run Residential Home (the Home).

Background

2. The resident was 51 years old in 2020. She has a learning disability, cerebral palsy[1] and is right sided hemiplegic[2]. She also has Meniere's disease[3], a perforated ear drum, hypothyroidism[4] and epilepsy[5].

3. The resident has lived in a Trust Learning Disability Residential Care facility (the Home) since 2015 and continues to reside there.

4. On entering the Home, the resident was able to walk using a rollator[6] with the support of one person. In September 2018, the resident's mobility seriously deteriorated and she began using a wheelchair.

5. At the beginning of 2020, the resident's seizures changed in terms of frequency and the time of day they occurred.

6. In January 2021, the complainants raised concerns with the Home Manager about the resident's health and safety. The Trust issued its final response to the complaint on 27 September 2021.

Issue of complaint

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

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[1] A group of disorders that affect a person's ability to move and maintain balance and posture.
[2] A condition caused by brain damage or spinal cord injury that leads to paralysis on one side of the body.
[3] A condition of the inner ear that affects balance and hearing. It causes sudden attacks of feeling like the room is spinning around you (vertigo), a ringing noise inside the ear (tinnitus), pressure felt deep inside the ear, hearing loss.
[4] Also called underactive thyroid. The thyroid gland doesn't produce enough hormones. Common symptoms include tiredness, weight gain, constipation, muscle cramps, depression.
[5] Epilepsy is a condition that affects the brain and causes frequent seizures**.** Seizures are bursts of electrical activity in the brain that temporarily affect how it works.
[6] A walking frame with wheels at the bottom to aid mobility.

Whether the Residential Home appropriately met the resident's needs.

INVESTIGATION METHODOLOGY

8. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

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

   A Registered General Nurse with 40 years' experience of hospital, outpatients, community and care homes (including older adults with learning disability). Also, 20 years' experience as an NHS Continuing Healthcare (CHC) Assessor and Nurse Advisor on local CHC eligibility Joint Panel (Council and Social Services).

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

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

Relevant Standards and Guidance

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

    The general standards are the Ombudsman's Principles[7]:

    - The Principles of Good Administration

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

- The Principles of Good Complaints Handling

12. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - Northern Ireland Practice & Education Council for Nursing and Midwifery Revised Standards for Nursing and Midwifery Record Keeping Practice, May 2017 (NIPEC 2017);
    - The Nursing Homes Regulations (Northern Ireland) 2005 Part 3 (NHR 2005);
    - The Residential Care Homes Regulations (Northern Ireland) 2005 (RHR 2005); and
    - Health and Personal Social Services (NI) Order 1972 (1972 Order).

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

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

14. A draft copy of this report was shared with the complainants and the Trust for comment on factual accuracy and the reasonableness of the findings. The Trust accepted my findings.

THE INVESTIGATION

Whether the Residential Home appropriately met the resident's needs.

Detail of Complaint

15. In January 2021, the complainants raised concerns with the Home Manager about the resident's health and safety. The complainants felt a Nursing Home, where there is 24-hour availability of trained staff, would best meet the resident's needs.

16. The complainants raised concerns regarding the resident's increased epileptic seizures, which occurred '*numerous times*' every night causing the resident distress. The complainants believed the resident had a considerable number of seizures. They said, '*she does not receive the understanding / support or medication she should*.' The complainants did not believe the resident received the medication required in her epilepsy management plan.

17. The complainants said the resident was '*suffering in silence'*. They explained that when she called staff; they either did not hear her, were too busy or told her she was not having a seizure. The complainants said the resident's suffering was due to staff not having the '*necessary skills*' to observe her sufficiently and / or they did not understand the signs.

18. The complainants also raised concerns with the initial Person-centred Nursing Assessment and Plan of Care dated 29 January 2021, which the Trust undertook at the complainants' request. The Community Learning Disability Nurse completed the assessment. The complainants were dissatisfied with the assessment as they said the Trust did not invite them to contribute to it. They said it '*looks like little or no care or thought was taken about most of the so called answers. It gives the impression that it was completed by someone with no understanding of what was required and who doesn't know [the resident].*'

Evidence Considered

Legislation/Policies/Guidance

19. I considered the following legislation and guidance:
    - NIPEC 2017;
    - NHR 2005;
    - RHR 2005; and
    - 1972 Order.

Trust response to investigation enquiries

Care and treatment including epilepsy

20. The Trust said the resident attended a Consultant Neurologist about her epilepsy on 14 January 2021. The Neurologist recommended increased monitoring of the resident during the night.

