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

Report Reference: 202001546

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk
@NIPSO_Comms

The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

The complaint was about the actions of the Western Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her late mother (the patient) between 9 October 2020 and 26 November 2020. She also believed the patient was not medically fit for discharge on 14 October 2020.

The investigation established there were failures in care and treatment in relation to the following matters: -

- failure to carry out and record lying and standing blood pressure for the patient;
- failure to carry out proactive screening in relation to the patient's delirium or capacity in accordance with relevant guidance;
- failure to provide an onward plan for further management of incontinence following discharge.

I also found maladministration in relation to complaints handling, specifically the Trust's failure to provide the complainant with anticipated timescales for response and a failure to respond to the complainant's requests for a meeting.

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failures I identified in this report and offer to meet with the complainant to go through the patient's medical records. I also made further recommendations for the Trust to reflect on the learning identified by the IPA.

THE COMPLAINT

1. I received a complaint about the care and treatment the Western Health and Social Care Trust (the Trust) provided to the complainant's late mother (the patient), between 9 October 2020 and 26 November 2020. The complainant said the standard of care provided to the patient from her admittance to the Emergency Department (ED) and subsequent care and treatment on admission to a ward was not appropriate. On 14 October 2020, the patient was discharged home with a package of care. She also believed the patient was not medically fit for discharge on 14 October 2020.

2. The complainant said that their entire experience and the Trust's handling of her complaint was inadequate.

Background

3. On 9 October 2020 at approximately 18:03, the patient was admitted to ED in Altnagelvin Hospital due to a fall. During her time in ED, the patient rang her daughter (the complainant) to say she had become incontinent, left unattended and staff did not change her clothes. The complainant said the patient was in ED for approximately 24 hours before moving to a ward.

4. On 14 October 2020, the hospital discharged the patient with a reablement package[1] and was deemed medically fit for discharge. On 15 October 2020, reablement commenced.

5. On 16 October 2020, the Ambulatory Care Unit (ACU)[2] was due to review the patient but she was unable to attend. The complainant, who is a nurse, repeated the patient's bloods as requested and left these to the hospital while collecting magnesium from ACU.

6. On 26 November 2020, the patient sadly passed away.

7. A full chronology can be found at Appendix five to this report.

[1] Care after illness or hospital discharge (reablement). Reablement is a type of care that helps you relearn how to do daily activities, like cooking meals and washing.
[2] The Ambulatory Care Unit (ACU) is a service which offers same day care to patients at the hospital. This means that patients are assessed, diagnosed, treated and are able to go home the same day, without being admitted into hospital overnight.

Issue of complaint

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

Issue one:

- **Whether the care and treatment provided by the Trust to the patient between 9 October 2020 and 14 October 2020 was reasonable and in accordance with relevant standards.**

Issue two:

- **Whether the follow up care provided to the patient between 14 October 2020 and 26 November 2020 was appropriate and in accordance with relevant standards.**

Issue three:

- **Whether the Trust's handling of the complaint, was appropriate and in accordance with the relevant standards.**

INVESTIGATION METHODOLOGY

9. To investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's handling of the complaint.

Independent Professional Advice Sought

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

    - A Registered Nurse (BA(Hons), MSc, PGCert (HE)) with 30 years' experience and a speciality of nursing older people in hospital, community and care homes. Consultant Nurse for Older People 2021-2022 and a Clinical Lecturer (N IPA);

- A Consultant Physiotherapist (DProf, MSc, BSc (Hons), MCSP, MMACP) with 30 years' experience. They are clinical lead for audit, education and research and who also works across primary, community and secondary care clinics (P IPA); and
- A Consultant Physician (MBiochem, BMBCh, FRCP (Edin), MedSci (ClinEd), CMgr, FCMI) in Acute Internal Medicine and Divisional Director for Medicine at a large NHS trust. In clinical practice, they see and diagnose acutely unwell adults including the elderly with multiple medical issues (C IPA).

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

11. The information and advice which informed the findings and conclusions are included 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

12. 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[3]:

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

13. 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.

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

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, as updated April 2019 (GMC Guidance);
- National Institute for Health and Care Excellence (NICE), Clinical Guideline 161 – Falls in older people: assessing risk and prevention, June 2013 (NICE Guideline 161);
- Health and Social Care Board (HSC), Reablement Service for Northern Ireland and Regional Reablement Pathway, July 2016;
- Health and Care Professions Council (HCPC), Standards of Proficiency for Physiotherapists (May 2013);
- Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (January 2016);
- Department of Health (DH), Good Practice in Continence services (2015);
- National Institute for Health and Care Excellence (NICE), Clinical Guideline 103, Delirium: prevention, diagnosis and management in hospital and long-term care, July 2010 (NICE Guideline 103);
- National Institute for Health and Care Excellence (NICE), Clinical Guideline 50, Acutely ill adults in hospital: recognising and responding to deterioration, July 2007 (NICE Guideline 50); and
- National Health Service (NHS), Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care, June 2018.

14. I also considered The Regulation and Quality Improvement Authority (RQIA), review of discharge from acute hospitals (2014).

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

16. 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.

17. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant provided comments on the draft report which were fully considered.

THE INVESTIGATION

Issue one:

- **Whether the care and treatment the Trust provided to the patient between 9 October 2020 and 14 October 2020 was reasonable and in accordance with relevant standards.**
  In particular this will examine the care and treatment of the patient in ED, her admission to the ward and whether the patient was medically fit for discharge and reablement.

Detail of Complaint

18. The complainant said when the patient was admitted to ED on 9 October 2020, the patient rang the complainant to say that she had wet herself and had not been changed by staff. The complainant believed that the patient was denied a basic Human Right of being able to relieve herself with dignity.

19. The complainant said that once her mother was moved to the ward, medics never contacted the family regarding the patient's medical history, and this was evident in her mother's notes.

