Investigation Report

Investigation of a complaint against the South Eastern Health & Social Care Trust

NIPSO Reference: 202001750

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The Role of the Ombudsman

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

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

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

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

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

Reporting in the Public Interest

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

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

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Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

I received a complaint about care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the complainant on 30 September 2020 at the Emergency Department (ED) of the Ulster Hospital, Dundonald.

The complainant attended Ards Minor Injury Unit (MIU) after he got a chemical splash to his eyes. He went the same day to Ulster Hospital Dundonald ED to be treated. While being treated there, he had a Health Promotion discussion which he feels was unjustified and unnecessary.

Following my investigation, which included the receipt of Independent medical advice, I found a service failure in the form of incomplete record keeping. I found a failure to record a pain score, a failure to record an assessment of visual acuity, a failure to record advise on what to do should vision deteriorate and the conversation relating to health promotion to be contrary to GMC Guidance. I also found the failure to examine the complainant's eye using a slit lamp to assess for damage or inflammation to the cornea and the failure to use Fluorescein to also represent a failure in the care and treatment afforded to the complainant. These failings caused the complainant the injustice of loss of opportunity to have his condition fully assessed and frustration and uncertainty over the appropriateness of the care and treatment he received.

I recommended that the Chief Executive of the Trust offer an apology to the complainant for the failings identified and that these failings be brought to the attention of the relevant medical staff.

THE COMPLAINT

1. This complaint was about care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the complainant at the Emergency Department (ED) of the Ulster Hospital, Dundonald.

Background

2. The complainant attended Ards Minor Injury Unit (MIU) on 30 September 2020 after he got the chemical 'Cillit Bang' in his eyes. He was sent the same day to Ulster Hospital Dundonald ED to be treated. While being treated there, he had a Health Promotion discussion which he feels was *'unjustified'*.

Issue of complaint

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

Whether the care and treatment provided to the complainant by the Trust on 30 September 2020 was appropriate and in accordance with relevant standards and guidelines

INVESTIGATION METHODOLOGY

4. 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 consisted of all the relevant clinical records.

Independent Professional Advice Sought

5. After further consideration of the issues, I obtained independent professional advice (IPA) from a consultant in Emergency medicine since 2007 in a District General hospital. His clinical duties include attending acutely unwell or injured patients, in addition to providing supervision for doctors in training. As a general hospital the IPA manages all major and minor presentations including patients with eye injury. In his department he undertakes the initial assessment and management of patients presenting with emergency eye conditions, e.g., a chemical splash/ burn, and liaises with the Ophthalmology team to organise ongoing care for patients as required.

I attach a copy of the clinical advice received at Appendix two to this report.

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

Relevant Standards and Guidance

7. 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[1]:

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

The specific standards and guidance referred to are those which applied at the time the events occurred. The specific standards and guidance relevant to this complaint are:

- Slit Lamp Induction
- Protocol for liquid or gaseous chemical eye injury
- Generic Processional Capabilities Framework
- GMC Code of Conduct

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

9. A draft copy of this report was shared with the complainant and the Trust for comment on its factual accuracy and the reasonableness of the findings and recommendations. In response to receipt of a copy of the draft report the complainant was generally accepting of its content. The Consultant in Emergency Medicine who responded on behalf of the Trust provided

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

comments on the complaint and the IPA advice received. Whilst not changing my findings and conclusions I have made certain changes to the report where I found it appropriate.

THE INVESTIGATION

Whether the care and treatment provided to the complainant by the Trust on 30 September 2020 was appropriate and in accordance with relevant standards and guidelines

10. Within this area of complaint, I also considered the appropriateness of the referral to the ED of the Ulster Hospital, Dundonald and also a Health Promotion talk which the complainant received.

Detail of Complaint

11. The complainant attended Ards MIU on 30 September 2020 after he got the chemical 'Cillit Bang' in his eyes. He went, the same day, to Ulster Hospital Dundonald ED to be treated. While being treated there, he had a Health Promotion discussion which he feels was unjustified.

