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

**Report Reference: 202001066**

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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:** 202001066

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

## SUMMARY

I received a complaint regarding the actions of the Northern Health and Social Care Trust (the Trust). The complainant's father (the resident) resided in Chester Care Home (the Home) since September 2020. The complainant raised concerns to the Home and the Trust about care and treatment the Home provided to the resident. The complainant said the Trust did not treat these concerns with enough seriousness. He subsequently submitted a complaint to my office about its decision not to initiate Adult Safeguarding[1] procedures, nor raise a Serious Adverse Incident[2] (SAI), regarding his concerns.

The investigation examined the details of the complaint, the Trust's response, evidence from the Home, and from other multi-disciplinary organisations. I also obtained relevant policies and guidelines relating to Adult Safeguarding and Serious Adverse Incidents.

I acknowledged the reasons for the complainant's concerns. However, the investigation found that the Trust followed relevant policies and guidance in its consideration of Adult Safeguarding concerns and whether raising an SAI was appropriate. I did not uphold the complaint.

[1] Protecting an adult's right to live in safety, free from abuse and neglect. The aims of adult safeguarding are to: prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
[2] Any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage to Service Users.

## THE COMPLAINT

1. This complaint was about the actions of the Northern Health and Social Care Trust (the Trust). The complainant raised several concerns with the Trust about care and treatment Chester Care Home (the Home) provided to his father (the resident) following his admission on 7 September 2020. The complainant said that despite the care and treatment issues raised, he was not satisfied with how the Trust dealt with the concerns.

2. The complainant said the Trust did not initiate Adult Safeguarding procedures[3], nor did it raise the matter as a Serious Adverse Incident[4].

### Background

3. On 7 September 2020, the resident moved to the Home. Prior to this move, the resident lived at another care home.

4. On 31 January 2021, the Home held a Covid-19 Vaccination Clinic on the Home's premises. The Trust mobile vaccine team intended to administer a Pfizer vaccine to one resident. It later decided to administer vaccines to Trust staff during that clinic. On 4 February 2021, the complainant raised a concern regarding the decision to hold the Vaccination Clinic.

5. On 9 February 2021, the Trust received a complaint from the complainant's MLA, raised on his behalf, regarding the Vaccination Clinic. On 16 February 2021, the Trust initiated an Adult Safeguarding Initial Strategy meeting to consider the concern. The meeting concluded that the Trust acted in accordance with the Covid-19 procedures, and that it was not appropriate to raise an SAI.

6. On 13 March 2021, the complainant raised concerns about the resident falling in the Home. The complainant said this was due to the condition of his father's

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[3] Protecting an adult's right to live in safety, free from abuse and neglect. The aims of adult safeguarding are to: prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
[4] Any event or circumstance that led or could have led to unintended or unexpected harm, loss or damage to Service Users.

feet. On 31 March 2021, the resident had another fall and the complainant said this was again due to the condition of his feet.

7. On 16 March 2021, the Trust proposed the commencement of a facilitated conversation between the complainant, the Home and the Trust. The Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Care Home Advice and Support (CHASNI) facilitated this meeting. The Trust stated it hoped that a therapeutic approach may help to resolve issues and promote positive working relationships.

8. On 26 March 2021, the complainant raised a concern regarding the quality of the food and the plate used to serve the resident's food in the Home. Following this incident, the Home investigated the concern and issued an apology about the quality of the food with an emphasis on improving quality going forward. The Home also explained that the plate used was specialist dementia crockery which acted as a visual aid and helped to promote independent eating.

9. On 9 April 2021, the complainant raised concerns about the resident's incontinence pads. The complainant took photos of the resident's groin area as evidence, which he sent to RQIA.

10. On 26 April 2021, the Trust conducted an Adult Safeguarding investigation about this issue involving RQIA and the Home. Following this investigation, the Trust and RQIA were satisfied that the Home appropriately met the resident's needs. The Trust and RQIA agreed that the resident had been toileted appropriately and pads changed frequently.

