Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against the Northern Ireland Children's Hospice

NIPSO Reference: 17949

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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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SUMMARY

I received a complaint about the actions of the Northern Ireland Children's Hospice (the Hospice). The complaint concerned the care and treatment provided by the Hospice to the complainant's daughter, who sadly passed away at home on 2 May 2017.

I accepted the following issues of complaint for investigation:

Issue One: Whether the treatment and care afforded to the complainant's daughter was reasonable and appropriate?
Issue Two: Whether the Hospice's handling of the complaint was reasonable?

I have investigated the complaint and have found failures in care and treatment in relation to the following matters:

- Failure to establish an unambiguous feeding plan
- Failures in communication about care and treatment

I have also found failures amounting to maladministration in relation to the following matters:

- Failures in policy and investigation of equipment faults
- Failures in the complaints handling by the Hospice

I have not found failures in care and treatment:

- In "fluid overloading" of the complainant's daughter during care in the Hospice leading up to 22 April 2017

I am satisfied that the failures in care and treatment and maladministration I identified caused the complainants to experience the injustice of distress, uncertainty, frustration and time and trouble taken to pursue their complaint to my office.

Recommendations

I recommended:

- The complainants should receive a written apology from the Chief Executive of the Hospice, in the terms of my guidance on Apology, for the failures identified in this report and a payment of £2000 by way of solatium for the injustices I have identified within **one** month from the date of this report
- The Hospice should offer to meet the complainants to learn from their complaint experience
- The Hospice should ensure the complainants are made aware of the Hospice bereavement support services

In order to improve the service delivery of the Hospice I recommended:

- The Hospice should further review their Admission procedure for children to ensure clarity on issues such as feeding regime between staff, other health professionals and parents/patient (where appropriate) within **three** months of the date of my report. I also recommend that the Hospice review staff training on clear communication with patients/carers following the issues highlighted in this report.
- The Hospice should conduct a review of their operation of the Hospice complaints process considering my findings and report the outcome to me within three months and implement an action plan to incorporate any recommendations of that review and should provide me with an update within **six** months of the date of my final report.

THE COMPLAINT

1. The complainants submitted a complaint about the actions of the Hospice. This related to the care and treatment of their daughter and the way their subsequent complaint was handled. The complaint covered a number of areas, summarised as: delayed provision of saline nebuliser[1]; uncertainty regarding provision of humidified oxygen; delayed provision of a specific feeding plan; timing of medication; clarification on feeding regime; and defective feeding pump issue.

2. The complainant's daughter was born on 31 December 2016. She was diagnosed with Trisomy 13[2] while in hospital. She was allowed home from hospital with community based care and arrangements for respite at the Hospice.

3. The complaint was accepted by this office for investigation on 1 November 2017.

Issues of Complaint

4. The issues of complaint which I accepted for investigation were:

   Issue One: Whether the treatment and care afforded to the complainant's daughter was appropriate and reasonable?

   Issue Two: Whether the Hospice's handling of the complaint was reasonable?

[1] Nebuliser: a machine that helps you to breathe in a medicine as a mist through a mask or a mouthpiece and can help control build-ups of phlegm and mucus.
[2] Trisomy 13 is a genetic disorder in which a baby has 3 copies of genetic material from Chromosome 13, instead of the usual 2 copies. It is a life-limiting condition where 90% of children suffering from the condition die in their first year.

INVESTIGATION METHODOLOGY

5. In order to investigate the complaint the Investigating Officer obtained from the Hospice all relevant documentation together with the Hospice's comments on the issues raised. The Hospice had already had sight of the complaint and the issues that the complainants had brought to my office. This included: their daughter's hospice medical and nursing records; Hospice complaints records; records of review team meetings; and the review team report. I note that the Hospice obtained access to the child's Hospital notes and records during its investigation of the complaint and obtained a report from the Hospital consultant who oversaw her care. A series of clarifications and comments were sought from the Hospice during the investigation. The manner of investigation is a matter for my discretion under the 2016 Act. In this instance the Hospice were critical of my decision not to interview staff about the issues of complaint

Independent Professional Advice

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

   - A Consultant in Paediatric and Neonatal Intensive Care – Medical IPA
   - A Senior Neonatal palliative care nurse – Nursing IPA

7. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have provided me with 'advice' which I have considered in their entirety. However, how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

9. The general standards are the Ombudsman's Principles[3]:
    (i) The Principles of Good Administration
    (ii) The Principles of Good Complaints Handling
    (iii) The Public Services Ombudsmen Principles for Remedy

10. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions of the Hospice and the professional judgment of the clinicians whose actions are the subject of this complaint.

11. The specific standards relevant to this complaint are:
    - Nursing and Midwifery Council (NMC), The Code (2015)[4]
    - "Guidelines for caring for an infant, child or young person who requires enteral feeding". Guidelines and Audit Implementation Network (GAIN) Feb 2015
    - Northern Ireland Hospice Complaints Policy (2016)
    - DHSSPS Regional Complaints Guidance (2009) [5]
    - DHSSPS Minimum Care Standards for Independent Healthcare Establishments (July 2014)[6]

12. I have not included all of the information obtained in the course of the investigation in this report. However I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

[3] [3] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[4] https://www.nmc.org.uk/standards/code/read-the-code-online/
[5] https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-complaints-standard-and-guidelines-for-resolution-and-learning-updated-february-2015.pdf
[6] https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Standards/Independent_Healthcare_Minimum_Standards.pdf

THE INVESTIGATION

Issue One: Whether the treatment and care afforded to the complainant's daughter was appropriate and reasonable?

