Investigation Report

Investigation of a complaint against the Belfast Health and Social Care Trust

NIPSO Reference: 16741

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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 regarding the actions of the Belfast Health & Social Care Trust (the Trust). He complained to this office on 10 January 2017. The complaint concerned the care and treatment his wife received at the Emergency Department (ED) of the Royal Victoria Hospital (RVH), and subsequently while an in-patient at the Mater Infirmorum Hospital (MIH). The complaint focused on specific issues of the patients care. The patient complained in particular about the assessment, management and administration of pain relief, the lack of co-ordination with cancer care, delay in referral to palliative care and a failure to diagnose fractured vertebrae during an ED attendance. The patient was treated by ED staff on 24/25 May 2014 and 15 June 2014, she was then admitted to a ward in the RVH until 19 June 2014; She was later admitted from home to the CCU at MIH before transfer to Ward B MIH where she was remained in the period 22 June 2014 to 7 July 2014 before transfer to the Northern Ireland Hospice. The patient sadly died on 26 July 2014.

The investigation identified that the care and treatment provided to the patient in relation to Oncology, medical treatment in ED and the general medical treatment and nursing care on Ward 7C, CCU and Ward E were in accordance with good general medical and nursing practice.

However the investigation established failings in the following specific areas which were the focus of the complaint in relation to the following specific matters:

(i) failure to have in place an appropriate pain management, assessment, scoring and recording system while the patient was in CCU, Ward 7C and Ward E.

(ii) failure to have adequate records of patient choices, decision making and communication around referral for community specialist palliative care for the patient.

The investigation also established failures by the Trust in how they handled the complaint including inordinate delay of 425 working days beyond target for response

which amounted to maladministration.

I have made a number of recommendations including an apology to the complainant, service improvements and a small consolatory payment.

THE COMPLAINT

1. The complaint is about the actions of the Belfast Health and Social Care Trust (the Trust). This was in relation to care and treatment provided to his wife, following her two attendances at the ED at RVH and later admission to MIH from 22 June 2014 until 7 July 2014. The complaint focused on specific issues of the patient's care and treatment. In particular that: (i) there were occasions where the patient received inadequate pain relief; (ii) the pain assessment and management in CCU was inappropriate; (iii) there was a lack of co-ordination with cancer care; (iv) there was a delay in the patient's assessment for palliative care; and (v) a fractured vertebrae was not diagnosed during the patient's ED attendance on 24 May 2014.

Background

2. The patient was diagnosed with a Grade IV Glioblastoma[1] in February 2014 and subsequently underwent chemotherapy and radiotherapy treatment. Physical symptoms of her diagnosed condition included a risk of seizures and the need for ongoing pain management with medication.

3. On 24 May 2014 the complainant and his daughter witnessed his wife have a 20 minute seizure. She was then taken by ambulance to the ED at RVH.

4. After initial triage assessment the patient was sent for a CT scan and X ray. The patient was transferred from the ED at RVH to Belfast City Hospital (BCH) for further review and subsequently discharged home on 25 May 2014.

5. On 15 June 2014 the patient had a second attendance at the ED at RVH. She attended complaining of "back pain". She was triaged and x rayed. The complainant was told she had a "fractured vertebrae" and possibly some old fractures. The patient was then admitted to a ward and treated until discharged

[1] Glioblastomas are the most common high grade (cancerous) primary brain tumour in adults. They belong to a group of brain tumours known as gliomas, as they grow from a type of brain cell called a glial cell. They are fast growing and likely to spread. Grade IV is a high grade tumour likely to grow and spread quickly.

home on 19 June 2014.

6. On a third relevant admission on 22 June 2014 the patient was admitted via the ED at MIH to the Critical Care Unit (CCU) at MIH. For the purposes of this report the term CCU will be used to include what can also sometimes be known as an Intensive Care Unit (ICU) or Intensive Therapy Unit (ITU). The patient was transferred to Ward B MIH on 27 June 2014. She was nursed on Ward B until 7 July 2014 when she was transferred to the Northern Ireland Hospice. The patient sadly died in the Hospice on 26 July 2014

7. The complainant made his initial complaint by telephone call to the Trust on 4 August 2014. A meeting with Trust staff took place on 20 February 2015. The minutes of that meeting were provided to the complainant on the 3rd September 2015. The Trust responded to the complainant by letter dated 4 May 2016. The complainant remained dissatisfied with the response and indicated areas of outstanding concern by telephone. The complainant was still awaiting a further response from the Trust when he first contacted this office in January 2017.

Issues of Complaint

8. The issues of the complaint which I accepted for investigation in respect of the Trust are:

   Issue 1: Whether the care and treatment the patient received from the Trust in the period May to July 2014 was reasonable and appropriate? Including: the attendances at RVH ED on 24/25 May 2014, RVH ED on 15/19 June 2014 and MIH 22 Jane 2014 to 7 July 2014;

   Issue 2: Whether communication between medical staff, the patient and her family was adequate?

   Issue 3: Whether the BHSCT complaint handling was adequate?

INVESTIGATION METHODOLOGY

9. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. The documentation included: the patient's medical notes and records and information relating to the Trust's investigation of the complaint. A series of clarifications and comments were sought from the Trust during the investigation. As part of the NIPSO process a draft copy of this report was shared with the complainant and the Trust.

Independent Professional Advice

10. After consideration of the issues, I obtained professional advice from the following independent professional advisors (IPA):
Consultant in Critical Care Medicine and Anaesthesia with more than 20 years' experience including as a Clinical Director - Consultant Critical Care IPA

    Consultant Neurosurgeon with oncology experience – Consultant Neurosurgeon IPA

    Consultant Emergency Physician in a large Teaching Hospital and Major Trauma Centre - Consultant ED IPA

    Nurse Practitioner, MA – Nurse with more than 17 years' experience – Nursing IPA

    Critical Care Matron –Nurse with more than 30 years' experience - CCU Nursing IPA

    Consultant Nurse Palliative and Supportive Care with more than 30 years' experience – CSPC Nursing IPA

    The clinical advice I received is enclosed at Appendix Three to this report.

11. 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'. However, how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

12. 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.