**Issue of complaint**

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

**Whether the Trust followed the relevant guidance/procedures when it made its decision not to proceed with an Adult Safeguarding Investigation or action a Serious Adverse Incident.**

*In particular this will include consideration of how the Trust actioned the following concerns the complainant raised*:

- The decision to hold a vaccination clinic in the Home
- Foot care
- Quality of food
- Changing of incontinence pads

12. I considered the Trust's actions relating to Adult Safeguarding and the decision not to raise an SAI jointly in this report. I addressed how the Trust actioned each of the concerns the complainant raised insofar as the decisions made about Adult Safeguarding and an SAI.

## INVESTIGATION METHODOLOGY

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

**Relevant Standards and Guidance**

14. 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[5]:

    - The Principles of Good Administration

15. 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.

[5] 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:

- Adult Safeguarding: Prevention and Protection in Partnership Policy, 2015 (Adult Safeguarding Policy);
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016);
- Northern Ireland Adult Safeguarding Partnership (NIASP) - Adult Safeguarding Operational Procedures: Adults at Risk of Harm and Adults in Need of Protection, September 2016 (Operational Procedures);
- Safeguarding Vulnerable Adults, A Shared Responsibility: Standards & Guidance for Good Practice in Safeguarding Vulnerable Adults, 2010 (Safeguarding Policy);
- Covid-19: Guidance for Nursing and Residential Care Homes in Northern Ireland, Version 2.9 – 15 January 2021 (Covid-19 Guidance);
- Department of Health, Social Services and Public Safety – Residential Care Homes Minimum Standards, August 2011 (Residential Care Home Standards); and
- National Institute for Health and Care Excellence (NICE), NICE Guideline 19 – Diabetic foot problems: prevention and management, October 2019 (NICE Guideline 19).
- Department of Health – Procedure for the Reporting and Follow up of Serious Adverse Incidents, Version 1.1 – November 2016 (DoH Guidance);

16. I also considered information obtained from the RQIA's report on the Quality Assurance of the Review of the handling of all Serious Adverse Incidents, reported between 1 January 2009 and 31 December 2013 (December 2014).

17. 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.

18. 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.  Neither party wished to make any comment on the draft report.

## THE INVESTIGATION

**Whether the Trust followed the relevant guidance/procedures when it made its decision not to proceed with an Adult Safeguarding Investigation or action a Serious Adverse Incident.**

*In particular this will include consideration of how the Trust actioned the following concerns the complainant raised*:

- The decision to hold a vaccination clinic in the Home
- Foot care
- Quality of food
- Changing of incontinence pads

**Detail of Complaint**

19. The complainant said his father (the resident) *'…suffered serious neglect and ill treatment'* by the Home.  The complainant raised concerns that the Trust did not initiate Adult Safeguarding procedures or raise an SAI regarding the issues outlined above. The complainant provided the following information:

Vaccination Clinic

20. The Trust held the Vaccination Clinic in the Home on 31 January 2021.  At this time, the Home restricted the complainant's visiting due to the risk of the Covid-19 infection.  The complainant believed this was contrary to the decision to hold the clinic.

21. The complainant disagreed with the outcome of the Trust's Adult Safeguarding initial strategy meeting on 16 February 2021.  The outcome of this meeting found the Trust appropriately followed Covid-19 procedures and that an SAI investigation was not appropriate.

22. On 24 February 2021, the Trust received a complaint from the PCC raised on behalf of the complainant. In the complaint, the PCC raised Adult Safeguarding concerns in relation to the Vaccination Clinic held at the Home.

Podiatry[6]

23. The complainant said the Trust left his father's feet in a very poor condition and that he did not have frequent podiatry appointments. The resident had a fall in the Home on 13 March 2021, which the complainant attributed to the condition of the resident's feet. On 31 March 2021, the resident had another fall, which the complainant again believed was due to the poor condition of the resident's feet.

Quality of Food

24. On 26 March 2021, the complainant raised a concern regarding the quality of food the Home provided to his father. The complainant also enquired about the type of plate the Home used for the resident's meals.