Detail of Complaint

13. Shortly after her birth the complainant's daughter was diagnosed with Trisomy 13. While in Hospital, she was noted to have a bilateral cleft lip/palate, bicuspid aortic valves[7], small PDA[8] and generally experienced some feeding and respiratory difficulties. She was discharged from Hospital on 14 February 2017 with a home based care plan which included a referral to the Hospice for continuing community and respite care. She had a number of periods of care in the Hospice; from 4 March to 7 March 2017; 25 March to 14 April 2017 and 16 April to 22 April 2017 when her mother took her from the Hospice directly to Hospital. She died on 2 May 2017 at home.

14. The complainants wrote a letter to the Hospice on 27 April 2017. The letter contained a detailed chronology of events during the above periods of hospice admission. The complaint centred on a number of distinct areas of care and treatment while in the Hospice, including: delayed provision of a specific feeding plan; delayed provision of saline nebuliser; uncertainty regarding provision of humidified oxygen; Losec[9] administration; clarification on feeding regime; and a defective feeding pump issue.

15. The Hospice responded to the complaint by letter dated 27 June 2017 setting out the results of an independent review conducted by it into the complaint. The complainants responded to the review outcome with a further detailed letter and submission outlining their dissatisfaction with the outcome of the review. They met with the Director of Care and Quality Governance on 17 July 2017. After

[7] A bicuspid aortic valve is an aortic valve that only has 2 leaflets, instead of 3. The aortic valve regulates blood flow from the heart into the aorta. The aorta is the major blood vessel that brings oxygen-rich blood to the body
[8] Patent ductus arteriosus (PDA) is a condition in which the ductus arteriosus does not close. The word "patent" means open. The ductus arteriosus is a blood vessel that allows blood to go around the child's lungs before birth.
[9] Losec contains the active substance omeprazole. It belongs to a group of medicines called 'proton pump inhibitors'. They work by reducing the amount of acid that your stomach produces.

the meeting the complainants remained dissatisfied with the Hospice response to their complaint.

16. I set out below the details of the complaint under each area. In respect of the provision of a specific feeding plan for the complainant's daughter I note that during her first stay in the Hospice the complaint was that there was confusion among staff about feeding her using an enteral feeding device[10] when the pH[11] reading of aspirates[12] were above a certain level. The Hospice response to this issue was that:

'…there was a need for an individualised, unambiguous feeding plan which included the ability to feed [the child] outside the recommended guidelines. In addition, the priorities for feeding should have been agreed between [the child's] parents and … staff and other key professionals including [her] Paediatrician.'

17. In respect of the provision of a saline nebuliser on 27 March 2017, the parents complained that nursing staff gave them a clear impression that this was being actioned in a short space of time and in fact the nebuliser was not provided until the evening of 27 March 2017. The Hospice response to this issue was that:
'The use of a nebulizer in this instance would not be considered an emergency medication but rather for relief and improved comfort and as such the time from discussion to prescription is very unlikely to have caused any clinical deterioration in [the child's] condition. However the rationale for suggesting a nebulizer …may not have been explained in sufficient detail…'

18. I note that in respect of the provision of humidified oxygen, the complainants said that they had discussions with a member of Hospice staff on 27 March 2017 who appeared unaware that their daughter was to be treated with humidified oxygen, save for when on trips out. They felt this indicated she had not been receiving humidified oxygen since her readmission on 25 March 2017.

[10] Enteral tube feeding is the delivery of nutrients directly into the digestive tract via a tube. The tube is usually placed into the stomach via either the nose or mouth.
[11] A figure expressing the acidity or alkalinity of a solution on a scale on which 7 is neutral, lower values are more acid and higher values more alkaline.
[12] A sample drawn from the body, in this case the stomach, by suction.

The Hospice response to this issue was that:
'…review team concluded that [the baby] was receiving humidified oxygen from her admission…It was unfortunate that when this was checked by [her] parents that the Health Care Assistant … was unable to satisfactorily clarify the current practice, which led to confusion and anxiety…'

19. In respect of the administration of the medication Losec, the complainants said that their daughter was not given this medication in accordance with her prescription. It was also indicated by the complainants that the delays in giving the medication were indicative of a desire on the part of Hospice staff to avoid higher pH readings and reliance upon the specific feeding plan mentioned above. The Hospice response to this issue was that:
'…[the child's] records include the rationale for delay in administration. It is unlikely that the delay had any impact on tolerance of feeds; …clear communication on the part of …staff is paramount to avoid added anxiety.'

20. I note that in respect of the feeding regime that the complainants said that Hospice staff fed their daughter water instead of Dioralyte[13]. This came to their attention on 21 April 2017 and may have happened earlier. They also felt there was a failure to comply with her agreed feeding regime. The Hospice response to this issue was that:
'The review team concluded that [the] feeding regime needed frequent adjustments taking account of changing factors such as vomiting, bowel habits, respiratory symptoms, tolerance of volume and rate and practical issues… The review team considered a report from the …hospital medical team concerning [the child's] condition on admission…'

21. In respect of the feeding pump issue, the complainants state they also became aware on 21 April 2017 that there had been errors in the amount of fluid their daughter had been given use a feeding pump. They state that a member of staff demonstrated the feeding pump was giving 30mls extra fluid. They also state they were advised the error had been noticed by Hospice staff on 17 April 2017, which they had not been informed about. They believed that the

[13] Fluid and electrolyte replacement

consequences of a feeding pump error would have been their daughter receiving extra fluids (approximately some 240mls) each day from 17 April 2017. They believed that the combination of the feeding regime issue and defective feeding pump issue had resulted in physical symptoms of over hydration or fluid overload such as their daughter being puffy (eyes, hands, feet and legs) sweating and sleepy.