Evidence Considered

The Trust's response to investigation enquiries

12. The Trust stated that the complainant was referred to the Ulster Hospital ED as there were no appointments available that afternoon in Ards MIU, so therefore an ED referral was appropriate for further assessment, given the frequent attendances for treatment and appropriate aftercare for eye injuries. The Trust stated Emergency Nurse Practitioners (ENPs) take a holistic approach to every patient attending MIU's to explore any concerns and would also refer to other specialities if they felt this was in the patient's best interests to do so. The ENP provided practical advice on the safe disposal of chemicals to reduce the risk of future eye injuries. There is no evidence that the complainant was wasting time and he had taken the correct steps based on his knowledge of first aid practice and sought further advice for his injury. The Trust was satisfied that its ENPs took an appropriate clinical history and made the correct decisions in relation to the complainant's care and treatment given the number of presentations with eye injuries to both MIU and ED.

13. In relation to any discussions regarding health promotion, the Trust stated that if a patient re-attends the ED with a recurrent problem, this is highlighted to medical staff as a mechanism of ensuring that problems are not missed and to prompt a reassessment. When the complainant was asked about issues such as anxiety, self-inflicted injuries or hypochondriasis, these were explored with the intent of addressing other potential causes of his symptoms to ensure that his management was correct. This is in accordance with good medical practice. Health promotion was appropriate in this case as the complainant sustained a similar pattern of injury on several occasions. The Trust stated that a common theme in the complainant's attendances was that of sustaining repeated splashes to the eyes involving cleaning solutions, diluted bleach and diesel, as well as concern about the presence foreign bodies.

Relevant Independent Professional Advice

14. The IPA advised that the complainant attended the ED at 17:32 on 30 September 2020. The reason for the attendance was recorded as 'Fluid in Eyes' and exposure to chemicals. There is additional information noted to state 'Cillit Bang chemical to eyes' and that the right eye was more affected than the left.

15. The IPA advised that patient had arrived by private transport and following registration in the department he was allocated to be attended in the Plaster room…. The Protocol for liquid or gaseous chemical eye injury has a flow chart which advises discussion with ED if the eye PH is >7.5. The IPA further advised that, on this basis, a discussion/ referral to ED would have been appropriate. The IPA advised as complainant presented to ED with eye pain following a chemical splash into his eyes, '*I would consider the decision to attend the emergency department for assessment and treatment to be appropriate'*.

16. The IPA advised that a health promotion talk is simply a conversation with a patient about ways to improve their health. It can include advice on adjustments to behaviours, strategies to ensure they remain safe without injury and to reduce the risk of chronic illness. Common examples would be discussions

around alcohol or smoking but can include ways to ensure safe environment at home e.g., safe storage of noxious chemicals, (this is often a focus when discussing injuries in children).

17. With regard to the treatment received by the complainant, the IPA advised that at the time of presentation to the ED the complainant complained of 'stinging' in his eyes despite attempts to wash his eyes at home. There were no observations or pain score recorded during the ED attendance on 30 September 2020.

18. Following the initial triage, the IPA advised that the complainant had an eye washout to the right eye commenced at 1800hrs. Prior to this, the IPA noted the eye PH was checked (this is simply a paper strip test to assess for the presence of acid or alkali chemicals). As the PH was 8, which is elevated and would suggest the eye had alkali present (this would be match with history of Cillit Bang exposure), which would benefit from irrigation (washout). The IPA advised '*this was appropriate.'*

19. Following the irrigation, the PH was re-checked to confirm that it had returned to normal (the normal PH range for the eye is 6.5-7.6 -mean value 7.0). The PH when rechecked was 7 so no further irrigation was required. At 19:15, an ED doctor has recorded a brief assessment of the patient, the notes outline the reason for the presentation and the eye PH before and after irrigation, (washout). The notes also record that the pupils were equal and reactive to light (PERLA) and there was full range of eye movements (FROEM). The visual acuity[2] is not recorded, though it is noted the complainant stated it was unchanged.

