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

Report Reference: 202000754

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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 and Social Care Trust (the Trust). The complaint concerned the care and treatment provided to the complainant's father (the patient) between 24 March 2021 and 29 March 2021.

The complainant cited several issues in the complaint, including concerns about the patient's clinical observations from his admittance to the Emergency Department to his discharge, relating to Cardiology input. Concerns were also raised relating to the patient's ability to eat and drink and the discharge arrangements for the patient.

The complainant said the coroner's report was in contradiction to the care and treatment provided by Cardiology. Finally, the complainant said that their entire experience and the Trust's handling of their complaint was protracted.

The investigation examined the details of the complaint, the Trust's response, clinical records and all relevant local and national guidance. I also obtained advice from an independent Consultant Nurse and independent Consultant Cardiologist.

The investigation established that in terms of the care and treatment provided to the patient, no failings were identified. I found that all observations, tests and procedures were carried out were in line with policies and guidelines. In addition to this, I found the clinical records from cardiology were in keeping with the findings from the post mortem report.

In terms of the complaints process, I found there was a delay in providing the complainant with a final response to their complaint which added additional distress and anxiety to the family. I recommended that regarding this issue of the complaint, the Trust provide the complainant with a written apology. I am pleased the Trust accepted my findings and recommendation.

THE COMPLAINT

1. I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's late father (the patient) between 24 March 2021 and 26 March 2021. The complainant said the standard of care provided to the patient during this period was not appropriate. The complainant also believed the care provided in relation to the patient's discharge on 26 March 2021 and decision making around this was not appropriate.

2. On 28 March 2021, the patient was readmitted to hospital via ambulance but sadly passed away following cardiac arrest[1]. On 29 March 2021, the complainant's family received a phone call relating to the completion of the patient's death certificate. The complainant believed this was inappropriate and the cause of death cited was in contradiction to the patient's medical notes.

3. The complainant said that their entire experience and the Trust's handling of their complaint was prolonged.

Background

4. On 24 March 2021 the patient attended the Royal Victoria Hospital. Emergency Department (ED) with a three day history of chest pains. Medical staff noted significant past medical history, vascular history[2] and it was noted that the patient was awaiting surgery regarding blood supply to his legs.

5. On arrival to ED, the patient's clinical observations were recorded. On admission his National Early Warning Score (NEWS)[3] was 0. Staff continued to monitor his clinical observations while he was in the ED. His NEWS score range in ED was 0 to 3. When his NEWS rose to 3, clinical observations were recorded within 15 minutes and his NEWS returned to 1.

[1] Cardiac arrest occurs when the heart suddenly and unexpectedly stops pumping.
[2] A large network of blood vessels that moves blood throughout the body.
[3] An early warning score is a guide used by medical services to quickly determine the degree of illness of a patient. It is based on the persons vital signs.

6. On 25 March 2021 the patient was transferred to the Cardiology Ward and a cardiology doctor reviewed the patient. From examinations it was considered the chest pain was due to lower than baseline haemoglobin. It was felt that no active cardiology treatment was required.

7. On admission to the Cardiology ward, the patient had been fasting overnight from 24 March 2021, as there was the potential that an oesophago-gastro-duodenoscopy (OGD)[4] could be performed on 25 March 2021. The nursing admission documentation noted the patient was independent with mobility, washing and dressing. Intravenous proton pump inhibitor medication was commenced and an OGD was requested.

8. On 26 March 2021, an OGD was performed which reported the oesophagus as normal, stomach showed Gastric Antral Vascular Ectasia (GAVE)[5], duodenum[6] showed Telangiectasia/angioma[7]. The patient was deemed fit for discharge having been commenced on iron with a repeat OGD in eight weeks.

9. On 28 March 2021 the patient was readmitted via ambulance due to leg pain and being unable to walk which had been ongoing since his discharge. Ambulance crew could not find any pulses in his legs.

10. The patient arrived at ED and there was a short episode of a pulse before the patient went into cardiac arrest. Resuscitation attempts were unsuccessful, and the patient was declared deceased at 03:55.

11. A full chronology can be found at Appendix four to this report.

Issue of complaint

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

[4] A procedure which involves looking at the upper part of the gut which includes the oesophagus (food pipe), stomach and the first part of your small bowel (duodenum).
[5] A condition in which the blood vessels in the lining of the stomach become fragile and become prone to rupture and bleeding.
[6] The first part of the small intestine immediately beyond the stomach.
[7] Dilated or broken blood vessels located near the surface of the skin or mucous membranes.

Issue one:

- **Whether the care and treatment provided to the patient by the Belfast Health and Social Care Trust at the Royal Victoria Hospital between 24 March 2021 and 26 March 2021 was reasonable and in accordance with relevant standards.**

  In particular this will examine the care and treatment of the patient in ED in relation to cardiology input, while on the ward and the subsequent discharge of the patient.

Issue two:

- **Whether the care and treatment provided to the patient's family by the Belfast Health and Social Care Trust at the Royal Victoria Hospital on 29 March 2021 in relation to the patient's death certificate was reasonable and in accordance with relevant standards.**

Issue three:

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

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

    - A Registered Nurse (RN, BSc, MSc, Independent Non-Medical Prescriber) with over 20 years' experience nursing (N IPA) and;
    - A Consultant Cardiologist (MD, FRCP, FESC, FHRS, FBHRS) with 30 years' experience as a consultant cardiologist (C IPA).