22. As part of the investigation enquiries Hospice medical and nursing records were examined. These included admission care plans; symptom management plan; emergency management plan; electronic nursing notes and entries by Hospice staff. Also the child specific protocols and emails exchanged with other health professionals were examined.

23. I considered the NMC Code as a relevant guidance document given that the majority of care and areas of complaint related to nursing care provided to the complainant's daughter. However the IPA also made reference to National Guidance and specifically the **"**Guidelines and Audit Implementation Network (GAIN) - Guidelines for caring for an infant, child or young person who requires enteral feeding". Feb 2015. I also considered the DHSSPS Minimum Standards that apply to the Hospice and a number of the specific provision informed my decision-making. Standard 5 "Patient and Client Pathways" states:

"The views of patients and clients, carers and family members are obtained and acted on in the evaluation of treatment, information and care.

…

5.4 Treatment and care services should be planned and developed with meaningful patient, family and carer involvement; facilitated and supported as appropriate; and provided in a flexible manner to meet individual and changing requirements."

Standard 6 "Care Pathway" states:

"Patients and clients have a planned programme of care from the time of referral to a service through to discharge and continuity of care is maintained.

…

6.3 On admission, patients and clients have a comprehensive assessment of

their health care needs using evidence based assessment tools. The results of assessments are used to draw up an individualised, person-centred care plan."

Standard 37 "Arrangements for Provision of Specialist Palliative Care" states:

…

37.4 A holistic assessment of patients' care needs using validated tools is carried out in accordance with procedures and within agreed timescales. The results of the assessments are used to draw up an individualised patient-centred care plan ensuring that attention has been paid to key elements of end of life care including communication, review of interventions, symptom control and hydration and nutrition.

37.5 Options for treatment and care are clearly explained to patients and carers giving sufficient information, time and support to enable them to make decisions and to give consent.

37.6 The care plan and ongoing care needs are agreed with the patient and carer and communicated to the multidisciplinary care team.

24. The Investigating Officer also had access to the Hospital notes and records. As part of investigation enquiries further clarifications were obtained from the Paediatric Consultant responsible for the child's care in Hospital.

25. In response to the Investigating Officer's enquiries about the issues raised by the complainants the Hospice responded in terms in line with their initial responses outlined above. Its response referred to the contents of the review panel report.

26. In the course of my investigation the Hospice's records and Hospital records were obtained and examined. The records covered the three periods of the child's stays in the Hospice.

27. In relation to the specific feeding plan the Medical IPA examined the relevant records and advised:

'…there was a child specific feeding protocol… written on 10 March 2017 and agreed with the parents. This specifically dealt with the situation when the pH of the gastric aspirate is high and >5.5. It was modified on 25 March 2017 on her second admission when her condition changed… Before this the hospice staff understandably would be following the regionally agreed protocol… (GAIN[14]).

…If this feeding plan for [the child] had been written and agreed … lot of misunderstanding could have been avoided.

…the child specific protocol was not always followed in the second admission.'

28. In relation to the provision of a nebuliser, the Medical IPA advised:

'…the saline nebuliser was recommended to help with […] secretions, and documented in nursing notes…It is reasonable and in line with the guideline in the Hospice that new medications are assessed and prescribed by the GP…Any delay in prescription and administration would not have caused any deterioration in [the child's] condition.'

29. In relation to the provision of humidified oxygen, the Medical IPA examined the relevant records and advised:

'It appears from the notes that [the child] was already receiving humidified oxygen from admission on 25 March 2017. The note on admission (page 422 of printed nursing notes) states that 'humidified oxygen and concentrator received from BOB at this time and set up'. [other notes in nursing notes]…All these were before she was seen by [Dr A] at 17.00 on 28 March 2017.'

30. In relation to the administration of Losec medication the Medical IPA advised:

'In a prescription, a time needs to be allocated to when a drug is to be given. However it does not have to be given at exactly that time, especially when there are other instructions (e.g. before or after feeds) which may be more

[14] GAIN – Guidelines and Audit Implementation Network – Guidelines for caring for an infant child, or young person February 2015

important…would not have any adverse effects if the dose is administered up to 4 hours after the prescribed time…'

The Nursing IPA also advised:

'There is a requirement to balance the needs for the medication versus the comfort and [the] specific needs…Good practice suggests that there needs to be ongoing discussions with both the family and the care team in ensuring the focus and the goals of care remain in the best interests of the child.'

31. In relation to the feeding regime, the Medical IPA advised:

'…she was not tolerating enteral feeds and her gastrointestinal tract was not working normally, either from an infection or due to the progression of her condition. The hypoxia[15] resulting from the repeated, frequent and prolonged periods of apnoea and desaturation would have an effect on her gut mucosa and is an indication of a clear deterioration in her overall condition. She was appropriately given dioralyte, as well as ¼ and ½ strength feeds rather than full milk on these occasions.'

The Nursing IPA advised:

'It is evident from [the] notes and fluid balance charts that fluids were prescribed and administered appropriately in relation to relevant guidance…When staff care for a baby with a life limiting condition where there are difficulties with tolerating feeding, it is of the utmost importance that a balance is struck between comfort of the baby and nutritional needs. Any departures or changes to the feeding plan must be discussed regularly with the family.'