20. The IPA advised that there was no record of the complainant having his eye examined with a slit lamp or fluorescein staining which would be used to assess for corneal abrasions or burns. The patient was discharged with antibiotic ointment (chloramphenicol) which *'was appropriate'*.

[2] The sharpness of central vision

21. The discharge diagnosis for the patient was ‘chemical burn to right eye. It is noted that the patient received an eye washout, and that the PH was normal. It would be reasonable to assume the patient was aware of this information. However, there are no records to determine whether there was any residual corneal injury present because of the chemical or what the patient was advised to do if symptoms persisted or changed. The IPA advised that the complainant should have been provided advice on what to expect during the recovery period including an estimate on how long he would be expected to have symptoms and what to do if they did not resolve as expected or if his vision changed or symptoms deteriorated. The IPA explained that for patients who present with a chemical splash to the eye it is appropriate to have initiated irrigation (washout) promptly which was done. However, following this the IPA stated that he would have expected there to have been a more detailed examination of the eye rather than simply checking the pupil response to light and eye movements. The IPA advised that he would consider it normal practice to examine the eye using a slit lamp as this gives a very close view of the cornea and allows assessment for inflammation or damage because of the injury.

22. The IPA further advised that he would also expect the attending clinician to use fluorescein to assess for an abrasion or burn to the cornea. (Fluorescein is an orange substance that can be put into the eye to stain the cornea and with further examination under blue light will fluoresce yellow/green in colour in areas where there is corneal injury). The IPA explained that this would be important as deep abrasions or burn may require more specialist assessment and treatment to ensure prompt healing. Of note, Fluorescein was used during the examination by the MIU staff at the subsequent attendances but not at the ED attendance on 30 September 2020.

23. The IPA advised that the focus of his advice was the ED attendance on 30 September 2020. Within his review of the case file and the associated documents there is a detailed presentation on use of the slit lamp. Unfortunately, on this occasion the attending clinical did not appear to make use of the slit lamp to fully assess the patient (or has not recorded this in the records). It is not clear why this is the case, perhaps it was due to the patient

being treated in the plaster room when he attended the ED. This would not be normal and may have inadvertently influenced the attending clinician as the slit lamp may not have been readily available at the time of the assessment. I was advised that staff should be reminded that despite operational pressures it is important to ensure patients are assessed in the right area and if necessary, moved during their time in ED to facilitate this.

24. The initial assessment of the complainant was brief and whilst initial treatment in the form of an eye washout was initiated shortly after arrival at the ED it would be reasonable to record the patients pain score, similarly, although it is noted that the patient did not complain of altered vision, with any eye injury it is important to formally check the visual acuity and record this in the notes. The IPA advised that the Trust should remind staff to record all the information they provide to patients (written or verbal) as this confirms what advice is given to the patient should this be queried after the attendance.

25. In conclusion the IPA advised that the patient attended the ED on 30 September 2020, following registration, he was identified as needing prompt treatment which was initiated in the plaster room. (It is not clear why this area was used but it is quite possible that the department was facing high operational pressures and staff simply needed an area to undertake the washout treatment). The doctor's assessment in the ED is brief and has limited records and does not record a full eye examination. There is no record of visual acuity being checked (though it is noted the patient had said his vision was unchanged after the incident). There is no record of the patient's eye being examined with a slit lamp during the ED attendance. There are no details recorded of the information given to the patient or any verbal advice/ discussion that took place. The working diagnosis was appropriate and suitable initial ongoing treatment was provided (antibiotic eye ointment), but there was no record of any advice to the patient should the symptoms not resolve as expected.

Analysis and Findings

26. My consideration of this complaint focused solely on the care and treatment the complainant received when he attended the ED of the Ulster Hospital Dundonald on 30 September 2020 and the reasonableness of his referral there. I am aware that the complainant had previously attended with eye problems, and I note that he subsequently attended either the MIU or ED with similar problems seventeen times over the next three months. My examination of his complaint did not consider either the previous attendances or those which subsequently occurred.