13. The general standards are the Ombudsman's Principles[2]:

- The Principles of Good Administration
- The Principles of Good Complaints Handling; and
- The Principles of Remedy

14. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative functions of the Trust and the professional judgement of the clinicians whose actions are the subject of the complaint.

15. The specific standards relevant to the complaint are:

- General Medical Council (GMC), Good Medical Practice (2013)[3].
- Nursing Midwifery Council (NMC) Code (2008)[4].
- Nursing Midwifery Council (NMC) Record Keeping: Guidance for Nurses and Midwives (2010)[5]
- Belfast Health and Social Care Trust (BHSCT) Policy and Procedure for the Management of Complaints and Compliments (2013).
- Health and Social Care Board (HSCB) - SAI Procedure (2013)[6]

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

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[2] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.
[3] General Medical Council (2013). Good Medical Practice. www.gmc.uk.org/guidance/good_medical_practice.asp
[4] https://www.nmc.org.uk/globalassets/sitedocuments/standards/nmc-old-code-2008.pdf
[5]https://nipec.hscni.net/download/projects/previous_work/highstandards_education/improving_recordkeeping/publications/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf
[6] HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents – October 2013

17. A draft copy of this report was shared with the complainant and the Trust for comment on the contents, findings and recommendations.

INVESTIGATION

Issue 1: Whether the care and treatment the patient received from the Trust in the period May to July 2014 was reasonable and appropriate? Including: the attendances at RVH ED on 24/25 May 2014, RVH ED on 15/19 June 2014 and MIH 22 Jane 2014 to 7 July 2014;

Issue 2: Whether communication between medical staff, the patient and her family was adequate?

As the issue of communication is linked to the patient's care and treatment I have decided to report on these two issues together.

Detail of Complaint

18. The complainant contacted the Trust by telephone on 4 August 2014, 9 days after his wife had passed away. The detail of the complaint as recorded by the Trust record of the telephone call included: occasions of inadequate availability of pain relief; treated in CCU but inappropriate pain relief regime; lack of co-ordination with cancer care; lack of earlier assessment for palliative care and failure to diagnose fractured vertebrae during the patient's' first ED attendance on 24 May 2014.

19. In considering the complaint to this office, I have focused on the primary complaints regarding the Trust's care and treatment of the patient and communication with the family. These issues are considered together below.

Evidence Considered

Clinical Records

20. As part of the investigation, the patient's medical records were obtained from the Trust and examined. In order to obtain advice, copies of the records and

relevant documentation was provided to the IPAs. I have noted the following summary timeline entries in the patient's records to be significant in considering this complaint:

February 2014	The patient Diagnosed with Glioblastoma
13 March 2014	BCH Cancer Outpatient Clinic – seen by Neuro Oncology Clinical Nurse Specialist Record states: "Neuro-Oncology information pack given and consultation record, GP will be contacted and advised. Referral to Community Specialist palliative care team following discharge for on-going support, and future symptom control …GP will be contacted and advised. Referral to Community Specialist palliative care team following discharge for on-going support and future symptom control."
20 March 2014	BCH Cancer Outpatient Clinic– seen by Neuro Oncology Clinical Nurse Specialist. Staff Diary note recorded outside of Trust patient records and records states "CC xrt – concurrent radiotherapy chemotherapy Declined CSPCT TP – treatment plan"
24 May 2014	Attendance at RVH ED – admitted to BCH
25 May 2014	Discharged from BCH to Home
15 June 2014	Attendance at RVH ED admitted to RVH Ward 7C
19 June 2014	Discharged from RVH to Home
22 June 2014	Attended at MIH ED admitted to CCU
29 June 2014	Transferred CCU to MIH Ward E
7 July 2014	Discharged MIH Ward E to Hospice
26 July 2014	The patient died in Hospice.
KEY	BCH – Belfast City Hospital Belfast RVH - Royal Victoria Hospital Belfast MIH – Mater Infirmorum Hospital Belfast CSPCT – Community Specialist Palliative Care Treatment CCU – Critical Care Unit also known as Intensive Care IC and Intensive Therapy IT

Trust's Response to Investigation Enquiries

21. In response to enquiries by letter dated 7 February 2017, the Trust replied on 21 June 2017 and stated:

"The Trust met with the [the patient's] family including [the complainant], his son and [the patient's] sister in law in February 2015. In addition, present at this meeting were representatives from medical and nursing intensive and palliative teams involved in the care of [the patient] through her admission in the Mater hospital, as well as service management and complaints staff.

Subsequent to this meeting, the Trust provided the [ ] family with the notes of the meeting. Following contact from the complainant a further written response was issued in May 2016.

The Trust would consider that local resolution would still be available to [the complainant] and his family and staff remain open to meeting and addressing any issue not previously addressed.

…2.1 Comments re [the complainant's] statement that the x-ray department missed his wife's three crushed vertebrae on the night of her first seizure.

On the 15th June 2014, the Emergency Department requested the following x-rays:

- *x-ray of the Lumbar Spine and sacroiliac joint*
- *x-ray of the Thoracic Spine*

The x-ray of the Lumbar Spine and sacroiliac joint was reported and states, "there is a sub-acute grade 1 superior endplate fracture of L4 vertebral body. Otherwise, lumbar vertebral body heights and alignments are maintained. The sacroiliac joints are normal".

The x-ray of the Thoracic Spine was reported and states, "there is generalised osteopenia. Dorsal vertebral body alignments are maintained. Disc space heights are preserved. There is a mild thoracic Kyphosis due to a moderate compression fracture of a single upper dorsal vertebral body"

Learning has been identified regarding the management of pain medication. This has been shared with the [ ] ' family.

This learning has been reinforced at ward level.

Further improvement in regard to communication between specialist teams collectively sharing care has also been improved..”

The letter continued by addressing specific issues of the patient’s treatment including pain management; the patient being placed in a chair with fractured vertebrae and the availability of palliative nursing. I do not set out the detail of the letter in full but I will return to the Trust position during the analysis in the report.

22. In a Trust response letter, dated 27 September 2019, the Director of Unscheduled and Acute Care stated:

“The Trust accepts and acknowledges that the medical notes should have reflected a more detailed account of [the patient’s] distress concerning her diagnosis and decision making on referral for CSPC nursing.”