32. In relation to the feed pump issue and consequential fluid balance concerns in the days leading up to 22 April 2017 the Medical IPA advised:

'There does not appear to be a problem in her fluid balance from the clinical notes and blood test results.

…recorded amounts of fluid [the child] received [17 -22 April] would not exceed the usual daily recommended amounts of fluid for a 4 month old child.'

[15]Hypoxia is a deficiency in the amount of oxygen reaching the tissues

The Nursing IPA advised:

'On the 22nd April 2017, over a period of 5 hours, 4 separate nurses have documented their discussions with the parents, and what their actions were in relation to the feeding pump. The nurses… all acted appropriately in completing a test of fluids through the pump and recording the amount of fluid delivered. This action did not confirm that the pump was faulty, however the said pump was still removed with a new pump ordered to replace it.'

33. During the investigation, by letter of 28 February 2018, the Hospice Chief Executive accepted the clinical advice in the IPA reports and stated:

'I am grateful for the feedback from both independent experts, this gives me external assurance that the care delivered by the Northern Ireland Children's Hospice was safe, reasonable and appropriate. I appreciate that there may be learnings from your investigation…'

34. It is a feature of this complaint that the contents of some of the medical records are disputed by the complainants as not containing an accurate account of events. It is not unusual for two or more persons to have differing perspectives of events and therefore differing views of the accuracy of what has been recorded by one party, the health professional, in medical records. Medical records serve as a contemporaneous record of care and treatment.

35. I have considered the detailed comments of both IPAs regarding the need for a specific feeding plan for the complainant's daughter during her initial admission to the Hospice. Where the patient is being transferred from another clinical setting (as in this case from care at home supervised by a hospital community team to a specialised respite palliative care setting in the Hospice), it is essential that the specific needs of the patient are identified and addressed particularly where previously her feeding plan had been an issue. I have noted the appropriate minimum standards governing an independent healthcare provider such as the Hospice. There is no evidence of an explanation for the delay in the Hospice identifying and acting on this issue. The Hospice complaint review acknowledged the need for an 'individual, unambiguous feeding plan' to have been in place. In instances where difficulties with feeding were ongoing it

is clear that the distress to the complainants and their daughter was recurring. The IPA advice agrees with the Hospice complaint review report that clear verbal and written communication between the parents and Hospice staff would enable clear understanding of the required feeding regime parameters. In the period 4 March 2017 until the Child Specific Feeding protocol was completed on 10 March 2017, the complainants endured significant distress to see their daughter's feeding regime as fluctuating, lack of staff certainty about enteral feeding parameters and consistency. The Nursing IPA advised that the feeding regime in the period 4 March 2017 to 10 March 2017 was clinically justified. However there is no clear documented plan agreed with the parents, with explanations for the decisions made which was shared with staff. This was an obvious cause of distress and anxiety to them, who also found continuing uncertainty about staff dealing with the ongoing feeding requirements. I am satisfied the lack of adequate communication with the complainants about the feeding plan is a failing in care and treatment which caused continuing distress to them.

36. I consider that the failure to put in place an unambiguous feeding plan in the period 4 March 2017 to 10 March 2017 was a failure in care and treatment. A specific protocol was put in place by 10 March 2017 and the Hospice complaint review acknowledges this should have taken place during its admission process. Therefore I uphold this part of the complaint. I am satisfied that the initial lack of clarity around the feeding regime caused the injustice of significant distress to the complainants, at a time of heightened anxiety for them. The Hospice review report suggests that the provision of a named nurse and better communication would have assisted in addressing the uncertainty. However, I will address the remedy for the failure to have put in place an unambiguous feeding plan in the conclusion of my report.

37. The complainants indicated that provision of a nebuliser for their daughter was initially discussed with them early on 27 March 2017 around 9.00am. There is some divergence between timings recorded in the notes and their recollections, however, it is apparent that the prescribed nebuliser was not administered until after 18.00 on that day. I consider this issue is evidence of unclear

communication between staff and the complainants. The IPA advice makes clear that the provision of a nebuliser was a non-emergency prescription that was administered that evening. The advice is that this would have had no detrimental effect.

38. The complainants said that the issue was not addressed as they had expected. I am satisfied that had that information been conveyed fully the complainants would have been aware of the timescale involved. I consider that clear communication is a fundamental element of establishing a partnership between the patient, their family and health staff. I refer to statements 1 and 2 of the NMC code:

"1 Treat people as individuals and uphold their dignity
To achieve this, you must:
…
1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay.
…
2. Listen to people and respond to their preferences and concerns
To achieve this, you must:
2.1 work in partnership with people to make sure you deliver care effectively"

I consider this lack of clear communication to be a failing in care and treatment. I uphold this part of the complaint. I consider the complainants to have sustained the injustice of distress both at the time and after receipt of the review report. I will address the question of remedy in the conclusion of this report.