20. The complainant said that her mother was discharged on 14 October 2020 with reablement as she was deemed medically fit, but this was not discussed with the family.

21. Reablement commenced on 15 October 2020 and by 16 - 17 October 2020 the complainant said the patient's mobility had declined. The ACU was to review the patient on 16 October 2020, but she was unable to attend due to her poor health. The complainant said she repeated the patient's bloods as requested and left these to the hospital while collecting magnesium from ACU.

22. The patient passed away on 26 November 2020 and the complainant said she and her family still do not know what happened to cause this. The complainant said the death of her mother was not reported to the coroner.

Evidence Considered

Legislation/Policies/Guidance

23. I considered the following policies and guidance:
    - NICE Guideline 161;
    - NICE Guideline 103;
    - Department of Health (DH 2015), Guidance on Incontinence;
    - The RQIA Review of Discharge from Acute Hospitals (2014);
    - NHS, Excellence in Continence Care: Practical guidance for commissioners, and leaders in health and social care, June 2018;and
    - The GMC Guidance: Standard 21.

The Trust's response

24. Following the complainant's initial complaint to the Trust in December 2020, the Trust responded in a letter to the complainant on 31 March 2021 and 6 August 2021. It stated one of the consultant physicians reviewed the patient's clinical notes and record of the admission to Acute Medical Unit [4](AMU) on 9 October 2020. The Consultant stated he met the patient once in AMU on 14 October 2020, the day of her discharge. '*At this time, she was medically fit for discharge and the Multi-disciplinary Team (MDT) recommended Reablement'.*

25. In response to this Office's enquiries, the Trust stated that during a phone call on 13 October 2020 with the patient's husband, it was established the patient was *'independent with personal care, independent with bed/chair/toilet transfers and independently mobile with a wheeled zimmer frame prior to her hospital admission'*.

[4] The Acute Medical Unit is the first point of entry for patients referred to hospital as an acute medical emergency requiring admission from the emergency department.

26. On the day of discharge 14 October 2020, the patient mobilised with a zimmer frame under close supervision only and personal care required assistance of one. It is documented that the patient was *'keen to return home'* and her family was happy to take the patient home to wait for the reablement package to start.

27. The Trust stated the patient *'would benefit from a reablement service to facilitate discharge whilst she regained her confidence and confusion settled'.* The Trust stated as the patient *'had no care package prior to admission a package of care 1x3x7* [5]*was recommenced to support hospital discharge'.*

28. The Trust stated the consultant and multidisciplinary discussion declared the patient medically fit for discharge. The Trust stated it discharged the patient with the best intentions and had arranged for the hospital to follow up and further referred to her GP to review.

29. The Unscheduled Care Manager in the Trust advised that in his opinion, *'given facts at hand at the time of discharge, it was the correct decision to allow for discharge home with the reablement team'.*

Relevant Trust records

30. I reviewed the relevant Trust records.

Relevant Independent Professional Advice

31. The full independent professional advice I received is attached in Appendix three to this report.

ED

32. The C IPA advised the patient's symptoms on attendance to ED were '*the patient had collapsed, felt dizzy and, at the time of the collapse, was unable to speak.'* A Doctor took a clinical history. The past medical history, drug history and allergy history were taken. A cardiovascular examination, a respiratory examination, an abdominal examination were undertaken. An ECG[6] was recorded, a urinalysis was performed and a comprehensive set of bloods were

[5] This means one carer to visit the patient three times per day seven days per week

[6] An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity.

taken. Physiological observations were recorded. An abbreviated mental test examination was undertaken, as well as a full nursing assessment covering communications, mobility, eating, drinking and person care.

33. The C IPA advised '*this was a comprehensive assessment in ED. A diagnosis was formulated and a treatment plan commenced.'*

34. The C IPA advised the nursing documentation makes multiple references to toileting – in particular the patient is taken to or on the commode a number of times. It also makes reference to checking that incontinence pads are clear and dry. There is an entry at 15.25 which mentions that patient was upset at one instance because '*she had peed herself three times earlier that day.'* When asked about this the patient replied that '*sometimes it just happens*.'

35. The C IPA advised the ED notes list the initial observations on admission but no others. The patient's clinical presentation is addressed in the clinical clerking. The notes contain an abbreviated mental test score [7](AMT -4) which assess crudely the patient's mental state. She attained 4/4 meaning she was orientated to be able to recall her age, date of birth, the place she was and the current year. Her Glasgow Coma score [8] is all recorded as 15/15 meaning that she was not confused and able to communicate normally.

36. The C IPA advised there were no concerns noted that would suggest the family needed to be contacted during the patient's time in ED about her medical history. There is a past medical history section of the medical clerking filled out which would have been obtained from the patient. It is less comprehensive than the one obtained later on in the admission when access to old medical records would have been available. '*There was no acute illness of such a nature as to require immediate family input in ED.'*

37. The C IPA advised it would not be normal practice to contact a family member on admission to ED. A competent adult, as it must be assumed the patient

[7] a 10-point test for rapidly assessing elderly patients for the possibility of dementia

[8] Used to objectively describe the extent of impaired consciousness in all types of acute medical and trauma patients. The scale assesses patients according to three aspects of responsiveness: eye-opening, motor, and verbal responses.

was, is able to provide doctors with information about herself and would be expected to contact her family herself should she want to, to pass on information given to her if she felt she needed to, or to ask the nursing staff to do so on her behalf.

38. The C IPA advised the ED staff took into account the patient's medical history and this was explored at initial assessment. It is further refined this later on in the admission. It mentions, breast cancer, gout, hypertension and potential cognitive impairment for which the patient refused a memory clinic assessment. '*The actions within ED were appropriate'.* ED performs the initial assessment, starts essential treatment, and moves patients to a definitive care area. '*In this respect, the assessment and treatment in ED were of a reasonable standard'.*

Admission to ward

39. The N IPA advised that in terms of the patient's admittance, a fluid balance is recorded on 9 October 2020. Venous thromboembolism (VTE)[9] assessment was conducted and the patient was assessed as at high risk. Appropriate treatment (apixaban[10]) was prescribed. Enoxaparin[11] was also given.