Relevant Independent Professional Advice

23. The complainant raised particular concerns with the treatment of the patient during her emergency department admission on 24 May 2014 and the suggestion that vertebrae fractures were not detected until the 15 June 2014 attendance. The ED Consultant IPA examined the records from both ED admissions [24/25 May and 15 June] and advised:

“[24/25 May 2014]

Back pain was identified on examination and X-rays were performed to rule out underlying pathology. No comment on the result of the Thoracic spine X-ray is in the discharge summary. I do not feel that any further imaging was required to rule out thoracic spine injury on this occasion. The report, dated 27th May, states that there was no fracture identified

[The patient] was offered analgesia but declined. [The patient] is recorded as having taken her own analgesia. I was unable to find a regular record of pain scores being assessed. Having given analgesia there should be a record of a

review to ensure adequate analgesia had been provided

In my opinion, the treatment of [the patient] was generally of an acceptable standard. My only concern is around nursing a patient on chemotherapy on a corridor with resulting increased exposure to infection opportunities.

[15 June 2014]

[The patient] was correctly assessed and treated when she was admitted to A&E on 15 June 2014. X-rays taken on 15th June are reported on 20th June as identifying "a grade 1 superior endplate fracture of L4 vertebral body". They also identified a "moderate compression fracture of a single upper dorsal (T) vertebral body." They do not record which dorsal vertebral body.

The doctor that saw [the patient] felt it was T5 and managed her care appropriately.

Conclusion: [The patient] had a complex presentation of a rapidly deteriorating life shortening illness. The A&E management seems appropriate in my judgement based on the records I have seen."

24. I note that the Consultant Neurosurgeon IPA considered the treatment of the patient' glioblastoma, covering the period March 2014 to July 2014, he advised:

"… I would have referred her to palliative care once I had discussed the results of the first brain MRI with patient and her family.

…The doctors treating her did a fine job of keeping [the patient] alive for a substantial period of time. (With palliative care from the outset she would not have lived very long.)

…Given she was for active treatment, it was reasonable to avoid excessive doses of opiate as it would (and did on occasion) compromise respiratory function. I feel she should have been for palliative care, and therefore pain control is a priority and any untoward side effects which will shorten her life expectancy are less of a concern.

…[The patient] met the national criteria for active treatment in terms of performance score, therefore no criticism can be made in this regard.

…made some effort to explain the poor prognosis but [the patient] refused to be fully informed. These are difficult conversations to have but repeated attempts should have been made to help the patient come to terms with the fact that she has a terminal disease. End of life decisions should have been addressed as soon as possible."

25. In relation to the patient's care within the MIH CCU from 22 June 2014 to 27 June 2014, the CCU Consultant IPA examined the relevant records and advised:

"…treatment was in accordance with nationally accepted sepsis and pain and intensive care treatment guidelines and practice.

No specific pain assessment is recorded. It would have been better if her pain levels had been subject to formal recorded assessment throughout her ITU stay as this would have provided good evidence as to how effective her pain relief was overall.(Assessment of Pain BJA: British Journal of Anaesthesia, Volume 101, Issue 1, 1 July 2008, Pages 17–24, https://academic.oup.com/bja/article/101/1/17/357820)

Whilst it is usual to assess a formal pain score in post operative patients, or on an "Early Warning Score" (eg NEWS), it is sometimes not recorded routinely on ITU charts. This is because many ITU patients are sedated with painkillers and other drugs, and are not able to respond. AM was able to respond, however, and during her stay the nurses have recorded when she was felt to be in discomfort or pain, and have regularly discussed this with the family, or the doctors. As a result, her opiate medication was reintroduced. The nurses have noted the effects of this in their records. It is of note that on the day she was discharged to the ward, and the NEWS score chart re-established, that her pain score is recorded as "0" at least twice."

I also note the explanation provided by the CCU IPA regarding the patient 'sitting up out of bed':

"Therefore there is no barrier to sitting the patient out as the treatment is

generally symptomatic.

(Vertebral Compression fractures. A review of current management and multimodal therapy https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3693826/)

It would be regrettable if sitting the patient out did have undue effect on the patient's pain needs. However these can be addressed appropriately by giving extra pain medication and planning appropriately. As stated, failure to sit the patient out would put them at risk of further complications such as pressure sores and chest infections.

Therefore her treatment was appropriate in this regard."

26. In relation to the treatment of the patient's palliative symptoms and the care provided to the patient, the CCU Consultant IPA advised:

"It seems that some robust discussion took place between the intensive care doctors and the oncologists on this point in relation to [the patient] in that they felt that her underlying brain tumour was going to be rapidly more fatal than the consultant oncologists suspected, and that her admission to intensive care was an indication that palliative care should be considered as the limits of treatment. This discussion seems to have been witnessed by the family (as detailed in the original complaint) and caused some distress. This is regrettable if it is the case. Ideally, such discussions should take place in private, but this is not always possible for logistical reasons.

Learning: Some intensive care units include a formal pain assessment/pain score on their charts. This may have reassured [the patient's] family that her pain needs were being properly assessed."

27. In relation to the overall treatment while in the MIH CCU from 22 June 2014 to 27 June 2014, the CCU Consultant IPA advised:

2 [the patient] appears to have received care in accordance with nationally accepted standards and guidance. There were good clinical reasons as to why her pain relief was initially reduced; and then only cautiously increased."

28. The CCU nursing team in MIH cared for the patient from 22 June 2014 to 27 June 2014 team. In relation to the patient's care in this regard, the CCU Nursing IPA advised

"There is no mention of [the patient's] # vertebrae following her initial assessment on her admission to Critical Care.

… [The patient] does however appear to have had good nursing care documented.

[Pain Management]

There is no use of any Pain Scoring Tool used anywhere in the Nursing notes to denote what level of pain [the patient] had. There is only one day where her pain is mentioned in the Nursing Kardex and highlighted that she requires analgesia this is 23/6/14 at 12;00, 18:30 and 18:45 (this is a good example as it is documented how much pain relief [the patient] was given each time her pain was identified as an issue to her). However on this occasion a pain score of 12/10 is documented on communication chart but not transposed onto nursing notes, although there is a heading of Pain in kardex at 18:45 which leads to [the patient] being given 2.5mgs Oxynorm.