39. The complainants are clear in their recollection of a discussion with a member of staff that caused them to question whether their daughter had been given the appropriate humidified oxygen at the relevant time. Their concerns are not reflected in the medical notes which evidence several entries between 25 March and 28 March 2017 with reference to humidified oxygen. There was uncertainty on the part of the nursing auxiliary staff member in this respect, which the complainants were aware of. This occurred concurrently with the

issue of the delay in prescribing a nebuliser, I can therefore fully understand their heightened concerns. The Hospice review concluded that 'clear and accurate communication' will avoid unnecessary anxiety and issues should be checked with senior staff. I have considered the accounts in the notes and records of the child's fluctuating condition in the period 27 to 28 March 2017. Over that time period there is adequate evidence recorded in the notes of the complainants commenting on her care with responses from the Hospice staff. There is however no record of issues about humidified oxygen being noted or resolved. In light of this I conclude that the complainants had cause to question whether their daughter was administered humidified oxygen. This matter ought to have been reported to senior staff and recorded when resolved in the notes. I will comment further on how this type of complaint issue was investigated under the second issue. I consider that the complainants suffered the injustice of distress as a consequence of inaccurate communication on whether their daughter was receiving humidified oxygen. I will deal with the question of remedy in the conclusion of my report.

40. I note the Losec medication administration issue again reflects on poor communication between Hospice staff and the complainants. The IPA advice is clear that the recorded administration of Losec departed from the prescribed timing of dosage in a strict sense. However the IPA advice is that this is clinically justifiable and had no detrimental effect on their daughter. Nevertheless the complainants would clearly have benefited from clear communication of the rationale and justification for the actions of Hospice staff in the timing of the administration of Losec. The Hospice review identified that their "anxiety could have been alleviated by informing…why the timing of doses was not critical".

41. I consider that this is an example of unclear or less than full communication with the complainants and is a failure in care and treatment under statement 2.1 of the NMC code. I consider the Minimum Standards I have set out previously in this report. I uphold this part of their complaint. I consider that the complainants suffered the injustice of distress as a consequence of inadequate communication of the reasons for the timing of the Losec administration.

Participation of rights holders, in this case the parents of a child being treated, is a key aspect of a human rights based approach to medical treatment decisions. The First Principle of Good Administration: 'Getting it Right' requires the body to act in accordance with the law and have regard for the rights of those concerned. Full and proper communication of issues connected to medical treatment of their child is a fundamental pre-requisite. I consider a failure to communicate adequately as a failure in care and treatment with the injustice indicated above. I will deal with the question of remedy in the conclusion of my report.

42. I note the Hospice records and the complainant's account record that the feeding regime was changed on a number of occasions. The type and dilution of the feeds and fluid replacements were altered to attempt to achieve an optimal fluid and nutritional intake. There were also numerous instances when feed volumes and rates were adjusted in light of the child's symptoms and overall condition. The complainants were concerned at the lack of consistency with the feeding regime; the departures from the feeding plan; a concern that their daughter was not receiving adequate nutrition; and in some instances was given excess fluid. The Nursing IPA advised:

"Feeding issues can cause parents enormous distress, this should be recognised and discussed with parents at the earliest opportunity. Discussions should be initiated by specialist healthcare professionals focussing on the comfort of the baby, which may conflict with parents' perception of nutrition and hydration."

It is entirely understandable that the complainants had a heightened concern that their daughter's feeding regime was inappropriate. The frequent changes came against a background of poor communication and uncertainty in other areas of her care. Clear communication of a patients feeding regime ought to have included communication of changes in the plan. By its nature a care plan in a hospice setting must balance nutritional needs with palliative care needs. It is imperative that full and regular discussions with the parents take place to explain the rationale behind decisions. The child's stay in the Hospice was a period of respite from home based community care where her parents were

following feeding advice. I can fully understand in this context that it was challenging for her parents to observe frequent changes in feeding mix and volumes/rates without full discussions and explanations which would be necessary to ensure continuity of care on her return home. I refer to Statement 1 and 2 in the NMC Code which state:

*"**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

…

1.5 respect and uphold people's human rights

2. Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely"

I consider that the failure discuss fully and provide explanations to the complainants for changes in the feeding plan was a failure in care and treatment on the part of Hospice staff. I uphold this part of their complaint. They experienced the injustice of distress and uncertainty at the lack of clear and consistent explanations for changes in the feeding regime. I will deal with the appropriate remedy in the conclusion of my report.

43. The complainants also complained about a defective feeding pump. This issue was the incident that resulted in the complainants removing their daughter from the Hospice and taking her to Hospital. The Hospice records suggest that the child's mother approached staff on 22 April 2017 with concerns about the volume of fluid being dispensed by the feeding pump and the possibility of excess fluid. Both complainants are clear that the issue arose because a staff member informed them of the excess fluid being dispensed and that it had happened over a period of time. They are clear this was demonstrated to them by a member of staff. This account is not reflected in the notes and records. The fluid balances and the child's clinical records have been examined by both IPAs.

44. The Medical IPA has advised that there is no issue of excessive fluid overload or clinical signs of overloading. The Nursing IPA has reviewed the notes and found that staff acted appropriately in withdrawing the pump when the issue was raised. The complainants have clarified that the father telephoned the supplier and ordered a new pump which was delivered to the Hospice. However an incident report was not completed as the pump was not Hospice equipment. The Hospice informed my Investigating Officer that the pump was brought from home with the child and had been provided by the community care team from Ulster Hospital. After the child was transferred to the Hospital the original pump was retained by the complainants. Therefore there was no technical testing of the pump. I am faced with diametrically opposed accounts of how this issue arose. The Hospice review on this issue states:

    "In relation to potential issues with the fluid pump these are adequately documented as are all checks undertaken re volume of fluid administered."

    The issue with the feeding pump leads directly to the complainants saying that their daughter was "fluid overloaded".