Incontinence Pad

25. The complainant raised a concern that on 9 April 2021, the Home did not change the resident's incontinence pad. The complainant took photos of his father which he sent to RQIA on 26 April 2021. In this email, the complainant enquired about the level of care the Home provided to the resident.

26. The complainant said the Home did not change the resident's incontinence pad *'for a very long time'.* He said that an *'adult safeguarding investigation should have commenced long ago'.*

[6] A branch of medicine devoted to the treatment of disorders of the foot, ankle, and leg.

**Evidence Considered**

**Legislation/Policies/Guidance**

**The Trust's response to investigation enquiries**

27. The Trust stated it investigated the concerns and issues raised, *'involving a range of representatives from a number of organisations including the Trust, RQIA and the Care Home'*.

Vaccination Clinic

28. The Trust provided context for the Vaccination Clinic held on the afternoon of Sunday 31 January 2021. The Trust stated it delivered the Pfizer Covid-19 vaccine to residents of Care Homes (where clinically appropriate), and to Care Home staff, since December 2020 when the vaccine became available. It explained the vaccine delivery programme had to take account of the logistical challenges, which meant returning to a Care Home several times. The Trust stated; *'there is also the need to consider the fact that a Pfizer vaccine vial provides for six doses of the vaccine, and when the vial has begun to be used in the Care Home it cannot be taken to another location. An opened vial also has a usable lifespan of six hours, after which its potential for use expires'*.

29. On 31 January 2021, the Trust mobile vaccine team planned a visit to the Home to provide a Pfizer vaccine to one resident. Following the one resident receiving the vaccine, five doses remained in the vial. In addition to this, there was a second unopened vial which meant there were 11 vaccines available. The Trust said it invited 11 health care staff to the Home to receive their vaccination.

30. The Trust stated that each member of staff invited to receive their vaccine did so in the foyer of the Home. The Trust also stated those receiving the vaccine did not enter the main lobby or any other part of the Home. It said, '*Staff wore fluid shield masks and adhered to social distancing requirements'.*

31. The Trust informed this office that on 16 February 2021, it held an Adult Safeguarding Initial strategy meeting in respect of the Vaccination Clinic which the RQIA also attended. During this meeting, it was found that the Trust

followed Covid-19 procedures and that an SAI investigation was not appropriate.

Podiatry

32. The Trust provided a response from Podiatry services. It stated Podiatry first assessed the resident on 28 June 2018 following a referral placed on 15 June 2018. This assessment indicated that the resident, *'was a moderate risk patient and as detailed in the Regional Diabetic Foot Pathway a moderate risk patient should have access to Podiatry every 3-6 months'*. The Trust explained it based this timeframe on NICE Guideline19. It said it educates each moderate risk patient according to their presentation and provides advice on how to access the service when they require treatment. Podiatry further stated, in this case, six monthly reviews were adequate, as the only treatment he required was nail care.

33. The Trust stated that in line with the pathway, Podiatry services advised the resident and the Home to contact Podiatry again when the resident required treatment. Podiatry stated it reviewed the resident on 7 October 2020, following which, they recommended three monthly reviews due to his *'advancing nail pathology at this time'.* This timeframe is in accordance with the Regional Diabetic Foot Pathway. The resident's next appointment followed a referral on 16 March 2021, which exceeded the expected review of three months. The Trust stated that at this time the Home would have been experiencing and managing the risk of the next surge of Covid-19.

34. Podiatry stated they spoke with the complainant in August 2021. It said it explained the resident's risk category, and although the timescale for review was 3-6 months as per the regional risk tool, *'the Podiatry team will endeavour to see him every lower end of this timescale, he [the complainant] was accepting of this'*.

35. The Trust stated it managed this issue under Care Management Protocols, and '*the threshold for Adult Safeguarding was not met in respect of podiatry'*.