40. In terms of the patient's time on the ward, the N IPA advised the patient was admitted at 19:35 on 10 October 2020 due to a fall; acute kidney injury (AKI); low calcium level and low magnesium level, secondary to Proton Pump Inhibitor (PPI)[12]. The N IPA further advised swollen knees and sinus tachycardia[13] with ventricular ectopics[14] was identified on an electrocardiogram (ECG)

41. On admission, a patient centred nursing assessment and plan of care was completed. A summary of identified needs was completed which identified: gain consent; monitor early warning score (EWS); maintain a safe environment;

[9] Venous thromboembolism (VTE) is a condition that occurs when a blood clot forms in a vein. VTE includes deep vein thrombosis (DVT) and pulmonary embolism (PE).
[10] Apixaban is an anticoagulant medication used to treat and prevent blood clots.
[11] An anticoagulant medication. It is used to treat and prevent deep vein thrombosis and pulmonary embolism.
[12] PPI - a treatment for heart burn/related symptoms.
[13] Sinus tachycardia is a regular cardiac rhythm in which the heart beats faster than normal.
[14] Ventricular ectopics are a type of abnormal heart rhythm.

provide assistance with personal care; administer medications; monitor and manage pain.

42. A plan for further blood tests, echo and telemetry (all medical orders) is noted, plus lying and standing BP and urine dip (nursing / MDT responsibilities). ECG and chest X Ray were carried out. The elimination assessment did not identify any bladder problems / incontinence but did identify that assistance of two people was needed for use of commode.

43. Urinalysis was carried out on 10 October 2020 at 23:50 – recorded as '*positive*'. An "Additional Falls Risk Assessment for WHSCT" was carried out on 11 October 2020. This identified patient specific interventions under the following headings: mental state; environmental hazards; restricted mobility; footwear; bladder and bowel management; medication; vision/hearing; communication and referrals. Lying and standing BP is specified but not measured.

44. The N IPA advised the Falls Assessment correctly follows the NICE guideline CG161 Assessment and Prevention of Falls in Older People which recommends multi-factorial risk assessment and intervention. The N IPA also advised, '*older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service'*.

45. The N IPA advised *'from a nursing perspective, patient observations and assessments were correctly carried out…'* the ward team appropriately assessed the patient's falls risk using the Health Board Risk Assessment Proforma. However, although lying and standing blood pressure (BP) was specified, which is in line with Royal College of Physicians Guidance, '*I did not find any record of it having been carried out. This test requires the blood pressure to be measured firstly with the patient lying down, then secondly when standing. The BP is checked to find out if there is a significant drop on standing (postural drop/postural hypotension) as this can be a cause of falls. This test should therefore have been carried out and recorded*.'

Mental Health/Capacity

46. The C IPA advised the nursing documentation records the patient's view of her mental health and emotional well-being was described by the patient as '*good'*. The patient denies any diagnosed mental health conditions, denies any recent events affecting her mental health or emotional well-being, denies recent forgetfulness. The relative with the patient was also asked if there had been any recent change in the level of confusion (if any) or cognitive function and it is recorded that '*no such concerns are raised.'*

47. The C IPA advised at some point on or around 11 October 2020 nursing documentation mentions the patient being confused, which continues for a few days before getting better. There is no '*concern'* about this. It is documented as a statement of fact and is often seen in elderly patients with medical problems admitted to new environments.

48. The N IPA advised that from the nursing entries in the medical records, the patient potentially had early Alzheimer's Disease. The Abbreviated Mental Test Score was conducted on admission, with a score of 0, but on 11 October 2020 she was noted to be exhibiting "*confusion*" "*asking the same questions over and over*". The records are partially missing but state "*memory clinic but did not attend MRI appointment*". On 12 October 2020 "*confused today but family state she is under investigation for same. Was to attend memory clinic but did not attend for MRI appointment*.' This indicates that the hospital team were aware that the patient had memory problems and that these had not been fully investigated at the time of her admission.

49. Cross checking with the social work discharge summary, there is no record of any mental capacity assessment using the Mental Capacity Act (Northern Ireland) 2016 with regard to discharge planning. No concerns about capacity are recorded. However, in view of the fact that memory issues/confusion were known, the N IPA advised she was looking for confirmation the Trust had considered and were satisfied the patient had demonstrated mental capacity in

relation to discharge and that delirium had been ruled out with respect to her occasional and recent recently diagnosed urinary tract infection.

50. The N IPA advised in hospital care, delirium risk factors should be addressed. NICE Guideline 103 states '*1.1.1 When people first present to hospital or long term care, assess them for the following risk factors. If any of these risk factors is present, the person is at risk of delirium.*

    - *Age 65 years or older*
    - *Cognitive impairment (past or present) and/or dementia (for guidance on diagnosing dementia, see diagnosis in the NICE guideline on dementia). If cognitive impairment is suspected, confirm it using a standardised and validated cognitive impairment measure.*
    - *Current hip fracture*
    - *Severe illness (a clinical condition that is deteriorating or is at risk of deterioration;'*

51. The N IPA advised the Abbreviated Mental Test Score was carried out on admission with a score of 0, but this is not a delirium specific tool such as the 4AT test which is recommended by the British Geriatrics Society in their Delirium Hub.

52. The N IPA concluded that although no concerns were recorded regarding issues relating to capacity, there are no records that delirium or mental capacity were specifically screened for, in line with NICE Guidance on delirium and the Mental Capacity Act (Northern Ireland) 2016. In view of the patient's suspected Alzheimer's disease and onset of confusion in hospital, proactive screening should have been carried out and recorded.