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

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

Relevant Standards and Guidance

17. 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[8]:

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

18. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

The specific standards and guidance relevant to this complaint are:

- The General Medical Council's Good Medical Practice, as updated April 2019 (GMC Guidance);
- Fourth Universal Definition of Myocardial Infarction (2018) (Thygesen et al), Circulation 2018 (Universal Definition of MI);
- Assessment and Treatment of Patients With Type 2 Myocardial Infarction and Acute Nonischemic Myocardial Injury (DeFilippis et al), Circulation 2019 (Assessment and Treatment of MI);

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

- Health and Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (January 2016);
- National Institute for Health and Care Excellence (NICE), Recent onset chest pain of suspected cardiac origin: assessment and diagnosis, 24 March 2010, Updated: 30 November 2016 (Clinical Guideline 95);
- Department of Health, Guidance in Relation to the Health and Social Care Complaints Procedure (April 2019) (DOH Complaints Procedure);
- The Births and Deaths Registration (Northern Ireland) Order 1976 (Registration Order);
- The General Medical Council's Treatment and care towards the end of life: good practice in decision making (July 2010) (GMC Treatment Guidance);
- National Institute for Health and Care Excellence (NICE), Sepsis: recognition, diagnosis and early management, 13 July 2016, Updated: 13 September 2017 (NICE Guideline 95): and
- National Institute for Health and Care Excellence (NICE), High-sensitivity troponin tests for the early rule out of NSTEMI, (August 2020) Diagnostic Guidance (NICE Diagnostic Guidance 40).

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

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

21. I shared a draft copy of this report with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant submitted comments in response. I gave consideration to all the comments I received before finalising this report.

THE INVESTIGATION

Issue one:

- **Whether the care and treatment provided to the patient and family by the Belfast Health and Social Care Trust at the Royal Victoria Hospital between 24 March 2021 and 26 March 2021 was reasonable and in accordance with relevant standards.**

Detail of Complaint

22. The complainant said that she had concerns regarding the care and treatment her father received between 24 March 2021 and 26 March 2021. The complainant said that following the patient's discharge, he was subsequently readmitted via ambulance on 28 March 2021, but died following a cardiac arrest.

23. The complainant believed the care and treatment the patient received during this period was below an acceptable standard.

24. The complainant also raised concerns about the hospital records which documented the patient had no issues with eating or drinking. The complainant said she queries this as the patient had not eaten for at least seven days prior to his admission on 24 March 2021. The complainant also said that during the patient's time in hospital, a nurse rang the patient's wife to ask if he had been managing to eat or drink anything.

25. The complainant said the patient's clinical observations were reported to be stable however she believed this contradicted with the coroner's report which documented the patient was suffering from a heart attack at least three days before his death.

26. Regarding the patient's discharge, the complainant believed he was not medically fit to be discharged given he was not able to dress himself and was in physical pain.

27. The complainant has also questioned the tests carried out by cardiology on 25 March 2021. The complainant said the hospital notes contradict the findings in the coroner's report. The complainant said that cardiology believed the patient's chest pain was related to low blood levels when in fact it was a heart attack.

Evidence Considered

Legislation/Policies/Guidance

28. I considered the following policies and guidance:
    - NICE Clinical Guideline 95
    - Fourth Universal Definition of Myocardial Infarction (2018) (Thygesen et al), Circulation 2018;
    - Assessment and Treatment of Patients With Type 2 Myocardial Infarction and Acute Nonischemic Myocardial Injury (DeFilippis et al), Circulation 2019;
    - NICE Diagnostic Guidance 40.

The Trust's response

29. The Trust stated the patient attended the ED on 24 March 2021. On review in ED by medical staff, the patient had a three day history of chest pain. The Trust also stated the patient was noted to have a significant past medical history.

30. The Trust stated, staff considered the patient's vascular history, and it was documented that the patient was awaiting surgery regarding the blood supply to his legs. The Trust stated the patient's legs were examined, and it was felt that there was no evidence of poor blood supply. The Trust stated, *'his legs were warm and had good perfusion'*.

31. The Trust then stated, *'Initial blood tests indicated his blood count was lower than baseline (63) but [the patient] did have a long history of low blood count'*.

32. The Trust stated the *'emergency medical doctors referred [the patient] to the medical team due to his low blood count and to the Cardiology team due to his medical history and presentation of chest pain'*. Clinical observations were within the normal range. A blood gas sample showed that there was no evidence of organ damage.

33. The Trust further stated ED carried out an examination on the patient's chest, cardiovascular and abdominal systems. In addition to this, the Trust stated the patient was also known to have an abdominal aneurysm, which was under surveillance. '*Abdominal examination did not show any concerns regarding the abdominal aneurysm*[9]*'*. The Trust also advised an examination of the patient's rectum did not show any presence of blood or altered blood.

34. The Trust stated the patient was transferred to the Cardiology ward and the patient's past medical history noted. It stated *'the Cardiology medical team also assessed [the patient] at this time. His ECGs*[10] *were reviewed and his last heart scan (Echo) was reviewed from November 2020'*.

35. The Trust then stated the Cardiology team felt the '*chest pain the patient was experiencing was due to lower than baseline haemoglobin and no active cardiology treatment was required'*.

36. On 25 March 2021 the Trust stated the patient's clinical observations were stable and no chest pain was reported at that assessment. It was consultant cardiology's opinion that they were aware of the patient's previous history of small blood vessels in stomach. The medical plan following consultant review was *'[the patient] required an in-patient gastroscopy, repeat blood tests and to commence an oral ant-acid stomach treatment'.*

[9] Abdominal aneurysm is an enlarged area in the lower part of the major vessel that supplies blood to the body (aorta).
[10] An electrocardiogram (ECG) is a simple test that can be used to check your heart's rhythm and electrical activity.