Quality of Food

36. The Trust stated the Home investigated this issue. It explained the meal the complainant raised concern with was the resident's evening meal. The Trust said the Home used specialist dementia crockery which acted as a visual aid and the rim promoted independent eating. The manager of the Home issued an apology regarding the quality of the food and stated its emphasis on improving quality.

37. The Trust also stated that the complainant said his father had lost weight. It said that the Alzheimer's Society carried out an Independent Advocacy Report[7] in which it states, *'the issue of weight loss was found to be inconsistent with the Home records which show that the patient [resident] weighed 70.4kg on admission to the Home in September 2020 and in July 2021 he weighed 73.6kg'.* Therefore, showing the resident gained weight.

38. The Advocacy Report also stated, *'Quality of food was also dealt with, the Home admitted that there was one occasion where gravy had inadvertently been poured over a lasagne dish and the Home apologised for this error.'*

39. The Trust advised that this issue did not meet the threshold for initiation of Adult Safeguarding procedures.

Incontinence Pads

40. The complainant submitted a complaint to RQIA highlighting his concerns. This included photos of the resident's clothed groin area alleging that the Home did not change the incontinence pad in-situ. Following an Adult Safeguarding initial meeting on 26 April 2021, the Trust stated both it and RQIA were satisfied the resident's *'needs were being appropriately met, the patient [resident] had been toileted regularly and pads changed frequently'*.

41. Finally, the Trust stated it referred the resident to the Alzheimer's Society advocacy service (the Independent Advocate) on 6 May 2021 due to ongoing

[7] The role of an Independent Advocate is to provide independent support and represent the person and to facilitate their involvement in the key processes and interactions with the Trust and any other organisations as required.

issues the complainant raised.  It stated the Independent Advocate carried out extensive work with the resident and family.  The Independent Advocate submitted a report to the Trust on 9 November 2021 with various recommendations.  The Independent Advocate stated that plans must be put in place and actioned to ensure the resident's right to continue his residency in a familiar and safe environment.  All involved parties should work together in order to expedite this process.

42. The Trust stated that during the Independent Advocate's investigation, the complainant *'was critical of advocate's role and condemnatory of professionals overseeing the patient's [resident's] care, including the Trust and RQIA'*.

**Relevant Trust records**

43. I reviewed the relevant Trust records.

**Analysis and Findings**

44. The Adult Safeguarding Policy states how safeguarding is based on fundamental human rights and respecting the rights of adults as individuals.  It states;
*'Safeguarding adults is complex and challenging. The focus of any intervention must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the adult's choices and preferred outcome for their own life circumstances'.*

45. I considered this complaint in terms of the complainant's views, along with those of the Trust, the Home, the Alzheimer's Independent Advocate and other professionals involved.  In addition to this, I examined relevant policies and procedures relating to initiating Adult Safeguarding and Serious Adverse Incidents.  The complainant raised several concerns with the Home and the Trust's handling of the concerns.  I acknowledge the complainant's concerns and the wish for his father to be appropriately cared for and safeguarded.

Vaccination Clinic

46. I acknowledge the complainant's concerns about the potential spread of Covid-19 and the need for social distancing including adherence to all regulations. I also acknowledge the complainant's concerns for his father and other residents that a potential Covid-19 outbreak could have significant consequences for service users and their families.

47. Section 9.1 of the Adult Safeguarding Policy states that the Trust was required to '*work closely with service providers to assist them to address ongoing concerns.'* It was also required to '*monitor the quality of the performance of service providers and identify any deterioration in standards of care and risks this may present.*' Furthermore, Section 8.2 of the guidance states that where there is a concern, '*the role of inspection and that of the relevant regulator is critical in addressing the safeguarding concern and the prevention of harm*.' The policy also states that the RQIA will ascertain whether the provider is in breach of regulation or minimum standards.

48. On 16 February 2021, the Trust held an Adult Safeguarding Initial Strategy meeting, which also involved the RQIA (the relevant regulator). This meeting was to discuss the concern raised about the vaccination clinic and establish if it presented any risks. Both the Trust and the RQIA concluded that the Trust followed Covid-19 procedures and that an SAI investigation was not appropriate. I note the bodies based their decision on safety measures the Home put in place on the day of the Vaccination Clinic. These included the use of fluid shield masks, and that those staff invited to receive their vaccine did not enter the main lobby or any other part of the Home.