27. The referral to the ED occurred after the complainant first attended the MIU in Newtownards. He arrived at the ED unaccompanied at 17.32. The Trust has stated that he was referred to ED as there were no appointments available that afternoon. I understand the pressures that the Health Service generally and, in particular EDs and MIUs, have been under over recent years and unfortunately accept the difficulties patients experience with delays in getting to see a medical practitioner in such settings. I am also aware that the timeline for this complaint occurred in September 2020 which was in the midst of a global pandemic which placed additional strain on the Health Service. For this reason, I make no criticism of the Trust that an immediate appointment was not available to the complainant that afternoon at the MIU. Due to the nature of his injury, which concerned a chemical spill to his eye, I accept the advice of the IPA who advised that it would be appropriate that anyone presenting with eye pain following a chemical splash should attend an ED for assessment and treatment. This is reinforced and justified by the advice received from the IPA and which I accept, that when tested in the ED, the PH reading from the complainant's eye was elevated indicating that alkali was present. On the basis of the circumstances surrounding this complaint and on the advice of the IPA, I accept that it was both reasonable and appropriate that the complainant was referred to the ED where any injury to his eye could be assessed and treated.

28. While at the ED the complainant stated that he had a '*health promotion discussion which I still doubt that the Trust would bestow onto a patient who is pregnant*' and complains that he was accused of having anxiety and being a victim of abuse/self-harming.

29. The IPA advised that a health promotion 'discussion' as such is '*simply a conversation with a patient about ways to improve their health'.* While I appreciate that the complainant considered such a conversation to be condescending, in particular after he had disclosed that he was a first aider, I do not consider this to be the case. I note that a common theme in the complainant's attendances at the MIU and ED over a period of months was the accidental splashing of various substances to his eyes. I consider that a discussion between clinicians and a patient who presents requiring medical intervention with recurrent similar injuries and symptoms to represent good medical practice. I would consider it remiss of clinicians, in the face of multiple attendances for similar injuries sustained over a short period of time, not to have such a conversation. Irrespective of a patient's background or life experiences any conversation which seeks to limit the number or extent of injuries sustained can prove to be beneficial to a patient. Therefore, although I note that there is no record of this conversation having taken place, I do not uphold this element of the complaint.

30. In relation to the treatment the complainant received, I accept the IPA's advice. I note that much of the treatment received was appropriate for his presenting symptoms. Within half an hour of his attendance at the ED, the complainant had been triaged and an eye washout to his right eye commenced. Prior to this he had a PH paper strip test to assess for the presence of acid or alkali chemicals which had revealed an elevated alkali presence. The clinical record states that after the irrigation, the alkali levels had returned to within a normal range, the pupils were equal and reactive to light and that there was a full range of eye movements. The complainant was then discharged with appropriate antibiotic cream. These elements of the assessment and treatment all represent good medical practice.

31. Having said that, the IPA advised of a number of deficiencies in the complainant's assessment and in record keeping. I accept the advice of the IPA and consider the following to represent a failure in the care and treatment and in record keeping by the ED on 30 September 2020.

32. At 17.15 the complainant was examined, and it was noted in the clinical record that he was complaining of '*stinging*' in his eyes despite having washed them out at home. There was no pain score recorded in the clinical notes. I appreciate that the complainant did not complain of untreated pain during his attendance, and I note that pain medication was not prescribed during this time. However, when a patient complains of stinging i.e. pain, I would expect some form of assessment in the form of a pain score to determine the level of pain and for this to be recorded.

33. I accept the advice of the IPA that '*the patient should have been provided advice on what to expect during the recovery period including an estimate on how long he would be expected to have symptoms and what to do if they did not resolve as expected or if his vision changed or symptoms deteriorated'.* Similar to the advice concerning health promotion, if such advice was provided to the complainant, it was not recorded in the clinical record.