37. Cardiology reviewed the patient on 25 March 2021 and felt that there was no acute cardiac issue. Later that day the patient was transferred to a Gastroenterology[11] ward.

38. The Trust stated the patient was not requiring any additional support such as oxygen therapy or intravenous fluids. Cardiology diagnosed the patient with Type 2 Non ST Elevation Myocardial Infarct (NSTEMI)[12].

39. The Trust stated in terms of discharge, a consultant reviewed the patient on 26 March 2021 at the morning ward round. The patient's *'blood count had improved to 77, which was an improvement following blood transfusions administered on 25 March 2021'*.

40. The Trust further stated blood tests revealed the patient's Vitamin B12 was low, potentially explaining low haemoglobin on admission. Consultant prescribed an oral vitamin B12 supplement.

41. The Trust stated there were no further signs of bleeding since the patient's admission to hospital and have stated *'international guidelines were followed as they suggest aiming for blood count· 70-80 if a patient suffers from a gastrointestinal bleed'*.

42. In relation to the issue of food consumption, the Trust stated on admission, nursing staff documented that the patient was able to eat and drink independently. The Trust stated that it is noted in the medical notes the patient experienced pain after eating and noted his appetite had been poor the week prior to his admission.

43. The Trust stated intravenous proton pump inhibitor[13] medication was commenced. Proton pump inhibitors (PPIs) are medicines that work by

[11] Gastroenterology is the branch of medicine that focuses on the digestive tract and the gallbladder, liver, bile ducts, and pancreas.
[12] A type of heart attack that usually happens when your heart's need for oxygen can't be met. This condition gets its name because it doesn't have an easily identifiable electrical pattern (ST elevation) like the other main types of heart attacks.
[13] A faster way to achieve gastric acid suppression in the stomach.

reducing the amount of stomach acid made by glands in the lining of the stomach aiming to reduce or eliminate abdominal pain associated with eating.

44. As stated, when the patient was transferred to Gastroenterology ward, nursing records stated the patient was eating and drinking. The Trust stated the patient was able to tolerate food and fluids when he was not fasting in preparation for his OGD. The Trust stated they are unclear as to why a nurse would call the patient's wife to ask if he had managed to eat or drink anything.

45. On 26 March 2021, a gastroscopy was performed which confirmed that there was no active bleeding or blood in his upper gastrointestinal tract. The Trust organised a repeat gastroscopy for eight weeks.

46. The patient was deemed medically fit for discharge as his *'clinical observations were stable, his blood count was stable and the consultant was satisfied that Cardiology had reviewed your father twice and they felt no intervention was required'*.

47. The Trust stated on the morning of discharge, the patient *'reported to feeling well on the ward round'*. He did not require any additional support such as oxygen therapy or Intravenous fluids and was not reporting any chest pain. There were no new symptoms reported or documented in either the medical or the nursing notes.

48. The Trust stated the patient said he was *'very keen to return home and did not wish to wait for his discharge letter and medication'*. The Trust further stated the patient *'declined to change his clothing and elected to travel home in nightwear'*.

49. The Trust stated it accepts the ward communication with the patient's partner was *'not good'* however, nursing staff discussed everything with the patient prior to leaving the ward.

Relevant Independent Professional Advice

Care and Treatment in ED

50. The C IPA began by detailing the patient's comorbidities and history of several serious medical conditions predating the admission of 24 March 2021. These conditions include:

Haematology

i. Chronic iron deficiency anaemia, dating back to at least 2013, attributed to GAVE (gastric antral vascular ectasia) which is characterised by dilated small blood vessels in the pyloric antrum (part of the stomach), may be associated with portal hypertension (high blood pressure in the main liver vein). This had been treated in 2013 by ablation.

ii. Essential thrombocythaemia[14] (excess platelet – clotting cells in the blood - production by the bone marrow), treated with mild immunosuppression and antiplatelet therapy.

Cardiovascular disease

iii. Aortic valve stenosis (narrowing), treated in 2013 by aortic valve replacement, and again in 2019 by TAVI (trans catheter aortic valve implantation), when the 2013 prosthetic valve failed.

iv. Ischaemic heart disease, (narrowing's in the arteries supplying blood to the heart) treated in 2013 by CABG (coronary artery bypass graft surgery).

v. Peripheral vascular disease, (narrowing's in the arteries supplying blood to the legs), on urgent waiting list for bilateral femoral endarterectomies [15](surgical removal of fatty deposits in the arteries to the legs); this complicated by ischaemic ulceration of the left heel.

vi. *Abdominal aortic aneurysm (AAA, enlargement of the main blood vessel carrying blood to the body), under surveillance.*

Gastrointestinal disease

vii. GAVE, see above, dating back to 2013.

[14] A rare blood disorder that causes a high number of blood cells called platelets to form. These are blood cells involved in blood clotting.

[15]This is a large blood vessel in the leg. When plaque builds up in the artery, it can make it hard for blood to flow in your leg. After surgery, blood may flow better in your leg.

viii. Hiatus hernia with Barrett's oesophagus [16]2016.

ix. Diverticulosis 2016.

x. Colonic and/or gastric polyps under surveillance 2015.

Liver disease

xi. Primary biliary cirrhosis, scarring of the liver, under surveillance.