49. I consider that by convening a multi-disciplinary Initial Strategy meeting, and by involving the relevant regulator in the decision making process, the Trust acted in accordance with the Adult Safeguarding Policy.

50. The complainant also raised a concern that the Trust did not raise an SAI regarding this matter. I refer to the DoH Guidance, which outlines criteria for an SAI. I consider that as the Initial Strategy meeting established there was no

risk, the clinic did not constitute an '*unexpected serious risk to a service user*'. Therefore, I am satisfied the Trust's decision not to raise an SAI in this instance was appropriate. I do not uphold this element of the complaint.

Podiatry

51. The complainant said he reported to the Trust that he considered the resident's falls were due to the condition of his feet. He said he also informed the Trust it was due to Podiatry services not assessing his father with sufficient frequency.

52. The Home had a Care Plan in place for the resident, which included his foot care. Having reviewed the records, I consider this was in accordance with Section 9.1 of the Adult Safeguarding Policy. It states that the Trust must '*ensure that there is a personalised care plan detailing the needs of the adult and specifying how the service provided will safely meet the needs and mitigate any risks identified*.'

53. I also note that Podiatry Services reviewed the plan and increased the frequency of its reviews of the resident's feet. I consider this also was in accordance with Section 9.1 of the Adult Safeguarding Policy. It states that the Trust should '*ensure that the care plan is reviewed regularly, as specified in the Care Management Guidance, or more frequently as required in order to respond to changing needs and/or risks*.'

54. The Trust said it addressed the complainant's concern during a multidisciplinary meeting held on 30 April 2021. I note representatives from the Trust, the Home, RQIA and the DOH attended this meeting. The Trust said it established that '*the threshold for Adult Safeguarding was not met in respect of podiatry*'. It stated that it managed the concern under Care Management Protocols.

55. The Adult Safeguarding Policy requires Trust to assess the concern and decide if it meets the threshold for referral. It also requires involvement of the relevant regulator in the decision making process. I consider the Trust did so in this instance. I consider that by involving other professional bodies (including the relevant regulator), the Trust again acted in accordance with the Adult Safeguarding Policy.

56. I note that on one occasion, Podiatry services did not review the resident within the revised period of three months. The Trust stated it and the Home acknowledged the complainant's concern and apologised for the delay in the Podiatry review. I consider this an appropriate response.

57. In relation to the decision not to raise an SAI regarding this matter, I again refer to the HSCB Guidance. I consider that as the Initial Strategy meeting established that there was no risk to the resident, the clinic did not constitute an '*unexpected serious risk to a service user'*. Therefore, I am satisfied the Trust's decision not to raise an SAI in this instance was appropriate. I do not uphold this element of the complaint.

Quality of Food

58. I note the complainant's concerns that he wants his father to have a balanced and varied diet, and food that is at an acceptable standard.

59. The Trust explained that following its review of this issue, it did not consider it met the threshold to initiate Adult Safeguarding procedures. I considered if the Trust's decision was appropriate and in accordance with guidance.

60. Section 4 of the Adult Safeguarding Policy refers to the underpinning principles of Adult Safeguarding. It involves *'empowering and enabling all adults'* and that a '*Person-Centred Approach'*[8] is used to promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings. A person-centred approach to adult safeguarding demonstrates respect for the rights of the individual.

61. Section 5 of the Adult Safeguarding Policy defines an *'adult at risk of harm'* and an *'adult in need of protection'.* It states that the decision as to whether the threshold for a safeguarding referral has been met will demand the *'careful exercise of professional judgement'* applied on a case by case basis. This will

[8] Person-Centred is about focusing care on the needs of the individual. Ensuring that people's preferences, needs and values guide clinical decisions, and providing care that is respectful of and responsive to them.

consider all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances.