Physical Health

53. The N IPA advised concerns about the patient's mobility and safety are raised in the nursing notes 12 October 2020 "*encouraged [patient] to get into bed for comfort as sitting hunched over at bottom of bed. Assisted to bed, nursed lowest level, bedrails insitu, buzzer at hand ….patient very poor on her feet.*

Found it difficult to transfer. Both needs very swollen". Referrals to therapists and social worker had been made. She "*remained confused*" and "*very unsteady on her feet" "seen by OT/PT*". 12 October 2020 "*patient usually mobilises at home with a zimmer frame, requires assistance of 2 and ZF at present… monitored for risk of falls*". The N IPA concluded '*the team were aware of an acute decline in mobility and took appropriate measures to maintain safety and provide multidisciplinary support*.'

54. The P IPA advised the patient was seen with an occupational therapist at the initial assessment and treatment session on 11 October 2020 (the notes do not specify a treatment time). The patient was complaining of decreased mobility and a history of falls over several weeks leading up to hospital admission (the physiotherapist stated in the records the patient attributed the falls to the legs feeling weak). The patient also had long-standing low back pain.

55. The P IPA advised the physiotherapist ascertained that the patient could stand from sitting with the assistance of one, and that transfers and walking short distances required a wheeled simmer frame (WZF) and the assistance of two. The patient also required the assistance of two to carry out personal activities of daily living (ADL). An assessment of range of movement in the arms and legs and strength testing the legs were carried out.

56. The P IPA advised the problems checked off a list in the physiotherapy assessment form on the day of the initial assessment (11 October 2020) were:

    - Difficulty with transfers
    - Decreased exercise tolerance
    - Poor balance
    - 'Erratic' use of walking aid/erratic mobility
    - Poor safety awareness
    - Social issues

57. The P IPA advised the physiotherapy notes documented '*very poor safety awareness when mobilising, reaching out and trying to sit before reaching*

toilet/chair.' The physiotherapist also recorded the patient had a '*flexed posture'* and was at a high risk of falls.

58. The P IPA advised the physiotherapist ticked the following treatment plan items of another list in the physiotherapy assessment form:

    - Transfer practice
    - Little and often mobility
    - Mobility practice with assistance
    - Safety awareness advice
    - Gait re-education
    - Liaise with OT and social worker

59. The P IPA advised, in addition, the physiotherapist listed the following short- and long-term goals:

    - Mobilise safely with WZF and two (short term goal). An approximate timeframe of two days was recorded for this.
    - Mobilise safety with WZF with assistance and facilitate safe discharge home (long term goal). No timeframe was stated for this.

60. The P IPA advised there is limited information in the physiotherapy notes, but the documentation records the patient had been experiencing mobility issues and had suffered several falls in the weeks leading up to the admission to hospital. The notes state the patient had said this was because her legs were feeling weak. Someone (we do not know who as no job title given) – had completed a '*falls plan'* on 11 October 2020 at 03.00, which had a review date of 18 October 2020. The physiotherapy notes do not mention any falls risk assessment, but there is reference in 11 October 2020 entry stating that the patient was a high risk for falls.

61. The P IPA referred to NICE Guideline 161 which states:

'*Ensure that any multifactorial assessment identifies the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay. These may include:*

- *cognitive impairment*
- *continence problems*
- *falls history, including causes and consequences (such as injury and fear of falling)'*

62. The P IPA advised the physiotherapist documented they had liaised with nursing staff about the patient's risk and '*this was in line with NICE guidance.*

Continence

63. The N IPA advised no concerns about incontinence are recorded until 10 October 2020, when it is noted the patient "*declined pad change*" and was "*assisted to commode as unable to walk to bathroom*" On 12 October 2020 she was "*incontinent at times*". By 13 October 2020 a UTI is identified, incontinence pads still being used, AKI resolved.

64. Department of Health (DH 2015) guidance on incontinence is clear that Primary Care setting, rather than hospital, is the most appropriate place for treatment of urinary incontinence. However, it recognises that some people will present or be identified for the first time during a hospital admission and hospital nurses must be trained to carry out the initial management. A key principle is that pads should only be issued after initial assessment.

65. The N IPA advised if the patient presented with incontinence, the Trust should have carried out an initial assessment of the problem such as urine test, bladder diary and bladder scan (if available). Use of containment products (e.g. pads) could then be used for short term management of incontinence.

66. The N IPA advised '*the urine testing that was carried out was appropriate an identified that she had a urinary tract infection*.' They did not carry out a bladder scan, '*but I cannot comment on this further as the availability of a bladder scanner is not confirmed*.' Containment products were provided for short term use whilst she was on the ward and this was appropriate. '*I did not*

find an onward referral to community nursing for further investigation and management of incontinence.'

67. The N IPA advised there is no information to suggest the nursing staff had any further concerns regarding the patient's physical health, or any issues relating to capacity with respect to her treatment and care.

Analysis and Findings

ED

68. The medical records document the patient's symptoms on attendance to ED were '*the patient had collapsed, felt dizzy and, at the time of the collapse, was unable to speak*.' A past medical, drug and allergy history were taken. A cardiovascular examination, a respiratory examination and abdominal examination were undertaken. An ECG was recorded, a urinalysis and bloods. Physiological observations were recorded. An abbreviated mental test examination was undertaken together with a full nursing assessment.

69. The C IPA advised '*this was a comprehensive assessment in ED. A diagnosis was formulated and a treatment plan commenced.'* I accept this advice.

70. The ED notes contain an abbreviated mental test score which assesses the patient's mental state. The patient attained 4/4 which meant she was orientated to recall her age, date of birth, the place she was and the current year. The patient's Glasgow Coma Score was recorded as 15/15 meaning she was not confused and able to communicate normally. The C IPA advised '*There was no acute illness of such a nature as to require immediate family input in ED*.' I accept this advice.