It would appear that [the patient's] pain relief was changed daily on the prescription chart, with the increase of strong pain relief given at least 12 hourly as medication also needed for breakthrough pain. However this is not documented anywhere why or what her changed pain score is.

[Sitting Out]

There is no documentation by Nurses, Doctors or Physiotherapists show that [the patient] has been assessed as to her suitability to sit out

[Conclusion]

[The patient] was in a great deal of pain and this is evident by the quantity of pain relief she was prescribed. However there is no process documented to ascertain if pain relief was sufficient as no pain scoring documented.

[The patient] had # vertebrae and this isn't documented in nursing, medical or

physiotherapy notes as to her ability to be sat out (when this did occur she deteriorated and treatment needed to be escalated).

Her nursing care however is documented well and all her pain relief given in a timely manner."

29. As part of the investigation, I considered the role of general nursing care and pain management in the patient's treatment on RVH ward 7C and MIH ward E. The Nursing IPA advised:

"*In summary; in order for nursing care to be appropriate and reasonable there should be evidence of assessment, care planning and evaluation. Medication should be administered as prescribed and the patient should be monitored at regular intervals in accordance with their level of need.*

[RVH Ward 7C 16.June.2014 – 19.June.2014]

[The patient's] nursing needs over this time-frame were assessed, planned and evaluated in line with national standards. Her nursing needs were anticipated and planned for.

[the patient's] nursing documentation was in line with national standards (Reference d) as it was clear and written at the time of the events.

[MIH Ward E 27.June.2014 – 07.July.2014]

The nursing assessments for this episode of care should have been completed on admission to hospital … but it is a poorly completed assessment, specifically the section for pain assessment as this is blank.

I cannot see any care plans for this episode of care. Care planning should continue on from any risks or potential risks identified through assessment, thus if assessment is poorly completed, care planning is also likely to be poor or absent.

Despite poor nursing assessment and care planning, there was no apparent impact on [the patient].

[The patient's] nursing documentation was not in line with national standards …as her assessment was poorly completed and there were no individualised

care plans. Her pain assessment was completely blank and yet this was her main concern both on its own and for the fact that it impacted on other areas of her care such as hygiene, moving, mood, appetite.

As with her previous admission to RVH (16-19th June 2014) there were no pain scores documented on the NEWS chart.

Pain is a subjective, personal experience, really only known to the person who suffers. Accurate and meaningful assessment and reassessment of pain is essential and optimises pain relief ... Integral to any assessment of pain is a requirement to assess the effectiveness of analgesia that has been administered

RVH Ward 7C 16 June 2014 – 19 June 2014

Pain was identified as a problem through the nursing assessment (page 133 binder 1) and a care plan was commenced (page 122 binder 1).

Analgesia was administered as per the prescribers' instructions throughout this admission and is documented as having 'good effect' (page 125 binder 1).

Pain scores were not recorded on the NEWS charts, but because there is evidence of care planning and daily evaluations, this appears to be a record keeping issue rather than a failing in pain management.

Overall pain management was appropriate during this admission.

MIH Ward E 27 June 2014 – 07 July 2014

From a nursing perspective pain management in terms of assessing and monitoring was poor during this admission. Pain was not recognised as a concern on assessment and there is no pain management care plan. Pain has not been scored on the NEWS charts and the effectiveness of analgesia has not been assessed. However; this has not impacted on [the patient] because she was reviewed every day, often in fact twice a day, by the Palliative care team. They monitored [the patient's] pain and they evaluated the effectiveness of the analgesia that she was given. They communicated well with [the patient] and her family and explained the rationale behind any changes to analgesia that they made. The nursing team followed the pain management plan as documented by the Palliative care team."

30. The investigation considered the question of referral of the patient for community specialist palliative care nursing. The complaint questioned the level of community palliative support available to his wife. The patient's Trust Notes and Records contained a consultation record from 13 March 2014 indicating:

"Neuro-Oncology information pack given and consultation record, GP will be contacted and advised. Referral to Community Specialist palliative care team following discharge for on-going support, and future symptom control."

The patient's GP Notes and records were obtained, which clarified in a note made on 17 March 2014 that the patient and her family were aware of the "incurable and terminal nature" of her condition. The GP notes also contain a copy of the Trust record from 13 March indicating a referral to Community Specialist Palliative Care. From the complaint made it was clear that he did not feel that community specialist palliative care was made available to his wife.

31. The CSPS Nursing IPA sets out the chronology available from the the patient's neuro-oncology clinic notes and records and advised:

"Patients with High grade brain tumours require significant support due to the complexity of the disease and symptoms and referral to Palliative care is recommended at diagnosis in recognition to the poor survival. (NICE).

… The summary of events presented and the consultations and interventions between the NOCNS [Neuro Oncology Clinical Nurse Specialist] and palliative care teams in hospital is quite comprehensive but does not extend to support in the community setting.

I note on March 13th 2014 the NOCNS spoke with [the patient] regarding the Palliative care community support available from the hospice however the Belfast Health Care Trusts response letter states the patient declined the referral at this point. I could not find documented evidence in the clinical notes to this refusal only that [the patient] is upset during the consultation and it was felt inappropriate by the NOCNS to discuss. The hospice referral is further raised on March 20th in the clinic setting and again declined.

Various opportunities arise to refer [the patient] to the hospice community team during her transfer of care to the cancer centre from April 14, especially as the family are telephoning the CNS frequently for advice.

However recommendations and standards can only be put in place following informed consent with the patient unless mental capacity is lacking. Mental Capacity does not appear to be questionable in this case within the clinical records despite a diagnosis of a brain tumour. It's clearly stated from diagnosis that [the patient] does not want to discuss her disease and prognosis which does make it difficult to guide and support both the patient and family effectively during a terminal illness

Carer's holistic assessment of needs has been identified as a National priority (NICE) to improve outcomes for patients and families in the last 12 months of life however limited evidence exists across the UK to this being done in practice.