45. I am unable to determine whether the feeding pump was in fact defective. The accounts from the Hospice and the complainants are incompatible. There was no technical examination of the feeding pump by the Hospice or referral back to the community care team. While the nursing record was completed to show that a number of staff found the machine to be working properly, it was still removed

from use by the nursing staff. The Hospice policy on faulty equipment was not followed. It cannot be the case that testing by nursing staff is sufficient to establish whether an item of equipment is working properly where the item was withdrawn from use. I consider that more could have been done at the time by the Hospice during its review to establish accurately whether there was an issue with the feeding pump. The Hospice policy on "Reporting Equipment Faults" does not clarify what should happen with a query or fault with a piece of equipment that came into the Hospice with the child. The Hospice informed my Investigating Officer that for this reason and because Hospice staff recorded in the notes that the pump was delivering the recorded volumes no incident reporting was initiated. I do not accept this explanation. I note from my investigation two incident report forms were recorded on the child's file regarding potential nut allergy risks in chocolate brought into the Hospice. Staff were fully aware of incident reporting mechanisms. I note staff concluded the pump should be removed from use. This ought to have resulted in an incident report being completed and a technical examination.

46. Although I am unable to determine that the feeding pump was faulty, I consider that the Hospice did not apply their policy for dealing with equipment faults, where the equipment came into the Hospice and from another service. I also consider that it was clearly the responsibility of the Hospice, who were using the equipment in their care of their daughter, to have the feeding pump verified at the time or to attempt to do so as part of the complaint handling process. I consider that the failure to have in place a suitable policy to deal with this situation and to have taken action is not in accordance with the first Principle of Good Administration: Getting it Right. The Hospice is required to comply with the Department of Health's minimum standards for independent Healthcare Establishments. Standard 23 makes clear that equipment must be properly maintained:

"23.1 There are clearly defined lines of accountability for the management of medical devices and equipment.

23.2 The policies and procedures for the management and use of medical devices and equipment are in accordance with manufacturers' guidance.

23.5 There are systems in place for confirming that any medical device or equipment on loan has been maintained and checked in accordance with manufacturers' and installers' guidance and records kept of the confirmation received."

I consider that the failure to have in place a suitable policy to deal with this situation and to have taken action is not in accordance with the first Principle of Good Administration: Getting it Right by acting in accordance with guidance. I consider that this failure amounts to maladministration. I uphold that part of the complaint. I consider that the complainants have suffered the injustice of uncertainty and distress at the failure by the Hospice to determine if the feeding pump was functioning properly, to have it tested and the results documented. I will deal with the remedy in the conclusion of my report.

47. In relation to the issue of "fluid overloading" the Medical IPA advised:

"The oedema of her hands and feet is likely to be from fluid retention due to her underlying condition and concurrent illness at the time. There was no other evidence from the clinical notes of fluid overload as there has been no evidence to suggest generalised oedema (puffy eyes, wet lungs or a big liver on examination), or from the investigation results. The oedema resolved without any targeted treatment with diuretics and fluid restriction."

The Nursing IPA advised:

"To ensure correct fluid balance management, the exact amount of volume of feed, flush and aspirate needs to be calculated each time [the child] is fed. With the discrepancies regarding how much feed was in the hung bag and how much was needed to prime the giving set, it is difficult to ascertain this with certainty."

48. In the course of the investigation clarification was sought from Dr A who treated the complainant's daughter at the time of her admission to Hospital on 22 April 2017. Dr A had also provided a report to the Hospice Review. Dr A recorded:

"My opinion would be that [the] weight gain was more in keeping with fluid retention due to her genetic condition, likely poor functioning cardiovascular system/+/- renal function exacerbated by her respiratory tract infection."

Dr A clarified to my Investigating Officer:

> *"Clinically [the child] was fluid overloaded at the time of admission – this is clear from presentation with oedema, weight loss over relatively short period and settled without diuretics or active fluid management… no access to any notes/records from NICH and was unable to comment on any potential cause other than as outlined above."*

49. The Medical IPA questioned the terminology employed:

> *"…there might be some confusion between the words 'fluid overload' and 'fluid retention'. Although these are sometimes used interchangeably, they do not have exactly the same meaning or implications. Fluid overload implies that too much fluid has been given to the patient who is then unable to cope with the excessive fluid load. This would usually lead to more symptoms and signs than just puffy hands and feet, and frequently result in the need for diuretics to help clear the excess fluid. Fluid retention however can occur for different reasons (e.g. unwell child, low protein, decreased urine output, etc.), even if the correct amount of fluid has been given."*

50. I have to weigh on balance the accounts given by the complainants, the contents of the Hospice notes and the IPA advice I have received. I accept the IPA advice on the clinical issue that there is no certainty of fluid overloading in this case. I note the Hospice review was conducted using the notes and records. No attempt was made to interview staff or the complainants about their specific recollection of this issue or to attempt to resolve the technical issue by having the pump examined. The IPA advice is based on both the Hospice records and hospital clinical records relating to the child's admission to hospital on 22 April 2017. The feeding pump was never technically tested or examined to determine conclusively if it was delivering excess fluid. I do not conclude on the balance of probabilities that the Hospice administered excess fluid to the complainant's daughter because of a defective pump.

Issue Two: Whether the Hospice's handling of the complaint was reasonable?

Detail of Complaint

51. The complainants made an initial complaint to the Hospice by letter dated 27 April 2017 forwarded by email on 28 April 2017. The complaint outlined the chronology of events and issues of compliant covered earlier in this report. The Hospice acknowledged the complaint by letter dated 28 April 2017. The Hospice is required to comply with the DHSSPS (NI) regional guidance on Complaints[16]. The Hospice decided to undertake an independent review panel ("Panel") to deal with the complaint. The Hospice sourced three external advisers from the Belfast Trust to join the Panel: a consultant paediatrician; a consultant in paediatric neurodisability; and paediatric neurology nurse specialist. The Hospice Director of Care & Quality Governance (Director) and Children's Palliative Care Lecturer made up the other panel members.