71. The C IPA advised '*the actions with ED were appropriate,'* and '*the assessment and treatment and ED were of a reasonable standard*.' I am satisfied the patient was provided with appropriate care and treatment whilst in ED. I do not uphold this element of complaint.

Observations

(i) *Admission to ward*

72. The patient was admitted to the ward at 19.35 on 10 October 2020. On admission a patient centred nursing assessment and plan of care was completed. A summary of identified needs was completed. A plan for further blood tests, echo and telemetry is noted. The elimination assessment did not identify any bladder problems/incontinence but did identify assistance of two people were needed for use of commode. An Additional Risk of Falls Assessment was carried out on 11 October 2020.

73. The N IPA advised '*the Falls Assessment correctly follows the NICE guideline CG161 Assessment and Prevention of Falls in Older People'* which recommended multi-factorial risk assessment and intervention. The N IPA advised '*from a nursing perspective, patient observations and assessments were correctly carried out…'*

74. The N IPA advised although lying and standing blood pressure (BP) was specified, which is line with the Royal College of Physicians Guidance, '*I did not find any record of it having been carried out. This test requires the blood pressure to be measured firstly with the patient lying down, then secondly when standing. The BP is checked to find out if there is a significant drop on standing (postural drop/postural hypotension) as this can be a cause of falls. This test should therefore have been carried out and recorded.'* I consider the Trust's failure to carry out and record lying and standing BP a failure in care and treatment.

(ii) Mental health/capacity

75. Nursing documentation records the patient's view of her mental health and emotional well-being and was described by the patient as '*good'.* The relative with the patient was also asked if there had been any recent change in the level of confusion (if any) or cognitive function and it is recorded that '*no such concerns raised.'*

76. On 11 October 2020 nursing documentation mentioned the patient being confused which continued for a few days before getting better. The C IPA advised there is '*no concern'* about this. The records also document the patient potentially had early Alzheimer's Disease. The Abbreviated Mental Test Score carried out at admission had a score of 0, but on 11 October 2020 the patient was noted to be exhibiting '*confusion' 'asking the same questions over and over*.' On 12 October 202 it is recorded '*confused today but family state she under investigation for same. Was to attend memory clinic but did not attend or MRI appointment.'* The N IPA advised this indicates the Trust was aware the patient had memory problems and these had not been fully investigated at the time of her admission.

77. The N IPA advised the social work discharge summary has no record of any mental capacity assessment using the Mental Capacity Act (Northern Ireland) 2016 about discharge planning. The N IPA advised in hospital care, delirium risk factors should be addressed and refers to NICE Guideline 103 (previously quoted in paragraph 52). The N IPA also advised the Abbreviated Mental Test Score is not a delirium specific tool such as the 4AT test.

78. The N IPA concluded that although no concerns were recorded regarding issues relating to capacity, there are no records that delirium or mental capacity were specifically screened for in accordance with NICE guidance on delirium and the Mental Capacity Act (Norther Ireland) 2016. '*In view of the patient's suspected Alzheimer's disease and onset of confusion in hospital, proactive screening should have been carried out and recorded*.' I accept this advice. I consider the Trust's failure to carry out proactive screening in relation to the patient's delirium or capacity in line with relevant NICE guidance a failure in care and treatment. I uphold this element of complaint.

(iii) Physical health

79. An occupational therapist (OT) reviewed the patient at the initial assessment and treatment session on 11 October 2020. It was ascertained the patient could stand from sitting with assistance of one, and that transfers and walking short distances required a WZF and the assistance of two. An assessment of

range of movement in the arms and legs and strength testing the legs were carried out. The physiotherapy assessment form on 11 October 2020 notes the problems off the checklist (previously detailed in paragraph 58). Treatment plan items on another list on the physiotherapy assessment form were completed to include, transfer practice, little and often mobility, mobility practice with assistance, safety awareness advice, gait re-education, liaise with OT and social worker.

80. The records note short and long-term goals. The P IPA advised there is limited information in the physiotherapy notes but the documentation records the patient had been experiencing mobility issues and had suffered several falls in the weeks leading up to the admission to hospital. The notes do not mention any falls risk assessment, but there is reference in 11 October entry stating the patient was a high risk for falls.

81. NICE guideline 161 states '*ensure that any multifactorial assessment identified the patient's individual risk factors for falling in hospital that can be treated, improved or managed during their expected stay.'* The P IPA advised the physiotherapist documented they had liaised with nursing staff about the patient's risk and '*this was line with NICE guidance*.' I accept this advice. I am satisfied having viewed the records the patient's risk factors were identified and recorded by the physiotherapist and had liaised with nursing staff about these risks. I do not uphold this element of complaint.

(iv) Continence

82. The DH 2015 guidance on incontinence is clear that Primary Care setting, rather than hospital, is the most appropriate place for treatment of urinary incontinence. However, it recognises that some people will present or be identified for the first time during a hospital admission and hospital nurses must be trained to carry out initial management.

83. During the patient's time in ED the nursing documentation makes multiple references to toileting. The records also make reference to checking that incontinence pads are clear and dry. There is an entry at 15.25 which

mentions that patient was upset at one instance because '*she had peed herself three times earlier that day.'* When asked about this the patient replied that '*sometimes it just happens*.'

84. The records document no concerns about incontinence are recorded until 10 October 2020 when it is noted the patient '*declined pad change'* and was '*assisted to commode as unable to walk to bathroom.'* On 12 October 2020 the patient was '*incontinent at times.'* By 13 October 2020 a UTI is identified, incontinence pads still being used, AKI resolved. The N IPA advised '*the urine testing that was carried out was appropriate and identified she had a urinary infection.' 'Containment products were provided for short term use whilst she was on the ward and this was appropriate.'*

85. The N IPA advised the Trust '*managed the incontinence appropriately whilst she was on the ward…'* although the Trust should have provided an onward plan for further management following discharge, therefore in this respect the Trust did not fully act in line with standards and guidance on incontinence care. I accept this advice. I consider the Trust's failure to provide an onward plan for further management of incontinence and failure in care and treatment. I uphold this element of complaint.