The diary entry of the NOCNS 20/3/14 has the patients name which does not provide evidence of the intended action to complete a hospice referral for community support. The NMC Code of Professional standards (2008) for nursing states the importance of accurate records related to practice including actions which are date and timed as crucial. Patient and carer information, advice or guidance should be clearly documented alongside communication with all those included at the time of consultation. The clinical notes do not have clearly documented consultations with the family or evidence that informed choice has been carried out to reach decisions pertinent to clinical care.

It's not clear from the clinical records if [the patient] understood the gravity of her prognosis and the impact this may have on her family which could have informed her decision making in regards to community palliative care support.

In this case it appears the CNS acted in the best interest of the patient by respecting her rights to accept or refuse the referral and acted within the professional confounds of the code. Its assumed [the patient] has capacity to make decisions as there is nothing to contradict this assumption in the clinical notes

If the hospice community referral had been agreed by [the patient] and instigated from diagnosis then the support and care provided within the community setting should have been significantly better.

Co-ordination and planning of care with the family across all health settings enables a better experience and supportive network especially for families."

Trust's response to Independent Professional Advice

32. I have attached the Trust letters of reply, dated 3 July 2018, 4 July 2018 and 5 July 2018, to the content of the independent professional advice at appendix three to this report. The Trust responded to the Consultant Neurosurgeon IPA advice provided, in the following terms:

"The Trust can advise that the treatment decisions in this case were made by a team of experts at the Neuro-oncology Multi-Disciplinary Meeting (MDT). This plan was deemed to be in the patient's best interests and was discussed with and consented by the patient. While there are no specific guidelines … of for the treatment of glioma, best practice is deemed to be biopsy, surgery and chemo/radiotherapy.

[The patient] was discussed both pre-operatively and post-operatively at the regional Neuro oncology MDT and all treatment decisions made were made by the group and in accordance with local and National guidelines. She made an excellent recovery post-operatively and fulfilled all local (as well as national and international) criteria for active oncology intervention (this is acknowledged by the IPA). At her first oncology assessment, she was deemed to have a performance score of 1 and the standard of care in that patient population is concurrent chemoradiation. [The patient] was well motivated, with excellent family support and keen to avail of any treatments that would both prolong life and maintain/improve quality of life.

[The patient] and her family were made aware that her disease was incurable and that treatment was aimed at control/palliation - they were informed of the risks versus of benefits of proceeding with treatment and elected to proceed.

The implication in the independent report that active treatment was chosen to avoid having difficult conversations is not true."

33. The Trust responded to the CCU IPA advice in the following terms:

[Consultant]

"In response to identifying learning and service improvements, the Consultant clinical advice does state "that some intensive care units may use a formal pain assessment score on their charts" and "this may have reassured the family" regarding the [patient's] pain assessment.

Whilst the MIH CCU does complete a visual analogue scale (VAS) for acute pain assessment, [the patient] had complex and persistent pain and it was not appropriate to measure persistent pain using an acute pain score."

[Nursing]

"The Nursing Admission kardex for Ward E MIH where [the patient] was admitted initially, states in the previous medical history section, that [the patient] had previous # vertebrae. The CCU team uses this kardex as their admission documentation to prevent duplication. The MIH CCU was therefore aware of [the patient's] previous# vertebrae on admission.

CCU does complete a visual analogue scale (VAS) for acute pain assessment, [the patient] had complex and persistent pain and it was not appropriate to measure persistent pain using an acute pain score.

…[The patient] was assessed by the nurse caring for her prior to sitting out of bed; this included asking [the patient] how she mobilised at home and what assistance she would require, the help of two nursing staff and use of a 'steady standing aid'. In order to aid lung expansion to help treat her chest infection, [the patient] was supported to sit out of bed. [The patient's]' previous# vertebrae were assessed as stable as per the MRI report and her pain assessment was also completed prior to mobilisation. This is recorded in the nursing documentation.

In response to identifying learning and service improvements, CCU does complete a visual analogue scale (VAS) for pain assessment for the acute post operative/trauma/medical patient. This was not appropriate for [the

patient] who had a history of complex and persistent pain. Consideration will be given to the use of a formal pain assessment score for patients who have a history of persistent pain."

34. The Trust commented on the CSPC Nursing IPA that:

"The Trust also welcomes the comments on informed consent - "appears the NOCNS acted in the best interest of the patient by respecting her rights to accept or refuse the referral to community specialist palliative care (CSPC)" The Trust agrees with the IPA regarding the identified learning and service improvements (page 6). Please see … the service improvements for all patients with palliative care needs which have taken place since [ ] ' complaint was received in 2014."

Analysis and Findings

35. The complaint provided the Trust with a brief account of his areas of complaint in his initial telephone call. I have not identified any evidence that any effort was made by the Trust to obtain greater detail or explanation of the areas of complaint with the complainant. This process of obtaining greater detail was undertaken by the Investigating Officer during this investigation. I have carefully considered the account from the complaiant of his family's experience of supporting his wife as she coped with the symptoms of her terminal illness. His concerns fall into the following main areas: (i) there were occasions where his wife received inadequate pain relief; (ii) the pain assessment and management CCU was inappropriate; (iii) there was a lack of co-ordination with cancer care; (iv) there was a delay in the patient's assessment for palliative care; and (v) a fractured vertebrae was not diagnosed during the patient's ED attendance on 24 May 2014.

36. I have considered the detailed comments of all the IPA's relating to the patient's care. The patient's clinical presentation was challenging in light of the aggressive form of tumor identified in February 2014. I also note that the complainant makes no complaint around the patient's oncology treatment and care.

37. I have considered the advice from the Consultant Neurosurgeon IPA and the clinical comments from the Neurology and Oncology staff at the Trust. I accept that while there may be understandable philosophical differences between clinicians about the quality of life which a patient may obtain through extending treatment, this is a matter for the patient to decide. On the basis of the Consultant Neurosurgeon IPA advice I find that the general medical care and treatment provided to the patient in respect of her brain tumor and overall clinical management was reasonable and appropriate and met accepted clinical practice standards and guidelines.