51. In terms of the patient's symptoms when he attended ED on 24 March 2021, the C IPA advised the patient presented to ED with a three day history of chest/abdominal pain.

52. The C IPA noted the patient's symptoms were described variously as *'crushing, severe, associated with nausea and dizziness, worse on exertion, triggered by eating, and exertion, relieved by rest and by leaning forwards'.* The patient attributed this to indigestion.

53. C IPA noted the patient's pain was described as *'having some features suggesting a cardiac cause, and others suggesting a gastrointestinal cause'*. The patient also complained of passing black stools, interpreted as melaena, which is often due to bleeding from the stomach or duodenum.

54. The C IPA advised that a junior doctor ED examined and assessed the patient and routine observations were recorded, and an ECG and a chest x-ray were performed.

55. C IPA advised *'blood tests, including serum troponin, electrolytes and urea, liver function tests and a full blood count were performed. Arterial blood gases were measured'*.

56. The C IPA advised the tests carried out (points 50 and 51 above) would be in keeping with relevant procedures and guidance for a patient with similar issues and concerns. Furthermore, C IPA advised *'it is important to note that this patient had a very complex history, with multiple medical problems, with possible complex interactions'*.

[16] A medical condition where some of the cells in your oesophagus grow abnormally.

57. The hospital diagnosed the patient with Type 2 Non ST Elevation Myocardial Infarct (NSTEMI – Type 2 MI)[17]. The C IPA advised this is damage to the heart muscle attributed to an imbalance between the heart's need for oxygen and its supply, not related to sudden blockage of one of the arteries to the heart. *'An acute bleed, such as from the stomach, with resulting anaemia (low blood count) is recognised as one of the precipitants'*.

58. Further to this, the C IPA pointed to the Fourth Universal Definition of Myocardial Infarction (2018) (Thygesen et al) *"…an acute stressor such as an acute gastrointestinal bleed with a precipitous drop in haemoglobin or a sustained tachyarrhythmia[18] with clinical manifestations of myocardial ischemia[19], may result in myocardial"*.

59. The C IPA advised the patient may have had symptoms of *'acute myocardial ischaemia[20]…he did not have new ischaemic ECG changes'*. He did not develop pathological Q waves (on the ECG). There was *'no imaging evidence of new loss of viable myocardium, or of new regional wall motion abnormalities'*. The troponin was measured twice; 49ng/L at 00:33 and 56ng/L at 01:33 (normal <14). Both levels are raised.

60. In addition, the C IPA advised the Universal Definition of Myocardial Infarction (MI) suggests that a 20% change in troponin be used to make a diagnosis of MI. The C IPA advised the rise of 9 ng/L in this patient, as highlighted above, is probably within measurement error, and therefore does not represent a significant rise. This rise fails to meet the 20% criterion, and based on this, the patient therefore probably did not technically fulfil the Fourth Universal Definition of Myocardial Infarction criteria for a type 2 MI.

61. In response to the draft report, the complainant queried why the troponin was not repeated at three hours due to the high levels as per NICE guidelines. The

[17] A non-ST-elevation myocardial infarction is a type of heart attack that happens when a part of your heart is not getting enough oxygen.
[18] Abnormal heart rhythms.
[19] Occurs when blood flow to the heart muscle (myocardium) is obstructed by a partial or complete blockage of a coronary artery by a build-up of plaques (atherosclerosis).
[20] Occurs when blood flow to your heart is reduced, preventing the heart muscle from receiving enough oxygen.

C IPA advised the second test, an hour after the first test was performed in accordance with NICE guidance.

62. The C IPA advised, *'whether or not the patient had sustained a type 2 MI is academic; he was known to have ischaemic heart disease (previous coronary artery bypass graft surgery), so no further investigation of that was needed during the acute phase'*. In addition to this, the C IPA advised that hospital records show the patient's history was taken into account in the decision-making process.

63. The N IPA advised that on arrival to ED assessments were completed. The N IPA advised *'a good medical history was taken which established that the patient had a AAA (abdominal aortic aneurysm) and had some cardiac history'*.

64. The N IPA advised that the plan in ED was to admit the patient and to transfuse him with 2 units of packed red blood cells. N IPA advised *'this is supported by the NICE guidance for the 'recent onset chest pain of suspected cardiac origin: assessment and diagnosis (2016 and reviewed 2019). The steps taken by the doctor are in line with this guidance'*.

65. Further to this, N IPA advised that the medical records show *'clear assessments and the right escalations according to what one could expect clinically as well as according to the NICE guidance (2016 reviewed 2019)'*. N IPA advised that records show ED responded quickly and appropriately to the risk.

66. In response to evidence considered as part of the draft report the complainant said '*there is no way that his legs could have been described as having good perfusion. He was awaiting surgery and it had been noted on past examination that he has no pulse in his left leg. How is it possible that someone who is awaiting surgery (imminently) to correct the blood flow in his legs buts miraculously during this trip to hospital the entire issue appeared to have resolved itself. The complainant suggests this is an* '*impossibility*.' The C IPA advised on the balance of probability the condition of the legs did not change and does not think it is likely that they were "*warm and well perfused*" when the

patient was admitted. Theoretically the condition of the legs could have changed, however, it is likely the legs were never warm and well perfused.

67. The C IPA advised examination of the pulses in the legs was not well documented in the notes at any point. The notes did not state the legs were normal but gave the impression of normality by describing the patient's legs as 'warm and well perfused'. It is unclear when the records refer to 'pulses' whether or not this is in reference to the patient's legs. The IPA concluded '*it is unlikely but possible the condition changed, however it has not been documented well. The legs were in poor condition as the patient was on a vascular waiting list*.' I would remind clinicians that clear record keeping is an essential element of medical care and that on this occasion the records lacked clarity which then raised uncertainty for the patient's family.