Issue two

- **Whether the follow up care provided to the patient between 14 October 2020 and 26 November 2020 was appropriate and in accordance with relevant standards.**

  In particular this will examine if the patients discharge was reasonable and appropriate in terms of the reablement package of care.

Detail of Complaint

86. The complainant said she questions whether the patient was medically fit for discharge on 14 October 2020.

Evidence Considered

Legislation/Policies/Guidance

87. I considered the following policies and guidance:

- The RQIA Review of Discharge from Acute Hospitals (2014);
- NICE Guideline 161;
- HCPC Standards of Proficiency for Physiotherapists; and
- HSC Reablement Service for Northern Ireland and regional reablement pathway.

The Trust's response

88. The Trust stated on the day of discharge on 14 October 2020, the patient mobilised with a zimmer frame under close supervision only and personal care required assistance of one. It is documented the patient's family were happy to take her home to wait for a reablement package to start. With the progress the patient made on the ward and discussion with her regarding discharge home, the occupational therapist and social worker completed the homecare form which detailed the patient was keen and expressed consent of reablement referral.

89. The patient was independent with personal care, independent with bed/chair/toilet and independently mobile with a wheeled zimmer frame. Prior to admission it was noted the patient '*would benefit from a reablement service to facilitate discharge whilst regained her confidence and confusion settled.'* As the patient had no care package prior to admission a package of care 1x3x7 was recommended to support hospital discharge and facilitate further occupational therapy intervention/assessment in her own environment. The Trust explained given the facts at hand at the time of discharge, '*it was the correct decision to allow for discharge home with reablement team*.'

90. The Trust stated on review of all documentation it did not see any information that indicated the patient was in her last weeks of her life whilst an inpatient. Following the patient's discharge from AMU, plans had been put in place for a review and bloods in the Trust's ACU. Unfortunately, this was cancelled at the

family's request for the district nurse to check bloods and GP to refer if no improvement in bloods. From the documentation available the Acute Care at Home Consultant discussed the patient's condition with the family. Consultants normally carry out ACU reviews, but this had been cancelled.

91. The Trust stated the patient was declared medically fit for discharge. In the patient's Homecare form it is noted the patient is keen to return home and expressed consent for reablement referral. The patient's previous functional ability was clarified with her husband via a telephone call with the occupational therapist on 13 October 2020 where it was established the patient was independent with personal care, independent with bed/chair/toilet transfers and independently mobile with a wheeled zimmer frame prior to her hospital admission.

92. The patient's occupational performance was assessed on 11, 13 and 14 October 2022. This showed that on discharge the patient required assistance of one person to assist with personal care, toileting, functional mobility and assisting to bed at night. It was noted family to support between care calls.

Relevant Independent Professional Advice

93. The C IPA advised the patient was fit for discharge. Keeping a patient in hospital longer than they require is harmful to the patient. Patients decondition, lose the ability to walk and care for themselves. As soon as they are able manage at home, either independently, with a formal care package or with informal care from relatives, they should be discharged. Notes suggest that the patient was '*medically recovered*' – *she is passing urine well, she had a course of antibiotics for her chest infection. 'Physiological observations are all normal' on 14 October 2020.*

94. The C IPA advised the physiotherapist report that by 14 October 2020 the patient's confusion had resolved, she was '*keen for home',* she was able to mobilise well with a wheeled zimmer frame with increased safety awareness, and one person supporting. It is documented the family are happy to provide this level of support when the patient was discharged.

95. The C IPA advised. It was clear the patient wanted to get home as soon as possible even early on in admission. It is also clear the hospital had taken an unusual, but patient centred approach to her ACU follow up. Of note her blood tests reveal worsening of her kidney function however a conservative approach is put in place to managing this by suggesting the patient increase her oral fluid intake and repeat bloods would be taken in a few days to see whether this has worked. A plan for renal ultrasound is mentioned should they not improve with this minimal treatment.

96. The C IPA advised there are multiple conversations with the family in the nursing notes. The patient's '*discharge is medically sound and an appropriate plan put in place with an ambulatory care follow up to check progress.'* There is a '*social services referral for carers and physio assessment who work with the patient to improve her mobility to a point the family say they are happy to support her at home.'*

97. The N IPA referred to the RQIA Review of Discharge from Acute Hospitals 2014 guidance which states:

'*The key principles for effective discharge and transfer of care are that;*

- *Unnecessary admissions are avoided and effective discharge is facilitated by a whole system approach;*
- *The engagement and active participation of individuals and their carer(s), as equal partners, is central to the delivery of care and in planning of a successful discharge;*
- *Discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across primary, hospital and social care services;*
- *Staff should work within a framework of integrated multidisciplinary and multi-agency team working, to manage all aspects of the discharge process;*
- *Effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately, and individuals achieve their optimal outcome.'*

98. The N IPA advised from a nursing perspective '*the discharge planning was appropriate*.' Therapy and social workers referrals had been made in a timely way and the patient's daughter (the complainant) had been involved and kept updated. In relation to family engagement, a nursing entry on 14 October 2020 confirms arrangements for reablement follow up and records '*daughter informed and said she will take her mum home and aware S/W will follow up reablement tomorrow.'*

99. The N IPA advised on 13 October 2020 the nursing notes record '*daughter rang voicing concerns as she is really keen to get mum home and is hoping for reablement' 'advised that PT/OT/SW referral sent.'* It is further noted that she was still needing the assistance of two people for personal care.

100. The N IPA advised on 14 October 2020 the patient required '*assistance of 1 to mobilise'* and for personal care. The social worker saw her and contact was made with the reablement team. Reablement did not have a referral but were reported to '*after speaking to…..OPALS they hope to pick up a referral in the am.'* It further records '*fit for discharge'.* The patient was discharged at 17.30 with a plan for repeat CXR in six weeks and an echo as an outpatient.