52. Shortly after the complaint was made, contact was made with the complainants by the Hospice and the Panel met for the first time on 19 May 2017. At this stage Panel members were given access to medical notes and records. However, the complaint was already outside the usual time parameters at this point. The Hospice response indicates that the complaint had already been assessed as "significant". The terms of reference were drafted at the first Panel meeting and provided to the complainants at a meeting on 1 June 2017.

53. At the first meeting with the complainants on 1 June 2017, the Hospice Director provided them a copy of the draft terms of reference. The complainants made comments on the draft and provided additional information. The Panel met on 2 June 2017 to update members on progress and report on their provisional views. The next meeting on 9 June 2017 considered a draft response. The final Panel meeting to "sign off" on the report was held on 22 June 2017. After the complainants were provided with the report they prepared a detailed response

[16] DHSSPS Complaints in Health and Social Care –Standards & Guidelines for Resolution & Learning (April 2009) as amended.

and sought further answers from the Hospice. They met with the Director of Care and Quality Governance and an independent panel member on 17 July 2017 and detailed their response. They were informed that the Hospice considered the next step was to refer their complaint to my office as they remained dissatisfied.

54. In response to my investigation the Hospice provided its complaint file including minutes of meetings, terms of reference for review, review report and outcome letters to the complainants. Responses to investigation enquiries were also provided by the Hospice.

55. I considered the content of the Hospice complaint policy and the DHSSPS (NI) Regional Complaint Guidance (2009) as amended. Specifically I considered Annex 1: Standard 1 on Accountability which states:

3 HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;

Standard 3 on Receiving Complaints states:

6 Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements;

Standard 5 on Investigation of Complaints states:

4 Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;

Standard 6 Responding to Complaints states:

4 Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;

Analysis and Findings

56. I note at the outset the qualifications and experience of the panel members who were brought together to consider this complaint by the Hospice. I have a number of issues of process which in no way challenge the professional commitment of those on the Panel in attempting to deal with a challenging and emotive complaint.

57. The Hospice complaint policy comprises 20 pages with appendices. This is a substantial document. It sets out clearly in the first paragraph it has been based on the DHSSPS (NI) regional complaint guidance as is required. The DHSSPS (NI) regional guidance runs to some 53 pages with annexes.

58. The Hospice has indicated that this complaint was considered “significant”. There was no documentation available as to how the relative assessment or grading of the complaint was made, the parameters of assessment and consequences including for the investigation or outcome. The DHSSPS (NI) regional guidance details at 3.26, a risk based approach to grading complaints and settling on proportionate investigations. The decision on grading of the complaint is a discretionary decision. I am unable to challenge the merits of a discretionary decision unless it is attended with maladministration. The ‘grading’ decision ought to have been recorded with the relative reasons informing the decision. The first Principle of Good Administration: Getting it right involves acting in accordance with guidance. The third principle of Good Administration: Being Open and Accountable involves keeping appropriate records of the criteria/reasons for decision making. Such records are absent in this case.

59. I have been provided with “minutes” of Panel meetings that vouch brief records of what were undoubtedly lengthy, detailed and technical meetings. I appreciate the administrative task in capturing records of long meetings where complex and technical issues are dealt with. It may be that consideration could be given to transcribing such meetings if they were anticipated to be long and technical. In any event the absence of clear records of the specific considerations and views that led to the review outcome hinders my review. I consider that the third Principle of Good Administration: Being Open and Accountable requires being open and clear about procedures as well as keeping appropriate records and criteria/reasons for decision making. Such records are inadequate in this case as they do not provide a clear explanation of the views of the panel members in reaching their conclusions outlined in the Panel review report.

60. In considering the chronology of this complaint I have focused on the information conveyed to the complainants at the first "face to face" meeting with the Hospice regarding the complaint. This took place on 1 June 2017. The terms of reference document provided to them at the meeting had been prepared at the Panel meeting some two weeks previously. This provides a clear outline of what the complainants could expect from the investigation of their complaint. However it is significant that the inclusion of "hospice staff interviews" in the methodology was not taken forward. I note that no written reports were taken up from any staff involved in the child's care. I note that no details of the complaint set out by the complainants in great precision were put to staff, often named in the complaint, seeking a response. Only the written clinical notes and records were relied upon by the Panel. The response from the Hospice when asked for an explanation during the investigation was:

"…although staff interviews were part of the methodology, the Review Panel was of the view that the detailed and contemporaneous nature of the content of the clinical notes from all concerned with [the child's] care were significantly sufficient to avoid the need for interviews."