21. The Trust said the resident initially received hourly checks during the night. It increased these to half hourly checks for a trial period from 27 January to 21 March 2021 following the Neurologist's recommendation. The Trust said, '*During this time no seizure activity was noted and the half hourly checks were stood down and [the resident] reverted to having hourly checks.*'

22. The Trust said at the complainants' request, it resumed half hourly checks on 27 September 2021 for four weeks. The Trust explained that while it occasionally noted some '*minimal pre-seizure activity*', this was not sufficient to trigger administration of PRN[8] medication. It also said that the half hourly checks '*did not result in any increase in PRN medication being administered*.'

23. The Trust said that '*overall*' during the half hourly checks '*no observed patterns or trends could be identified in relation to [the resident's] seizures*.'

24. The Trust explained, at the time of writing on 5 January 2022, night duty staff continued to visually check the resident every hour.

[8] A medicine that is usually prescribed but is not required by the resident on a regular basis. It is usually prescribed to treat a short term or intermittent medical condition such as pain, indigestion or insomnia

25. The Trust said that following a meeting, on 9 June 2021, about the complainants' concerns, they completed a review of the nursing assessment. It referred the resident to Occupational Therapy and Physiotherapy to assess her needs to ensure a '*robust*' process. It also referred her to an Adult Safeguarding team for investigation into her '*care and treatment*' at the Home.

26. The Trust said the Adult Safeguarding Investigation covered the complainant's concerns about the resident's '*safety, physical and mental health'* and found it could not substantiate the '*allegations*'. The Trust said the investigation did not recommend any further action. The Trust further said that a range of '*multi-disciplinary assessments*' continued to advise that the Home met the resident's care needs.

Assessments

27. The Trust said the complaints received a copy of the initial nursing assessment completed in January 2021. The Trust said the complainants requested a review of the assessment and they provided further information about the resident for inclusion in the re-assessment.

28. The Trust stated that in addition to its nursing assessments, Occupational Therapists and Physiotherapists also completed assessments which both advised the resident's *'needs were being met within the Residential Care Home setting*.'

29. The Trust said in March 2021 it referred the resident for a Care Management Review indicating that the complainants requested a nursing care placement. The Trust explained the key worker makes the referral including relevant professional assessments. The Trust further explained the wishes of the resident and their family are '*very much part of this process*.' The Trust stated the Care Management Review found the resident's needs were being met at the Residential Home and a referral for a Nursing Home placement was not required.

Relevant Trust records

30. The Neurology letter about the resident's review on 14 January 2021 states:
    - The resident is prescribed '*Diazepam*[9] *5mgs PRN post seizure*'
    - No change to anticonvulsant regime currently.
    - *'I think the key is for the staff in the Home to try and monitor [the resident] more at night so that diazepam can be given more responsively*.' The complainant will discuss this with the Home.
    - Review in three months.

31. The resident's Epilepsy Monitoring Charts from 25 January to 21 March 2021 document that staff observed the resident every 30 minutes each night from midnight to 07.30hrs. The records document that staff did not observe any seizures.

Person-centred Nursing Assessment dated 29 January 2021

32. The Trust's handwritten record documents that staff carried out the assessment remotely via telephone.

Care Management Review dated 1 July 2021

33. The records document that the resident communicated with staff at night using an alarm / monitoring system when she needed to use the toilet or experienced an epileptic seizure.

34. The records document '*at present, [the resident's] care needs are currently being met at [the Home].*'

Safeguarding Investigation Report dated 17 September 2021

35. The records document that an Adult Learning Disability Team undertook an investigation regarding any potential harm to the resident at the Home. This was following the adult safeguarding concerns the complainants raised to the Trust in their letter dated 7 June 2021.

[9] Belongs to a group of medicines called benzodiazepines. It is used to treat anxiety, muscle spasms and seizures or fits.

36. The investigation found '*the adult safeguarding allegations could not be substantiated.*[10]'

37. The report documents that the complainants also raised concerns about the resident's care needs and recommended the Home address these at a multidisciplinary team meeting.

Relevant Independent Professional Advice

Care and treatment including epilepsy

38. The IPA considered the resident's epilepsy needs. She advised the resident required supervision and monitoring to observe her seizures and to maintain a safe environment. The IPA advised the resident had an audio monitor in her bedroom which allowed her to communicate with staff at night. The IPA advised that '*staff follow an epilepsy support plan*' which included detailed guidance on recognition of different types of seizures and advice on first aid and escalation. The IPA further advised that, '*The carers can deliver this and take action as per protocol without having to prescribe care or make treatment decisions*.'