62. Based on the evidence available to me, I am satisfied the Trust appropriately considered the relevant factors prior to deciding that the concern did not meet the threshold to initiate safeguarding procedures. Furthermore, as the Trust did not identify a significant risk to the resident, I consider its decision not to raise an SAI appropriate. As such, I do not uphold this element of the complaint.

63. I note the Independent Advocate referred to food in their report. They did not raise any concerns in relation to food and identified that the resident put on weight during his time in the Home. I consider this further evidence that there was no significant risk to the resident. I hope this provides the complainant some reassurance regarding this concern.

64. I note the Home issued an apology regarding the quality of the food. In relation to the use of crockery, I accept the Trust's explanation that the Home use specialist dementia crockery to help promote independent eating.

Incontinence Pads

65. In relation to the issue of the resident's incontinence pads, I again refer to Sections 8.2 and 9.1 of the Adult Safeguarding Policy. The policy also states that the RQIA will ascertain whether the provider is in breach of regulation or minimum standards. I also refer to Section 5 of the policy, which defines an *'adult at risk of harm'* and an *'adult in need of protection'.*

66. I note that in response to the concern raised on 9 April 2021, the Trust initiated an initial Adult Safeguarding multidisciplinary meeting. This occurred on 26 April 2021 and involved the RQIA as the relevant regulator. The Trust provided evidence that the bodies exercised professional judgement (and independent professional judgement) during this meeting. In doing so, the Trust and the RQIA concluded that the Home appropriately met the resident's needs, and the matter did not meet the threshold for raising an Adult Safeguarding concern or an SAI.

67. I consider that by convening a multi-disciplinary meeting, and by involving the relevant regulator in the decision making process, the Trust acted in accordance with the Adult Safeguarding Policy. I do not uphold this element of the complaint.

## CONCLUSION

68. This office received a complaint about the actions of the Trust. The complainant raised several concerns with the Trust about care and treatment provided to the resident in the Home. The complainant said the Trust did not initiate Adult Safeguarding procedures, nor did it raise the matters as an SAI.

69. I acknowledge the reasons for the complainant's concerns. However, having carefully considered the available evidence, I am satisfied the Trust acted appropriately and in accordance with relevant policy and guidance. I therefore do not uphold the complaint for the reasons outlined in this report.

70. I would like to conclude with a statement made by the Independent Advocate;
*The resident is a vulnerable adult with advanced dementia. He is a happy, relaxed, quiet, reserved, courteous, gentleman and has adapted well to the environment in the Home. He enjoys a good relationship with the staff, continues to participate in the daily activities offered and appears to relish his life in the Home. The staff at the Home have adopted a holistic, person-centred approach in their management of the resident and he is able to engage well.*
*'Most importantly he is made to feel fulfilled and gratified by participating periodically in little projects… he is happy in the Home'.*
I trust this independent assessment of his father's residency in the Home offers the complainant some reassurance.

**Margaret Kelly**
**Northern Ireland Public Services Ombudsman** **June 2023**

**Appendix One**

# PRINCIPLES OF GOOD ADMINISTRATION

**Good administration by public service providers means:**

**1. Getting it right**

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

**2. Being customer focused**

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

**3. Being open and accountable**

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

4. **Acting fairly and proportionately**

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.

- Dealing with people and issues objectively and consistently.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. **Putting things right**

- Acknowledging mistakes and apologising where appropriate.

- Putting mistakes right quickly and effectively.

- Providing clear and timely information on how and when to appeal or complain.

- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. **Seeking continuous improvement**

- Reviewing policies and procedures regularly to ensure they are effective.

- Asking for feedback and using it to improve services and performance.

- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

**Appendix Two**

# PRINCIPLES OF GOOD COMPLAINT HANDLING

**Good complaint handling by public bodies means:**

**Getting it right**

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

**Being customer focused**

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

**Being open and accountable**

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

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

**Acting fairly and proportionately**

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

**Putting things right**

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

**Seeking continuous improvement**

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