101. The N IPA advised '*discharge planning and engagement with the family were carried out appropriately and in line with guidance.*

102. The P IPA advised the physiotherapists discharged the patient (to home) on 14 October 2020. Their justification for this was that the patient was no longer confused and was now transferring (sitting to standing) and mobilising safety with a WZF. Although it is documented the patient still needed '*close supervision of one'* for these activities. The note of 14 October 2020 stated that the patient was still requiring verbal prompting (about keeping the frame closer to her when mobilising). The notes also stated the family were happy to provide supervision (support needed for transfers and mobilising) whilst they await reablement input (i.e. a package of care). There is no further reference in the physiotherapy notes relating to discharge planning (e.g. arrangements

for reablement team input, or a community falls service referral post-discharge).

103. The P IPA referred to the HSC Reablement Service for Northern Ireland and regional reablement pathway, specifically the eligibility criteria which states:

- *The Reablement service will be accessible and available across Northern Ireland to all Older People (65+) who are on the threshold of requiring a Domiciliary Care package.*
- *Where the assessed needs are identified as Critical and/or Substantial then the "Fair Access to Care Services" criteria must be applied.*
  AND
- *Requiring assistance of a single member of staff. *In exceptional circumstances a Service User may require the assistance of two members of staff as the Reablement episode commences. However, this must only be required in the initial phase of the Reablement episode.*
- *The referral to the Reablement service is from either the hospital or community pathways. Has a social care need that affects their daily living activities rather than a therapeutic need.*
- *Is medically stable (i.e. there is no immediate change or deterioration expected in the Service User's health/condition).*
- *Lacks confidence and/or requires support after a health or social care crisis, such as illness, deterioration in health or injury.*
- *Has difficulty in performing their essential daily living activities (e.g. personal care needs, mobility, medication management, meals management).*
- *Is motivated to actively engage with the Reablement service.*
- *The Services Users have the cognitive ability to relearn daily living activities.*

104. The P IPA advised '*the patient fulfilled the eligibility criteria*.' Referrals should be screened and triaged within reablement teams (priority and routine would mean initial visit arranged within one and three working days of receipt of referral respectively).

105. The P IPA advised given the physiotherapy records stated '*the family were happy to provide the supervision/support required for a safe discharge whilst they await reablement team input, the decision – making was appropriate*.'

106. The P IPA advised given the recorded improvement in the level of confusion and the documented preparedness of the family to manage the patient at home on discharge, '*the treatment and care provided by the physiotherapists was of an appropriate standard'*. There was an acknowledgment of the falls risk (the physiotherapists liaised with the nursing team about this) and evidence of involvement of local reablement to ensure an appropriate package of care in place (or being processed) for the patient at the point of discharge.

Analysis and findings

107. The complainant raised concerns about whether the patient was medically fit to be discharged.

108. I considered whether the discharge of the patient was appropriate. The C IPA advised the patient was fit for discharge. Medical '*notes suggest that she is medically recovered – she is passing urine well, she has had a course of antibiotics for her chest infection. Her physiological observations are all normal on 14 October 2020*.'

109. On 14 October 2020 the physiotherapist reports the patient's confusion had resolved, she was '*keen for home',* she is able to mobilise well with a wheeled zimmer frame with increased safety awareness and one supporting person. It is also documented the family are happy to provide this level of support when the patient is discharged.

110. The C IPA advised it was clear the hospital had taken an unusual, but patient centred approach to her ACU care follow up. The patient's blood test revealed worsening of her kidney function however a conservative approach is put in place to managing this by suggesting the patient increase her oral fluid intake and repeat bloods would be taken in a few days to see where this had worked.

A plan for renal ultrasound is mentioned should they not improve with this minimal treatment.

111. Within the nursing notes there are multiple conversations with family about discharge. The C IPA advised the patient's '*discharge is medically sound and an appropriate plan put in place with an ambulatory care follow up to check progress.'* There is a '*social services referral for carers and physio assessment who work with the patient to improve her mobility to a point the family say they are happy to support her at home.'*

112. The N IPA referred to the RQIA Review of Discharge from Acute Hospitals 2014 guidance (previously quoted in paragraph 85) and advised from a nursing perspective '*the discharge planning was appropriate.'* Therapy and social work referrals had been made in a timely way and the patient's daughter had been involved and kept updated. The N IPA concluded '*discharge planning and engagement with the family were carried out appropriately and in line with guidance.'*

113. The records document the physiotherapists discharged the patient to home on 14 October 2020. Their justification for this was that the patient was no longer confused and was transferring (sitting to standing) and mobilising safely with a WZF. The notes document the patient still required verbal prompting (about keeping the frame closer to her when mobilising). The notes also document the family were happy to provide supervision (support needed for transfers and mobilising) while they await reablement input. There is no further reference in the physiotherapy notes relating to discharge planning.

114. The HSC Reablement Service for Northern Ireland and regional reablement pathway specifically outlines the eligibility criteria (previously outlined in paragraph 91). The P IPA advised '*the patient fulfilled the eligibility criteria.'*

115. The P IPA advised the family were happy to provide the supervision/support required for a safe discharge while they await reablement input, the '*decision - making was appropriate.'* The P IPA concluded given the recorded improvement in the level of confusion and the documented preparedness of the

family to manage the patient at home on discharge, '*the treatment and care provided by the physiotherapist's was of an appropriate standard.'*

116. Overall I accept the advice of the IPAs in that the discharge of the patient for reablement was appropriate and reasonable and in accordance with relevant guidance. I do not uphold this issue of complaint.

Issue three

- **Whether the Trust's handling of the complaint brought by the patient's daughter, was appropriate and in accordance with the relevant standards.**

Detail of Complaint

117. The complainant said the complaints process was *'protracted and has been poorly managed'* which prolonged the pain and suffering her mother and wider family feel.