39. The IPA advised that the nursing assessments referred to above contained sufficient information indicating the '*quantity and quality*' of support needed to '*distinguish between need for residential social care or nursing care placement*.' The IPA explained it was important to understand the distinction between '*medical diagnosis, need for Registered Nursing and need for care*.'

40. The IPA advised that a person may have '*complex medical needs*' but at the same time have '*straightforward care needs*' without needing Registered Nurse input on a day-to-day basis. The IPA advised the January nursing assessment described the resident's condition as '*complex*' with different seizure types presenting which is '*reviewed regularly with neurology*.' The IPA noted that the neurology review in April 2021 concluded that things improved with the recommended increase in supervision and the resident remained '*free of*

[10] Reference to the report is included as the Trust requested it to investigate the resident's 'care and treatment' at the Home.

generalised convulsions.' The IPA advised the Consultant did not recommend the resident needed supervision from a Registered Nurse.

41. The IPA advised that the difference between care provided in a residential care home and nursing care home '*lies in the nature of the staffing*.' The IPA referred to NHR and RHR 2005 which state that residential care homes are not required to employ Registered Nurses, whereas nursing homes are required to do so by law. The IPA explained how each role provides care.

42. The IPA referred to the 1972 Order. The IPA advised that Registered Nursing care provides '*leadership, supervision and evaluation*' of care over and above the contribution of other care workers. The IPA advised personal care is care that does not require Registered Nursing input.

43. The IPA advised in the resident's case: '*if aspects of care (such as the epilepsy monitoring plan) have been planned by a qualified practitioner (neurology nurse or registered nurse), the delivery and monitoring can be provided by other types of carer as part of their personal social care.*' The IPA advised that the resident's Home provided staff at various levels. This included those who delivered social care needs including 24-hour care for residents, those who provided direct care and / or assistance to meet complex health needs of service users, and those responsible for medicine administration. The IPA further advised that these staff provided overnight care for the resident which allowed for the administration of anti-epileptic medication, if required.

44. The IPA advised the Consultant devised and signed the resident's epilepsy monitoring plan. The resident's GP, mother and LD nurse also countersigned the plan. The IPA advised the plan provided step by step instructions on the recognition of seizures. She also advised it was personalised for the resident and had explicit instructions on actions staff should take if they suspect seizure activity. The IPA advised that all staff signed to confirm they read the plan. The IPA advised; '*The plan is therefore sufficient to be followed by the care team at the [Home]*.'

Assessments

45. The IPA identified three person-centred nursing assessments carried out on 29 January, 1 July and September / October 2021. The IPA advised that registered nurses within community and learning disability roles carried out these Trust assessments using an appropriate format for Learning Disability (LD) assessment.

46. The IPA referred to NIPEC 2017 which sets out the standards for record keeping. The IPA advised that in relation to the Trust assessments carried out, '*the frameworks used were correct according to NIPEC guidance and were appropriate for determination of resident needs.*' The IPA added the structure and content of the assessments were appropriate to determine the resident's needs.

47. The IPA considered each assessment, to identify whether they reflected the resident's needs at the time, as outlined below.

Nursing assessment on 29 January 2021

48. The IPA advised this assessment was comprehensive and drew on information provided by telephone due to Covid restrictions. It also identified where professional referrals were required and summarised the needs identified. These needs comprised of '*direct personal care assistance*' (washing and mobility) and monitoring (sleeping, maintaining a safe environment).

49. The IPA advised that under normal circumstances, the service user should be present and included as far as possible. However, she advised that due to Covid restrictions, the resident was not present for this assessment. The IPA advised that '*this does not contravene the [NIPEC] Standards due to the exceptional circumstances*.'

Nursing assessment on 15 June 2021

50. The IPA advised this assessment addressed the needs as in the January assessment and identified '*no change in [the resident's] arising needs*.' The IPA advised it concluded that '*the full assessment remained stable*.'

Care Management Review dated 1 July 2021

51. The IPA advised the areas covered in this assessment provided detailed information drawn from professional reports, the resident's professional carers and her family. The IPA advised the Trust identified needs across most areas assessed, indicated the level of support required and sufficiently reflected the resident's needs at the time. The IPA further advised there were no significant changes from the previous assessments.

52. The IPA provided an analysis of how the Trust assessed the resident's needs at each assessment and compared this with the Trust's records. I enclose this with the clinical advice at Appendix two to this report.

53. In conclusion, the IPA advised the resident's needs at the time of assessment were '*appropriately identified and met within the Residential Care Home and that she would not have been eligible for Nursing Home level care at that time*.'