There are no records of the Panel discussion on this issue, the reasoning for its decision, and any consideration of referral back to the complainants to explain the decision. Regional complaint guidance promotes a "strengthened, more robust local resolution stage" with complaint handling arrangements designed to:

- *provide a well defined process of investigation*
- *promote the use of a range of investigative techniques*

The standard for investigation includes[17]:

Criteria

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;

[17] Regional Complaints Guidance page 59 Standard 5

The regional guidance also provides a link to further departmental guidance on incident investigation/review reports[18]

61. The complainants provided clear details with dates, times and where relevant names of staff involved in communication with them for a number of issues they raised. I note that the Hospice recorded their intention to interview staff in this complaint and did not carry out staff interviews. No rationale or reasoning was recorded for failing to follow the commitment to interview staff. It is obvious that interviews with staff within a matter of weeks of relevant events would ensure the best evidence was obtained when matters were fresh in the minds of relevant staff. There is no documented reasoning for not seeking specific comment from, or interviews with staff involved. This is a significant omission which in my view compromised the complainant's trust in the complaint investigation process. That is because there was a written commitment to interview staff in the terms of reference document. I have also considered the Regional Complaints Guidance. The first Principle of Good Complaints Handling: Getting it Right requires a body to act in accordance with guidance. The third Principle of Good Complaints handling: Being Open and Accountable also requires being open and clear about procedures as well as ensuring that proper and appropriate records are kept, stating the criteria for decision making and giving reasons for decisions.

62. I have also considered the layout and content of the panel's report. The hospice complaints policy indicates that the complaint response should be clear and "…identify clearly if complaint has been upheld, partially upheld, not upheld," The regional complaints guidance sets out a clear structure for the response to the complaint. I consider that the Hospice response to the complainants does not comply with that guidance. The Hospice response by letter of 27 June 2017 included the 7 page review report. Neither the letter nor the report make clear what if any aspects of the complaint were considered upheld, in full or part or not upheld. This is despite learning being identified under all of the issues and

[18] Regional Complaints Guidance page 36 3.30 – http://www.dhsspsni.gov.uk/hsc_sqsd__34-07__guidance.pdf

an apology for "…your experience and …for the distress caused". The apology is unclear if it relates to other than the complainant's experience and distress. I have issued guidance on the form and content of apology on the NIPSO website. The first Principle of Good Administration: Getting it Right requires a body to follow relevant guidance. I consider the Hospice did not follow the established guidance. The third Principle of Good Administration: Being Open and Accountable requires a body to state how it reached a decision and giving reasons. I consider that it is not clear the decision the review panel reached on all of the issues examined. The fifth Principle of Good Administration: Putting things right requires a body to acknowledge mistakes and apologise where appropriate as well as operating an effective complaints procedure. I consider that the Hospice complaints procedure adopted in this case has produced an unclear and unsatisfactory response.

63. I consider that the failings identified in the complaints handling by the Hospice and set out at above amount to maladministration for the reasons given. I uphold this issue of the complaint. I consider that the complainants experienced the injustice of distress in the handling and outcome of the Hospice complaints process, frustration and time and trouble taken to pursue their complaint to my office

Comments on draft report

64. The Hospice and the complainants were provided with a draft of this report for comment. I have received and considered comments from both. The comments from the complainants focused on their view that the fluid overloading, feeding regime and feeding pump issues had not been found as clinical failings in care and treatment.

65. The comments from the Hospice included a request to meet with me. I considered it more appropriate that my Director of Investigations met with the Hospice. The written comments and representations at the meeting from the Hospice focused on my findings in respect of communication with the parents across a number of issues of care and treatment. The Hospice also challenged my investigation methodology and conclusions on the Hospice complaint

process. I have considered and amended the draft report as a result of the comments.

CONCLUSION

66. I received a complaint about the actions of the Northern Ireland Children's Hospice. I have investigated the complaint and have found failures in care and treatment of the complainant's daugher in relation to the following matters:

- Failure to establish an unambiguous feeding plan
- Failures in communication about care and treatment

I have investigated the complaint and have found failures amounting to maladministration in relation to the following matters:

- Failures in policy and investigation of equipment faults
- Failures in the complaints handling by the Hospice

I have not found failures in care and treatment:

- In "fluid overloading" of the child during care in Hospice leading up to 22 April 2017.

67. I am satisfied that the failures in care and treatment and maladministration I identified caused the complainants to experience the injustice of upset, distress, delay, frustration and time and trouble taken to pursue their complaint to my office.

RECOMMENDATIONS FOR REMEDY

68. The complainants should receive a written apology from the Chief Executive of the Hospice, in the terms of my Guidance on Apology, for the failures identified in this report and a payment of £2000 by way of solatium for the injustices I have identified within **one** month from the date of this report.

69. I recommend that the Hospice should consider offering a meeting to the complainants with senior staff, after the provision of the apology, with the sole intention of allowing the complainants to reflect on their experience of the Hospice complaints process. Specifically the meeting would not be to repeat or rehearse the detail of the complaint but to enable staff to gain an insight into the "complainant experience". This exercise may inform the review of complaints indicated below.

70. I also recommend that the Hospice should ensure that the complainants are made fully aware of the range of bereavement support and follow up services that the Hospice offer and seek to welcome the complainants and their family to avail if they so desire.

71. I recommend that the Hospice should further review its Admission procedure for children to ensure clarity on issues such as feeding regime, between staff, other health professionals and parents/patient (where appropriate) within **three** months of the date of my report. I also recommend that the Hospice review staff training on clear communication with patients/carers following the issues highlighted in this report. The reviewed procedures should be cascaded to all staff with an implementation/action plan to incorporate any recommendations of the reviews and the Hospice should provide me with an update within **six** months of the date of my final report, supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training records and/or self-declaration forms which indicate that staff have read and understood any revised procedures).

72. I recommend that the Hospice should conduct a review of the operation of the Hospice complaints process considering my findings and report the outcome to me within **three** months and implement an action plan to incorporate any recommendations of that review and should provide me with an update within **six** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training materials, training

records and/or self-declaration forms which indicate that staff have read and understood any related policies).

MARIE ANDERSON
Ombudsman **July 2019**

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.