118. The complainant also said that she has been advised by the Trust on numerous occasions that a representative would meet with them to go through the medical notes but his never happened.

Evidence Considered

Legislation/Policies/Guidance

119. DOH Complaints Procedure

The Trust's response

120. The Trust's Complaints Department received a complaint letter from the complainant on 14 April 2021 and a signed Trust response was sent to the complainant on 2 July 2021. The Trust received an email from the complainant on the 16 August 2021 stating it was her intention to refer to the Ombudsman's office.

Analysis and findings

121. I considered this issue by examining the relevant Trust records and the relevant policies and guidelines in terms of complaints handling.

122. In terms of the complaints process, I note that the HSC Complaints Policy states that '*Complainants will receive an acknowledgement within 2 working days, their complaint will be investigated thoroughly, treated confidentially and responded to fully in writing within 20 working days*.'

123. I reviewed the Trust's complaint file in relation to the original complaint made on 11 April 2021 and note the Trust received the original complaint on 14 April 2021. The Trust acknowledged the complaint on 15 April 2021.

124. The complainant emailed the Trust on 18 May 2021 to advise of the 20 working days and enquiring when she could expect a response. The Trust contacted the complainant on 19 May 2021 to advise it was working on a response and was in contact with the relevant departments. The complainant responded acknowledging the Trust's letter and expressing concerns as to the delay.

125. I note the complainant emailed the Trust asking for an update on 7 June 2021 as it had been 32 working days from when the original complaint was submitted. The Trust responded on 9 June 2021 apologising, advising it was continuing to work on the response. The Trust sent a further email to the complainant on 30 June 2021 to update and apologise for the delayed response to her complaint.

126. The Trust issued its final response to the complaint on 2 July 2021, two and a half months from the initial complaint was submitted. I reviewed the complaints file for this case and consider those involved in the complaints process demonstrated sufficient urgency to respond to the complaint in terms of obtaining responses from all relevant staff. However, while the Trust did demonstrate its proactivity in obtaining responses from other professionals, at times this was not always communicated with the complainant. I note that any

correspondence with the complainant following the initial complaint was in response to requests for updates from the complainant.

127. The First Principle of Good Complaint Handling, '*getting it right'*, requires bodies to act in accordance with '*relevant guidance and with regard for the rights of those concerned*'. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with '*complainants promptly and sensitively, bearing in mind their individual circumstances'*. I consider the Trust did not provide the complainant with anticipated timescales and did not meet these standards. I consider this failing constitutes maladministration.

128. The complainant stated she had been advised by the Trust on numerous occasions that a representative would meet with them to go through the medical notes but this never happened. In considering this issue I viewed the complaints file and note there are no records demonstrating the Trust advised the complainant a representative would meet with the family. However, it is clear that on two occasions the complainant requested a meeting with Trust staff.

129. The first request was on 13 April 2021. I note an email referencing a telephone call with the complainant and it is recorded '*she asked if a meeting with staff involved in her mum's care could be arranged.'* The second occasion was via written communication from the complainant to the Trust dated 19 April 2021 which stated '*we would both like to request a meeting to discuss to medical issues during my mother's admission…'*

130. Having viewed the complaints file there are no records demonstrating any recognition of the two requests for a meeting from the complainant. The Second Principle of Good Complaint Handling, 'being customer focused' requires bodies to '*listen to and consider the complainant's views.'* I consider the Trust did not address the complainant's requests for a meeting nor give the requests appropriate consideration. As such the Trust's handling of this complaint did not meet these standards. I consider this failing constitutes maladministration.

131. Overall, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office. Therefore, I uphold this issue of complaint.

CONCLUSION

132. I received a complaint about the care and treatment the patient received from the Trust in relation to her admittance to the ED and her subsequent discharge from hospital. I upheld elements of the complaint for the reasons outlined in this report.

133. The investigation found the Trust's actions in relation to the care and treatment the patient received in the ED was appropriate. The patient's risk factors in relation to falls were identified and recorded by the physiotherapist in accordance with relevant guidance. The discharge of the patient for reablement was appropriate and in accordance with relevant guidance.

134. The investigation established that following the patient being admitted to the ward, observations and assessments were carried out appropriately. However, despite lying and standing BP specified to be taken, there are no records evidencing it was conducted. I consider the Trust's failure to carry out and record lying and standing BP a failure in care and treatment.

135. In relation to delirium and capacity the investigation found the Trust failed to carry out proactive screening in relation to the patient's delirium or capacity in accordance with relevant guidance.

136. In relation to incontinence the investigation found a failure as the Trust did not provide an onward plan for further management of incontinence following discharge.

137. In relation to complaints handling the investigation established the Trust did not provide the complainant with anticipated timescales for a response. The Trust did not address the complainant's requests for a meeting. I consider these failings constitute maladministration.

Recommendations

138. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified within one month of the date of this report).

139. I further recommend, for service improvement and to prevent future reoccurrence, that the Trust:

I. Contact the complainant and offer to meet with her to go through the patient's medical records to answer any outstanding questions she may have.
II. Reflect on the learning identified by the IPA.

Throughout my consideration of this complaint, it was evident that the complainant wanted the best possible care for the patient during her time in hospital. I offer my condolences on the loss of her much loved mother.

MARGARET KELLY **3 June 2024**
Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

Principles of Good Complaint Handling

1. **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.
- 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.

2. **Being customer focused**

- 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.

3. **Being open and accountable**

- 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.

4. **Acting fairly and proportionately**

- 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.

5. **Putting things right**

- 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.

-

6. **Seeking continuous improvement**

These Principles are not a checklist to be applied mechanically. Public bodies should use their judgment in applying the Principles to produce reasonable, fair and proportionate results in all the circumstances of the case. The Ombudsman will adopt a similar approach when considering the standard of complaint handling by public bodies in her jurisdiction.