Diagnosis of initial fracture 24 May 2015

38. The ED Consultant IPA examined the records of the attendances at RVH ED on 24 May 2014 and 15 June 2014. The issue raised by the complainant in his initial complaint telephone call referred to "missed fractures". On clarification by the Investigating Officer he states that the information relayed to him on 15 June 2014 suggested that at least one fracture was more than a week old. He felt it was suggested that it could have been missed at the earlier ED attendance on 24 May 2014. I accept the advice of the ED Consultant that the actions and treatment decisions made on 25 May 2014 and 15 June 2014 were reasonable and appropriate. The X ray report records:

    "These images are of reduced diagnostic quality, but no significant reduction in the vertebral body heights and disk spaces is identified. The alignment is maintained."

    The ED IPA has advised the standard of ED care was generally acceptable and there is no evidence of undiagnosed fractures. That is not to undermine or diminish that the patient may well have been in ongoing back pain which was very difficult for her family to accept. I do note that the ED IPA has commented on the issue of a cancer patient being nursed on a trolley in a corridor. The Trust should take note of this point. Therefore I do not uphold this element of the complaint concerning an undiagnosed fracture after the 24 May 2014 ED attendance. I will return to this issue in considering how the complaint was handled by the Trust.

Pain Management Ward 7C/Ward E and Communication with family

39. [ ] complained that there was inadequate attention to [the patient's] pain management, including when her pain was raised by the family. The Nursing IPA found the general ward nursing care during the RVH and MIH episodes of care as reasonable and appropriate and found no detriment or deterioration arising from any particular aspect. However, I accept the advice from the Nursing IPA that the records of pain assessment and scoring are lacking in regard to periods of [the patient's] time in RVH Ward 7C (16 June to 19 June 2014) and MIH Ward E (27 June 2014 to 7 July 2014).

40. The Trust response did not fully accept the nursing failings in their response which stated:

> "The Trust would however acknowledge there was evidence of nursing assessment and care planning on admission to the Mater Ward E. [the patient's] clinical condition had deteriorated to a point where it was more appropriate that the palliative care team plan was followed, as acknowledged by the IPA. In addition there is evidence within the nursing documentation of regular assessment and treatment in relation to [the patients] ongoing care and family involvement."

41. Clinical decisions on treatment can rely upon accurate and systematic recording of pain. I consider these were not adequately monitored and recorded in line with NMC guidance[7]. The assessment of pain is a fundamental of assessing, managing and monitoring the patient and is a central element of nursing. The Nursing IPA identified areas where the appropriate assessments as part of care planning, the use of a patient appropriate routine pain scoring or assessment tool was not being used on Ward 7C and Ward E or there were no records of appropriate pain scoring. I consider this to be a failing in the nursing care provided to the patient and not in line with the requirements to provide a "high standard of practice and care at all times" as set out in the NMC Code. I consider that the issue of communication raised by the complainant related to how ongoing concerns about how the patient's level of pain was handled. This

[7] See Appendix Four NMC Code Standards 15, 19 and 21 and NMC Record Keeping Guidance

is a difficult process to manage and although the Nursing IPA found evidence of good records of communication with the family, there is an absence of pain assessment and scoring. This would have led to an impression for the complainant that concerns about his wife's pain were not being systematically addressed. I consider that this is a failing of pain management process as a whole, rather than just communication. I therefore uphold the element of the complaint about failings to assess, manage, monitor and record the ongoing pain experienced by his wife while on RVH Ward 7C and MIH Ward E.

Critical Care Unit (CCU) Pain Management

42. The CCU Nursing IPA advised that the records reflect a good standard of care while [the patient] was in the CCU from 22 June 2014 to 27 June 2014. The CCU Nursing IPA notes that the records do not document appropriate pain assessment and scoring, assessment prior to [the patient] being "sat out" of bed and appropriate recording [the patient's] history of fractured vertebrae. All three of these elements I consider this to be failings of nursing care in line with the requirements to provide a "high standard of practice and care at all times" as set out in the NMC Code. I uphold this element of [the complainant's] complaint about the failings to assess, manage, monitor and record the ongoing pain experienced by his wife, assess the pain impact of her ability to "sit out" of bed and take account of her history of fractured vertebrae, all on the CCU ward. As acknowledged by the Consultant Critical Care IPA there was a clinical reason for sitting [the patient] out of bed but from my review of the records and with the benefit of the IPA advice the absence of a written assessment acknowledging her history of fractured vertebrae remains a concern.

43. I accept the advice from the CCU Consultant IPA that in general the care and treatment provided to the patient while in CCU was entirely reasonable and appropriate. It is noted that the treating medical staff were faced with a patient with a complex presentation and underlying terminal illness. The process of stabilising the patient's condition was successful, but involved changes to her medication and withdrawal of her main pain relief. Understandably the effect of withdrawing her main pain relief medication would be of a concern to her family. While the medical records note discussions with family, the importance of

regular assessment or monitoring of pain was inevitably an element of care and treatment that became an “hour by hour” patient experience for the patient and her family. I consider the communication issue further in paragraph 46.

45. I note that the CCU Consultant IPA records that there was no systematic pain assessment recorded for the patient. I accept the advice of the CCU Consultant IPA on this point. In many instances CCU patients are not able to respond to formal pain scoring however, the patient was able to respond. I consider that the care management should be sufficiently flexible to allow pain scoring where a patient is able to respond. This would also have impacted on the patient’s view of the communication with staff about his wife’s level of pain. Staff should have been clear how they were assessing, measuring and recording the patient’s pain level. I uphold this element of the complaint about the failings to systematically assess, manage, monitor and record the ongoing pain experienced by his wife on the CCU.

46. While the complainant and his family visited and stayed with his wife on the Wards, their most obvious interactions recorded in the nursing notes and records concerned their experience that the patient was in severe pain on occasions and required further pain relief. The fact that this is recorded repeatedly in the nursing notes for both RVH Ward 7C and MIH Ward E indicate that this was one of the most frequent communications between the family and nursing staff. The family perspective was that their concerns about pain relief and pain management did not always receive an adequate explanation. This led to the family’s perception of inadequate communication on this issue.