Care and Treatment by Cardiology

68. The C IPA advised the patient, on transfer to the cardiology ward, was assessed and examined by two cardiology registrars, and by a consultant the next morning (25 March 2021).

69. Further blood tests including haematinics (B12, folate & iron studies) and repeat full blood count were performed. An OGD examination was undertaken of the swallowing tube, the stomach and the part of the small intestine leading out of the stomach using an endoscope (a telescope inserted into the stomach via the mouth or nose).

70. The N IPA advised that NICE guidance (NG51) recommends the use of NEWS (National Early Warning Score) to *'determine the risk of sepsis and to help identify a deteriorating patient'*. The N IPA advised that the medical records document that the patient had a NEW score recorded from *'admission and through to the day of discharge with his other clinical observations. These were recorded appropriately'*.

71. The N IPA advised that on transfer to the cardiology ward it is clear by the documentation that mobility issues and any concerns with eating and drinking were assessed and taken in to account. The N IPA advised the patient was

assessed as being independently mobile and how to use the call bell should he need it.

72. Regarding the issue of food, the N IPA advised that the patients nutrition status was assessed. The patient did report that he had not eaten since 23 March 2021.

73. On transfer to the cardiology ward, the patient had to be nil by mouth[21] (NBM) as he was having an investigation the next day.

74. The N IPA advised the records show that *'[the patient] did have fluids on the day he came to the emergency department and when he went to the ward – both orally and via intravenous cannula[22] (IV) on 25 March 2021'*.

75. The N IPA advised *'there is no record that shows whether or not the patient had any food. [The patient] did report that his pain was worse when he ate and he was also nil by mouth so could not eat until reviewed by the doctor, after the endoscopy'*.

76. The N IPA advised that in this instance *'documentation regarding his eating and drinking or fluid intake and output could be improved'.* The N IPA advised that this is in terms of documenting clearly the reasons for no food consumption such as preparation for a medical procedure. The N IPA advised this *'did not have a detrimental effect on his overall care as most of that time frame he was nil by mouth and receiving blood transfusions intravenously'*.

Discharge of Patient

77. The C IPA advised the tests carried out on the patient were appropriate for someone with their symptoms. Further to this, the C IPA advised that hospital notes and the patient's observation charts do not highlight any issues of concern which may have required further monitoring in hospital and that discharge was appropriate in this case.

[21] You are not allowed to have any form of food, drink or medications by mouth.
[22] A small plastic tube, inserted into a vein, usually in your hand or arm. It is used to provide fluids when you are dehydrated or can't drink.

78. The C IPA advised they have found the overall care and treatment of the patient to be of an appropriate and reasonable standard.

79. The N IPA advised that from the patient's *'initial presentation to when he was discharged there is a definite trend of improving results (bloods) and tests (endoscopy did not show active bleeding)'*.

80. The N IPA advised the patient was 'communicating well with the staff on the ward and showed himself to be very independent despite not being very well'. The N IPA further advised from the patient's presentation on the day of his discharge *'there is nothing in his nursing needs that would highlight a concern that would necessitate him staying in hospital for longer'*.

81. It is recorded that the patient was keen to go home and was able to make those decisions for himself – this had never been in question. It is also clear that he did not wish to wait for the medication letter on discharge and was happy to return for anything like that.

82. The N IPA has highlighted the NMC Code of Conduct (2019). The N IPA advised that it states;

    'as registrants we should be prioritising people and maintaining their dignity whenever we can. Best practice would be to see if the patient had wanted to change out of his pyjamas before he went home in order to maintain his dignity and privacy however at the same time registrants must also communicate well and respect the patient's right to choose (NMC Code of conduct)'.

83. The N IPA advised from the records and the Trust's response to the complaint it is clear that a discussion was had with the patient regarding changing however he had been clear that he did not wish to change and was happy to go home with his wife in his pyjamas.

84. The N IPA further advised that the patient had capacity it was not necessary to speak with the family or the patient's wife prior to discharge as the patient had

communicated with the team for his entire stay on his own and had done so successfully.

Conclusion

85. The C IPA advised that based on the information provided, the Trust's actions in terms of tests carried out in ED were reasonable and appropriate. The C IPA also advised that the observations performed including blood tests were also appropriate and staff took into account the patient's history.

86. In relation to cardiology input, the C IPA advised that in terms of Type 2 MI, while the patient did not technically fulfil the criteria, this is academic, and he was known to have ischaemic heart disease (previous coronary artery bypass graft surgery) so no further investigation was needed.

87. In terms of discharge of the patient, C IPA has advised that hospital notes and observation charts do not highlight anything concerning which would have required a longer stay in hospital. Overall, C IPA advised that the decision making and the overall care and treatment of the patient was appropriate.

88. In relation to any learning, the C IPA has advised that while nursing notes do not suggest the patient had any further chest pain, this is not clear in the medical notes. Hospital notes and indeed all medical notes must be clear, concise and contain all relevant information.

89. The N IPA advised that she considered the NMC Code of Conduct as well as the NICE guidance for acute cardiac events and sepsis and she advised that the nursing care that was provided was of a reasonable and appropriate standard.

90. The N IPA advised the nursing care the patient received was of an acceptable standard and he was well cared for.

91. In terms of improvement, the N IPA advised that documentation for the reasons the patient did not eat, that is because he was nil by mouth could have been made clear however this did not have a detrimental effect on his overall.