34. I accept the advice of the IPA that, although the patient did not complain of altered vision as a result of the chemical splash, '*with any eye injury it is important to formally check the visual acuity and to record this in the notes'*. Although the complainant did not complain of altered vision there is no evidence that this was taken into consideration as it was not recorded.

35. There was not a more detailed examination of the complainant's eye other than checking his pupils' reaction to light and eye movements. This is despite the diagnosis being recorded as 'Chemical burn to right eye'. I accept the advice of the IPA that he would consider it normal practice to examine the eye using a slit lamp as it gives a close view of the cornea allowing for assessment of inflammation or damage. I acknowledge that this may have been because the examination took place in the plaster room and a slit lamp may not have been readily available at this location. Nonetheless I consider that the failure to

use a slit lamp in the assessment of the complainant to represent a failure in his care and treatment. In responding to this element of the complaint the Trust's Consultant in Emergency medicine stated that a slit lamp is not the only source of a 'blue light' to identify potential ocular injury as this can be found on the handheld opthalmoscopes commonly used in ED. He did however accept that if this equipment had been used, its use should have been documented.

36. I also accept the advice of the IPA that he would have expected Fluorescein to have been used to assess for an abrasion or burn to the cornea. The IPA explained that this is an orange substance used to stain the eye which can then be assessed under blue light for corneal injury. I also consider this failure to represent a failure in the complainant's care and treatment.

37. I refer to the GMC Guidance which states you must 'Record your work clearly, accurately and legibly' and that 'Clinical records should include:

    a. relevant clinical findings
    b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions
    c. the information given to patients
    d. any drugs prescribed or other investigation or treatment

38. I consider a failure in maintaining accurate and contemporaneous records impedes the thorough, independent assessment of care provided to patients. I also consider that maintaining accurate and appropriate records affords protection to those involved in providing patient care by providing a clear record of their actions and the treatment given. I consider that the failure to record a pain score, a failure to record an assessment of visual acuity and a failure to advise on what to do should vision deteriorate to represent a service failure and to be contrary to GMC Guidance. I therefore uphold this element of the complaint.

39. I consider the failure to examine the complainant's eye using a slit lamp to assess for damage or inflammation to the cornea and the failure to use Fluorescein to also represent a failure in the care and treatment afforded to the

complainant. These failings caused the complainant the injustice of loss of opportunity to have his condition fully assessed and frustration and uncertainty over the appropriateness of the care and treatment he received at that time.

40. I am pleased to note the Trust's confirmation that in subsequent visits to ED a slit lamp and fluorescein were used..

CONCLUSION

41. I received a complaint about the care and treatment received at the ED of the Ulster Hospital, Dundonald on 30 September 2020 for an eye injury. I upheld elements of the complaint for the reasons outlined in this report. I consider the failures identified in record keeping to represent a service failure and there to have been a failure in the Trust's care and treatment of the complainant.

Recommendations

42. I recommend that the Chief Executive of the Trust,

i. in accordance with NIPSO guidance on issuing an apology (July 2019), provides a written apology to the complainant for the failures in the care and treatment and record keeping identified in this report. The Trust should provide the apology to the complainant within **one month** of the date of my final report.

ii. The Trust share the outcome of this investigation with relevant medical staff in ED highlighting any learning outcomes identified.

iii. Staff should be reminded that despite operational pressures it is important to ensure patients are assessed in the right area, if at all possible, and if necessary, moved during their time in ED to facilitate access to necessary equipment. Even if a patient has to be treated in an area not specified for that injury, due to the stretched resources of the ED, the appropriate tools and tests should still be made available. Having said that I do appreciate the incredibly difficult and challenging circumstances facing ED staff currently

and most particularly at the time of the patient's attendance, which was at the height of the recent Covid-19 pandemic. I recognise the often heroic efforts that have commonly to be made by all staff and clinicians to maintain functionality in stretched ED Departments.

MARGARET KELLY
OMBUDSMAN **21 February 2023**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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