47. In terms of the injustice sustained by the complainant in respect of the failings identified at paragraphs 39-45, this would have caused distress, frustration and anxiety to the complainant and his family in witnessing his wife’s obvious pain and her requirements for attention and care. I will deal with the appropriate remedy in the Conclusion section of this report.

Access to Community Palliative Specialist Care Nursing

48. The complainant's initial complaint raised the issue of an absence of palliative care support. As the investigation of this complaint progressed further material came to light in relation to the patient accessing community specialist palliative care. The patient's medical notes and records appeared to record that she had been referred for community specialist palliative care for "on-going support, and future symptom control" at an attendance on 13 March 2014. This was at an attendance at the Neuro Oncology Clinic. The medical records did not sit comfortably with the description from the complainant and his family of their concerns regarding "on-going support and symptom control". On further enquiry the Trust provided a staff work diary from the Neuro Oncology Nurse Specialist which recorded on 20 March 2014, as at paragraph 23, that the patient was distressed and declined community specialist palliative care. This is not reflected in the Trust medical records.

49. The CSPC Nursing IPA advice set out at paragraph 32 details the difficult issues to be resolved against a background of such a shattering diagnosis. Discussions around prognosis, longevity and palliative care are dealt with in the most trying of circumstances. Even if there are no issues of informed consent, a terminally ill patient has little understanding of what lies ahead, and the impact on their lives and that of their families. I accept the advice of the CSPC Nursing IPA that the medical records should have documented more fully the decision making on the community specialist palliative care nursing referral. It would also have assisted Trust staff in appreciating the patient's decision and making further appropriate offers of assistance to the patient and her family. I also note the CSPC IPA advice that the issue of palliative care referral should have been revisited to give the clear benefit that access to this service would have been to the patient or her family.

50. I welcome that the Trust has accepted this failing in record keeping, as set out at paragraph 22. I also note that the Trust have outlined a substantial "action plan" and learning from this complaint in its letter of 27 September 2019. I will return to that matter in the Conclusion to this report. I accept that the Neuro

Oncology Nurse Specialist respected the patient's decision in this instance but the decision is not fully reflected in the medical records. This is not in keeping with the "high standard of practice" required by the NMC Code (2008) and the NMC Recording Guidance. The Trust has accepted this. I welcome the detailed action plan that the Trust has proposed to address the learning from this complaint and to improve the documentation and communication at such a critical and sensitive time for patients and their families.

51. I do not uphold this element of the complaint as it relates to palliative care not being provided to his wife. However as outlined above I have identified failures in the recording of the patient's future palliative care decision. I uphold the element of the complaint, that the Trust has not adequately recorded any decision making by his wife on accessing community specialist palliative care in her medical records and did not appropriately revisit the question of availability of community specialist palliative care for the patient and support for her family.

Issue 3: Whether the Trust's complaint handling was adequate?

Details of Complaint

52. The complainant complained about his wife's care and treatment by telephone on 4 August 2014 to the Trust. The complainant complains that the Trust response to the complaint was substantially delayed and did not adequately address his main issues of concern, namely the possible fractures oversight, pain management and palliative care.

53. In response to the complaint, the Trust arranged a meeting on 20 February 2015 for the complainant and some MIH staff. Summary minutes of the meeting were provided to the complainant on 3 September 2015. After the complainant asked for a full written response and raised further issues, the final Trust complaint letter of response was dated 4 May 2016. I have previously set out details of the Trust's response to the complaint.

When he made the complaint to this Office the complainant expressed

dissatisfaction with the responses received from the Trust to his areas of complaint and specifically the lack of a full apology for failures he had highlighted and failure of the Trust to accept the issues he had raised in "missed" fractures at ED, pain management, communication with the family and lack of palliative care support. In his complaint to me the complainant highlighted the time taken in his engagement with the Trust complaints process and the excessive delays in receiving a final response.

Evidence Considered

Trust's Response to Investigation Enquiries

54. The Trust response to investigation enquiries from this Office dated 9 February 2017 were only answered by letter dated 21 June 2017, with an explanation that the delay in part was due to unexpected staff absence. I have already set out extracts from the response in paragraph 21. I consider the entirety of the Trust correspondence but the bulk of the letter deals with a chronology of pain recording and pain medication administered to the patient.

Policy and Guidance

55. All Trusts were required to adopt a complaint policy and procedure in line with Regional Health and Social Care Complaints Procedure (2009) under the Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009[8]. The policy applicable at the time was the 2013 version of the Trust's Policy and Procedure for the Management of Complaints and Compliments.

56. The Trust complaints policy states in the section titled "Purpose":

> *'Learning from complaints can only take place when they are managed in a positive and open manner. It is the Trust's wish to promote an open, honest and just culture, where all staff can learn from complaints.*
> *Complaints will be dealt with promptly and effectively in order to eliminate the need for a complicated and time-consuming investigation process. "*

[8] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20Complaints%20Procedure%20Directions%202009.pdf

The Trust Complaints Policy and Procedure also outlines in detail the respective roles of those involved in the complaints process: staff, service directorate managers, complaints managers, Directors and the Chief Executive.

57. I have set out further relevant sections of the Trust complaint policy at Appendix four of this report.

Analysis and Findings

58. I have carefully examined the information and records the Trust provided about their complaint handling. In considering the records provided by the Trust at the relevant applicable policies, I have found the following, with relevant references to the Trust complaints policy in brackets:

(i) The Trust provided no record to evidence a contemporaneous record of an appropriate identification of the issues or service areas involved in the complaint, within the Complaints team. (Policy 8.18)

(ii) The complaint was forwarded directly to relevant service area staff on 5 August 2015. There is no record or contemporaneous evidence of any discussion of the complaint between the Complaints Manager and relevant Service Directorate Manager as to the issues to be investigated. (Policy 8.17) There is no evidence of consideration of whether the issues raised should be dealt with as a “serious adverse incident”, including potentially missed fractures or failures in pain management or community specialist palliative care. (Policy 8.20, Appendix 9 and HSCB SAI Procedure).