92. Finally, the N IPA advised there was nothing that was missed regarding his clinical presentation or from a nursing perspective that would have caused a concern prior to his discharge.

Analysis and Findings

93. I considered this issue in terms of both IPA's advice and guidance as well as the Trust's response to the complaint. In addition to this, I examined the relevant clinical records from the Trust and looked at the relevant policies and guidelines.

Treatment in ED

94. Following the patient's initial attendance at ED on 24 March 2021, their clinical observations (NEWS) were recorded, and staff continued to monitor these. From the clinical records provided, the Trust evidenced when the patient's NEWS score rose to 3, clinical observations were recorded within 15 minutes. I accept the C IPA's advice that these observations were carried out appropriately.

95. The GMC Guidance, Standard 15, point *'e'* states; '*investigations must be promptly provided and arranged'*. I am satisfied the Trust did act appropriately in providing and arranging all necessary investigations and provided appropriate care. These included an examination on the patient's chest, cardiovascular and abdominal systems.

96. I note the complainant's response to the draft report in which she queried why the troponin was not repeated at three hours due to the high levels as per NICE guidelines. The C IPA advised the NICE Diagnostic Guidance 40, point 1.2 states; '*The [high sensitivity troponin] tests are recommended for use with different early rule out test strategies alongside clinical judgement, including:*

    - *A single sample on presentation using a threshold at or near the limit of detection, which will vary depending on the assay being used. If this sample is positive it should not be used to rule in NSTEMI.*
    - *Multiple sample strategies, which typically include a sample at initial assessment followed by a second sample taken at 30 minutes to 3 hours*

(if clinically appropriate) and use of the 99th percentile thresholds or thresholds at or near the limit of detection of the assay.'

97. I accept the C IPA's advice '*the second troponin test one hour after the first test was performed in accordance with the above NICE guidance*.'

98. I also accept the C IPA's advice the ED staff did take into account the patient's medical history and considered the patients vascular history. I accept the C IPA's advice that given the patient's medical history and presenting symptoms, it was appropriate for the patient to be transferred to the Cardiology Ward for further review.

99. Based on the evidence and the IPAs' advice I am satisfied a good medical history was taken on admission to ED and all appropriate assessments including nursing assessments were carried out in accordance with NICE guidelines

100. I sought further C IPA advice in relation to the complainant's comments on the draft report that '*there was no way the patient's legs could have been described as having good perfusion. The patient was awaiting surgery and it had been noted on past examination that he has no pulse in his left leg.*' . I am concerned as the C IPA advised in her additional advice the condition of the *'patient's legs was not well documented'*. I accept this advice. However, the C IPA advised '*bleeding was the acute issue and was dealt with very well, attendance was not because of the patient's* legs'. Therefore I do not consider this record keeping failing impacted the standard of care received. Nonetheless I expect the Trust to consider this matter and the need to remind relevant staff of the importance of maintaining accurate records.

101. Based on the available evidence and the C IPA's advice, which I accept, I am satisfied whether or not the vascular disease was properly recorded would not have made a difference to the outcome.

102. Based on the available evidence, including the N IPA and C IPA's advice I am satisfied the care and treatment the patient received in relation to Cardiology in ED was appropriate. Therefore, I do not uphold this element of the complaint.

Treatment on Cardiology Ward

103. Following the patient's transfer to the Cardiology Ward on 25 March 2021, I note the patient's medical history was considered and a previous heart scan from November 2020 was reviewed for comparison.

104. I note the patient's clinical observations were stable and accept the Trust's assessment that due to the patient's previous history of small blood vessels in the stomach, the medical plan was an in-patient gastroscopy, repeat blood tests and the commencement of an oral ant-acid stomach treatment.

105. I accept the C IPA's advice that the records demonstrated that Cardiology appropriately assessed and monitored the patient. I also accept the C IPA's advice that all tests and observations carried out were appropriate and in line with relevant guidelines.

106. I accept the N IPA's advice that hospital records both in ED and on the ward demonstrate that nursing staff checked and documented both the patient's history and current clinical state which was then used in the decision making around the treatment he received to ensure that his presenting complaint was dealt with and that he was well enough before considering discharge.

107. I accept the N IPA's advice that records show the patient had fluids both in ED and on the ward both orally and intravenously. I accept the N IPA's advice that while the records do not show food consumption, the patient was nil by mouth dure to procedures carried out while an inpatient.

108. Based on the available evidence, including the N IPA and C IPA's advice I am satisfied the care and treatment the patient received was appropriate. Therefore, I do not uphold this element of the complaint.

Discharge

109. Regarding the discharge of the patient, I note the Trust stated a consultant reviewed the patient at the morning ward round and noted the patient's blood

count had improved. I also note the Trust records document the patient was deemed medically fit for discharge and the patient *'reported to feeling well on the ward round'*.

110. I note the C IPA's advice that tests carried out on the patient were appropriate for someone with their symptoms. I accept the C IPA advice that the hospital notes and patient's observation charts do not highlight any issues of concern which may have required further monitoring in hospital and that discharge was appropriate in this case. I accept the C IPA's advice that the patient was fit for discharge.

111. I note the Trust stated the patient said he was *'very keen to return home and did not wish to wait for his discharge letter and medication'*. I also note the Trust further stated the patient *'declined to change his clothing and elected to travel home in nightwear'*.