Analysis and Findings

Care and treatment including epilepsy

54. In January 2021, the complainants raised concerns about the resident's health and safety. The complainants felt the Residential Home staff '*don't have the skill and expertise needed*' to care for and treat the resident and staff do not provide the understanding, support or medication required relating to epileptic seizures.

55. In relation to the care and treatment the Trust provided to the resident, I refer to the Adult Safeguarding Team's investigation. I note it did not identify any health and safety concerns.

56. The resident attended an epilepsy review with the Consultant Neurologist on 14 January 2021. I note the IPA's advice that the Neurologist devised a plan which recommended an increase in the frequency of night-time monitoring for the resident to check for seizure activity. It also provided instructions for what action staff should take if they suspect seizure activity.

57. I refer to the complainants' concern that staff at the Home did not have the '*skills or expertise'* to provide appropriate care to the resident. The IPA advised that as a Consultant devised the plan outlined above, it was appropriate for Trust staff at the Home to follow it and provide care as the Consultant instructed. This included monitoring of the resident and administration of medication, if required. I accept the IPA's advice. I consider there is sufficient evidence within the records to suggest that Trust staff appropriately followed the plan. Therefore, based on the evidence available, I consider the Trust provided appropriate care and treatment to the resident during this period.

58. I appreciate the complainants' concern given their daughter's complex medical needs. However, I note the IPA's advice that a person may have '*complex medical needs*' but still have '*straightforward care needs*' without needing Registered Nurse input on a day-to-day basis. Based on the IPA advice, I consider the Trust's decision for the resident to remain in the Residential Home appropriate. I do not uphold this element of the complaint.

Assessments

59. The complainants raised concerns about the assessments undertaken for the resident. I first refer to the July Care Management Review. The IPA advised this review contained '*comprehensive information*' about the resident which '*sufficiently*' reflected her needs at the time. She further advised that the report considered information from records, professional reports, and also from the resident's professional carers, as well as her family. I accept this advice.

60. Based on the evidence and the IPA's advice on the thoroughness of the review, I am satisfied the Trust used care and attention to detail when it conducted the review. I am also satisfied it demonstrated that the Trust accurately identified and understood the needs of the resident. Further, the IPA advised of input from those who professionally care for the resident together with input from the complainants themselves (for this review). I accept the IPA's advice and find that those who knew the resident were involved in the review. The IPA further

advised that this was in accordance with NIPEC. Therefore, I have not identified a failing in the Trust's completion of the assessments.

61. I also refer to the January 2021 assessment. The complainants said the Home did not invite them to have input into the assessment. They explained it '*looks like little or no care or thought was taken about most of the so-called answers. It gives the impression that it was completed by someone with no understanding of what was required and who doesn't know [the resident].*' I appreciate this would cause the complainants concern. I also appreciate their input may have benefitted the process. However, as it was not a requirement for the Trust to request their contribution, I did not identify a failing. I note assessments completed since this date included input from the complainants. I welcome this inclusion.

62. Based on the evidence available to me, I am satisfied the Trust carried out appropriate assessments to determine the needs of the resident at the Home. I accept the IPA's advice that qualified practitioners were involved in the planning of the resident's care. I also accept her advice that the Trust provided appropriately trained staff to deliver and monitor the resident's personal social care. Therefore, I do not uphold this element of the complaint.

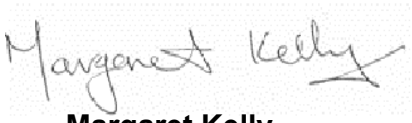
CONCLUSION

63. I received a complaint about the care and treatment the Trust provided, during 2020 and until 27 September 2021, to the complainants' daughter as a resident of the Home. The complainants said the Home did not meet the resident's needs and that she should have been moved to a nursing setting. The complainants believed the Trust's assessments were '*inadequate*' and did not accurately reflect the resident's complex needs.

64. I fully appreciate that the complainants want the most appropriate care and treatment to be provided to the resident. I am mindful that the resident's needs may change however, having considered the events leading up to September 2021, I find no evidence to indicate the Trust failed in its care and treatment of

the patient. I am satisfied the Trust appropriately assessed and met the resident's needs during the relevant period.

65. Throughout my examination of the complaint, I recognised the worry the complainants felt witnessing the resident's deterioration. It is clear from my reading of the records how involved the complainants are in the resident's care. I hope this report and the IPA's detailed analysis goes some way to address their concerns.



Margaret Kelly
Ombudsman **March 2023**

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 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.