(iii) There is no evidence or record of a contemporaneous discussion of the appropriate level of investigation to be carried out e.g. Root Cause Analysis (RCA) for complaints graded medium or above. (Policy 8.18)

(iv) There is no clear evidence or contemporaneous record of the appointment of any service directorate managers as investigators to undertake and complete the investigation into the various aspects of the complaint. (Appendix 7)

(v) The Trust did not provide details of actions taken during the investigation or records of an investigation with the exception of emails

outlining factual accounts or factual justifications of parts of care and treatment (Appendix 7) There is no evidence that:

> *"The investigator should establish the facts relating to the complaint and **assess** the quality of the evidence and call upon the services of others if required.*" (Appendix 7)[Emphasis Added]

(vi) There is no adequate record or contemporaneous evidence to explain why the complaint was not responded to by 2 September 2014, being 20 working days in line with the Trust policy.

(vii) The Trust response in arranging a meeting, may have been appropriate under the complaints policy if there was little complexity in the issues to be addressed. This was not the case with this complaint. By the time the meeting took place on 20 February 2015, which did not address all issues of the complaint, a response was **120 working days overdue** beyond the Trust complaint policy timescales. It took a further **136 working days** for the Trust to provide a minute of that meeting to The complainant. No adequate explanation for the delay appears on the complaints file.

(viii) The full response on clinical aspects of the patient's care delivered by Trust letter on 4 May 2016 was **425 working days overdue** from the 2 September 2014 target date. In some cases delay is inevitable due to the complexity of the issues being investigated. There is no adequate record or explanation for such an egregious delay in this matter. I acknowledge that the Trust apologised for the delay. However, in the context of the failings identified in the report I conclude that the complaint investigation undertaken by the Trust was tainted by delay.

(ix) There are no records or contemporaneous evidence of an appropriate level of investigation which meets Trust policy, regional procedures and HSC Complaint Practice Directions. This is of concern given my findings relating to the patient's pain management assessment and scoring, and the failure to address all the issues raised in the complaint. (Appendix 8) In the context of the failings identified in the report I conclude that the complaint investigation undertaken by the Trust was inadequate.

(x) There is no evidence of appropriate escalation to address the ongoing delay in addressing the complaint. This may be a matter for appropriate revision of the Trust policy.

(xi) In the Trust complaint records I have considered the evidence of communications between the complainant and the Trust complaints Department. I do not consider that there was adequate frequency of contact to update the complainant on the ongoing delay and any clarity of explanation for the ongoing delay.

59. The failures I have outlined by the Trust to properly apply its own policy and procedure for complaints; the regional procedures for complaints and "serious adverse incident" investigations fails to meet the Principles of Good Complaints Handling, individually and collectively, as set out in the appendicies. I conclude that this amounts to maladministration by the Trust in the operation of its complaints procedure in this case.

60. In summary I find the complaint handling attended by significant delay; failure to follow policy and failure to conduct a thorough investigation specifically addressing the issues of "missed fractures", pain management and community specialist palliative care. I therefore uphold this issue of the complaint. As a consequence of the maladministration I have identified I consider that the complainant suffered the injustice of uncertainty, delay, upset and frustration.

CONCLUSION

I received a complaint about the actions of the Trust in dealing with a complaint into aspects to the care and treatment provided to his wife.

I have investigated the complaint and have not found failures in the Trust care and treatment in relation to the following matters:

(i) General oncology treatment of the patient.
(ii) General medical treatment of the patient in ED
(iii) General medical treatment of the patient on Ward 7C, CCU and Ward E.

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

(i) failure to have in place an appropriate pain management, assessment, scoring and recording system while the patient was in CCU, Ward 7C and Ward E.

(ii) failure to have adequate records of patient choices, decision making and communication around referral for community specialist palliative care for the patient.

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

(i) deficiencies in the Trust complaints process including excessive delay;

(ii) failure to appropriately address issues raised in the complaint;

(iii) inadequate investigation of all aspects of the complaint; and

(iv) failure to consider whether a Serious Adverse Incident investigation was appropriate.

I am satisfied that the failures in care and treatment and maladministration by the Trust, I identified caused the complainant to experience the injustice of distress, frustration and anxiety to the complainant and his family in

witnessing his wife's obvious pain and her requirements for attention and care The failures and delay in complaint handling caused him uncertainty, delay, upset, and frustration in not obtaining redress for the injustice through the complaint process. There was also an element of time and trouble in pursuing the complaint.

RECOMMENDATIONS FOR REMEDY

I recommend:

- The complainant should receive a written apology from the Trust Chief Executive for the failures identified in this report (paragraphs 39, 43-45, 51 and 60) and a payment of £300 by way of solatium for the injustices I have identified within one month from the date of this report.

In order to improve the aspects of care and treatment provided by the Trust.

I recommend that:

(i) The Trust should conduct a review of "pain management" in CCU, RVH Ward 7C and MIH Ward E to ensure an appropriate standard of care provided to patients, with a particular focus on appropriate pain scoring, assessment, incorporation into nurse care planning and recording.

(ii) The Trust should conduct a review of the documentation, communication and recording in respect of community specialist palliative care options for Regional Cancer clinic patients. This would be in line with the Trust's suggested "action plan".

(iii) The Trust should provide me with a report of the outcome of both reviews within **six** months from the date of my final report. The report should include any necessary action plan indicating responsibility for implementing recommendations and timescales.

(iv) The Trust should provide me with an update on implementing any action plan arising from the reviews within **nine** months of the date of my final report. The update 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 or procedures).

In order to improve the service delivery of the complaint handling function in the Trust:

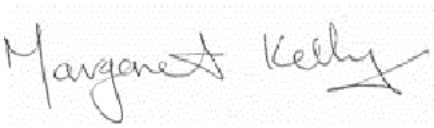
I recommend that:

(i) The Trust should conduct a review of the operation of its complaint process in light of the findings in my report including: delays in responding; compliance with complaints policy; adequacy of investigation; and screening for SAI issues.

(ii) The Trust should prepare a report on the outcome of the complaint review. The report and an action plan incorporating any recommendations should be provided to me within **three** months from the date of my final report.

(iii) The Trust should update me within **six** months, of the date of my final report, on progress on implementing recommendations from the review. The update should include 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 or procedures).

The Trust accepted my findings and recommendations



Margaret Kelly

Ombudsman **September 2020**

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.