112. I accept the Trust's response that ward communication with the patient's partner was 'not good' however, nursing staff discussed everything with the patient prior to leaving the ward.

113. I accept the N IPA's advice that while the nursing records are not very robust when discussing discharge, it is clear from the medical records that the patient was considered medically fit and could be discharged on the date he was discharged home.

114. I accept the N IPA's advice that it is recorded that the patient was keen to go home and was able to make those decisions for himself. It is also clear that he did not wish to wait for the medication letter on discharge.

115. I accept the N IPA's advice that the records show a discussion was had with the patient regarding changing out of his pyjamas however he had been clear that he did not wish to change. I accept the N IPA's advice that the patient had capacity and it was not necessary to speak with the family or the patient's wife prior to discharge as the patient had communicated with the team for his entire stay on his own and had done so successfully.

116. I accept the N IPA's advice that based on the records the patient had made a clear improvement clinically from his presentation to ED and it was a reasonable decision for the patient to be discharged.

117. Finally, I accept the N IPA and C IPA's advice that they have found the overall care and treatment of the patient to be of an appropriate and reasonable standard.

118. I therefore do not uphold this element of the complaint.

Issue 2:

- **Whether the care and treatment provided to the patient's family by the Belfast Health and Social Care Trust at the Royal Victoria Hospital on 29 March 2021 in relation to the patient's death certificate was reasonable and in accordance with relevant standards.**

Detail of Complaint

119. The complainant is unhappy with the handling of the completion of the death certificate and the doctor's telephone call to discuss it. The complainant also said that the cause of death on the death certificate is not in line with the response the family received from the coroner.

120. The complainant also questioned whether the doctor should have called the family to discuss the death certificate and whether it was an appropriate time to call the family.

Evidence Considered

Legislation/Policies/Guidance

121. I considered the following policies and guidance:

122. Registration Order:

"Where any person dies as a result of any natural illness for which he has been treated by a registered medical practitioner within twenty eight days prior to the date of his death, that practitioner shall sign and give forthwith to a qualified

informant a certificate in the prescribed form stating to the best of his knowledge and belief, the cause of death, together with such other particulars as may be prescribed."

123. General Medical Council, July 2010, Section 85 states:
"If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient's wishes if they are known".

The Trust's response

124. The Trust stated that there are monthly governance meetings with full representation across a range of Consultants and Junior Doctors alongside Nursing and Pharmacy colleagues. The governance meeting covers various topics including morbidity and mortality.

125. The Trust confirmed the patient's case was discussed at the monthly Gastroenterology patient safety meeting on 18 June 2021 due to his death.

126. The Trust stated the Clinical Director of Emergency Medicine discussed the complainant's concerns in relation the completion of the death certificate with the doctor involved.

127. The Trust stated the doctor who telephoned the patient's wife apologised for any confusion. The doctor stated he meant *'he had filled out the death certificate, and was explaining this to your mother, rather than looking for her to say yes or no to his decision'*.

128. The Trust stated the doctor *'will reflect on this ambiguity and ensure that he is clear and concise when speaking to relatives at such a difficult time'*.

Relevant Independent Professional Advice

129. The C IPA advised the post mortem report is in keeping with the clinical picture and the hospital admission a few days prior to death. The post mortem confirms

very severe disease in the coronary arteries (coronary artery atheroma[23]) with previous bypass graft surgery.

130. The C IPA advised the post mortem confirms the previous aortic valve replacement. It also confirms very severe disease in the aorta and the arteries to the legs, with clot within the arteries. Examination of the heart shows scarring from an old heart attack, possibly months or years old, and also a more recent heart attack.

131. The C IPA advised the pathologist estimated that this had occurred 48 to 72 hours before death. It is therefore likely to have occurred at around the time of hospital discharge. The C IPA advised; *'there is no clinical evidence to suggest that it occurred prior to discharge, the patient was described as well prior to discharge. There was no evidence of a new heart attack on the ECG'*.

132. The C IPA discussed further the patient's symptoms. She advised if the patient had chest pain when admitted to hospital, it was most likely due to acute coronary syndrome. *'The lack of oxygenated blood supply to the heart at that time was due to a combination of coronary artery disease and low blood count (insufficient haemoglobin to carry the required oxygen). The low blood count was corrected by blood transfusion (and treatment to the stomach to try and prevent recurrence), but the coronary artery disease and narrowing's obviously remained. The timing of heart attacks in patients with coronary disease is unpredictable'*.

133. The C IPA advised the pathologist gives a history of severe leg pains from discharge. The findings of clots in the arteries to the legs is consistent with this.

Conclusion

134. The C IPA advised that based on the information provided, the clinical picture as outlined by the Trust is in keeping with that of the post mortem. This advice however does not take into account the telephone conversation between the

[23] Coronary heart disease (CHD) is usually caused by a build-up of fatty deposits (atheroma) on the walls of the arteries around the heart (coronary arteries).

doctor and the patient's wife and the miscommunication which the Trust has acknowledged.

Analysis and findings

135. I considered this issue in terms of the C IPA's advice and guidance as well as the Trust's response to the complaint. In addition to this, I examined the relevant clinical records from the Trust and looked at the relevant policies and guidelines.

136. Regarding the completion of the death certificate, I note that a Medical Certificate Cause of Death (MCCD's) can only be completed by *'a registered medical practitioner who saw and treated the deceased during their last illness. No other person or practitioner may sign the certificate on his/her behalf*'.

137. I note the completion of MCCD's is a statutory duty with doctors being subject to regulation of their conduct by the General Medical Council, rather than a condition of employment in the NHS. They must state the cause(s) of death to the best of their knowledge and belief.

138. I accept the C IPA's advice that the post mortem report is in keeping with the clinical picture and the hospital admission a few days prior to death. The C IPA advised the post mortem confirms very severe disease in the coronary arteries with previous bypass graft surgery.

139. I accept the C IPA's advice that an examination of the heart shows scarring from an old heart attack, possibly months or years old, and also a more recent heart attack. I note the C IPA's advice that the pathologist estimated that this had occurred 48 to 72 hours before death. I accept the C IPA's advice that the more recent heart attack is therefore likely to have occurred at around the time of hospital discharge. I accept the IPA's advice that *'there is no clinical evidence to suggest that it occurred prior to discharge, the patient was described as well prior to discharge. There was no evidence of a new heart attack on the ECG'*.

140. Regarding the telephone conversation between the doctor and the patient's wife, I accept the Trust's explanation that this was a misunderstanding. While I accept the Trust's explanation, this was a very difficult time for all of the family which was further exacerbated by the timing of the telephone call and the worry that the cause of death was not in line with the response the family received from the coroner. This confusion has ultimately led to a great deal of anxiety within the family. I note the complainant reiterated this view in her response to the draft report.

141. The General Medical Council guidance; Treatment and care towards the end of life: good practice in decision making (July 2010), provides a framework for good practice when providing treatment and care for patients who are reaching the end of their lives.

142. Section 85 states;

"You must be professional and compassionate when confirming and pronouncing death and must follow the law, and statutory codes of practice, governing completion of death and cremation certificates. If it is your responsibility to sign a death or cremation certificate, you should do so without unnecessary delay. If there is any information on the death certificate that those close to the patient may not know about, may not understand or may find distressing, you should explain it to them sensitively and answer their questions, taking account of the patient's wishes if they are known."

143. I note the Trust's response regarding the telephone call to the patient's wife and the need for the doctor and indeed all medical staff to reflect on their conversations when speaking to families and relatives at such difficult times. I am satisfied the Trust have acknowledged this conversation and addressed the need to be mindful when communicating with patients and relatives. Therefore, I do not uphold this element of the complaint.

144. Based on the available evidence, including the C IPA's advice I am satisfied the medical records are in line with the post mortem and cause of death.

145. Therefore, I do not uphold this element of the complaint.

Issue three:

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

Detail of Complaint

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

Evidence Considered

Legislation/Policies/Guidance

147. DOH Complaints Procedure; Point 8.7.

The Trust's response

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

Conclusion

149. I reviewed the Trust's complaint file in relation to the original complaint made on 11 April 2021. The Trust received this complaint on 14 April 2021 and the Trust made contact with the complainant on 15 April 2021.

150. While this falls within the timescales set out in the Trust's policy for managing complaints, the final response was not issued until 2 July 2021, outside the complaints policy timeframe.

Analysis and findings

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

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

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

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

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

156. I note that the Trust issued its final response to the complaint on 2 July 2021, two and a half months from the initial complaint. I reviewed the complaints file for this case and I do consider that those involved in the complaints process demonstrated sufficient urgency to respond to the complaint in terms of obtaining responses from all relevant staff.

157. However, I do acknowledge that while the Trust did demonstrate its actions in obtaining responses from other professionals, at times this was not always communicated with the complainant. I also note that any correspondence with the complainant following the initial complaint were requests for updates from the complainant.

158. The First Principle of Good Complaint Handling, 'getting it right', requires bodies to act in accordance with 'relevant guidance and with regard for the rights of those concerned'.

159. The Second Principle of Good Complaint Handling, 'being customer focused', requires bodies to deal with 'complainants promptly and sensitively, bearing in mind their individual circumstances'.

160. I consider that the Trust did not provide the complainant with anticipated timescales do not meet these standards. I consider this failing maladministration.

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

CONCLUSION

162. I received a complaint regarding the actions of the Trust. The complaint concerned the care and treatment provided to the patient between 24 March 2021 and 29 March 2021. The complainant raised concerns that the patient was not cared for appropriately in ED and while on a cardiology ward. The complainant also raised concerns regarding the patient's discharge and following the patient's death, the completion of the death certificate. In addition to this, the complainant raised issues with the Trust's handling of the complaints process.

163. I recognise the distress and upset the complainant and their family have been through, which has been further exacerbated by the thought and worry that the care and treatment the Trust provided to the patient may not have been to an acceptable standard.

164. I understand the concerns the complainant raised, however I did not find any failings in the care and treatment the Trust provided. I am satisfied the Trust

acted appropriately and in accordance with all relevant policy and guidance in terms of the care provided to the patient. I recognise that in terms of communication relating to the death certificate, this was not carried out sensitively and therefore additional upset at an already extremely difficult time.

165. I note the Trust have acknowledged the need for medical professionals to reflect on the conversations had with families during difficult times. I welcome the learning to service improvement identified by the Trust following the complaint.

166. Regarding the complaints process, I note there were occasions when the complainant needed to seek updates on the delay of a response to their complaint. I accept that this caused the complainant and their family the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office. I therefore uphold this issue of the complaint.

167. I hope that this report provides some closure and the knowledge that the care and treatment the Trust provided was appropriate. The concerns raised by the patient's family about his care and treatment clearly reflect their love for the patient and their determination to ensure that he received the best care possible.

Recommendations

168. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures in complaint handling identified (within one month of the date of this report).

MARGARET KELLY **18 April 2024**
Ombudsman

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 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.