Investigation of a complaint against the Northern Health & Social Care Trust

Report Reference: 202003667

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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.

TABLE OF CONTENTS

Page

Case Reference: 202003667

Listed Authority: Northern Health and Social Care Trust

SUMMARY

This complaint was about the actions of the Northern Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her late father (the patient) from 2 to 4 April 2021 and 10 to 18 June 2021. The complainant raised concerns about how the Trust managed the patient's nutritional needs, his pressure sores and his DNACPR[1]. She also raised concerns about whether the Trust informed the residential home of the patient's Covid 19 concerns upon his hospital discharge.

The investigation established the following failings in the care and treatment the clinical staff provided to the patient from 2 April to 4 April 2021:

- Failure to make a reasonable attempt to contact the family to appropriately discuss the Trust's decision to enact a DNACPR form for the patient; and
- Failure to complete the DNACPR form in full and in accordance with national standards.

The investigation also established the following failings in the care and treatment the nursing staff provided to the patient from 10 June to 18 June 2021:

- Failure to complete a MUST[2] assessment upon the patient's admission to hospital;
- Failure to measure the patient's weight/MUCA[3] upon admission to hospital;
- Failure to provide the patient with a nutritional care plan during his hospital admission;
- Failure to provide clarity within the nursing records on the type of assistance the patient required during feeding; and

[1]DNACPR – Do not attempt cardiopulmonary resuscitation. Cardiopulmonary resuscitation (CPR) is a procedure which can be initiated on any patient who has stopped breathing.
[2] Malnutrition Universal Screening Tool.
[3] Mid upper arm circumference.

- Failure to appropriately manage the patient's risk of developing pressure ulcers and that these failings led to the patient unnecessarily developing a painful Stage 2 pressure sore.

I recognised the impact these failings had on the patient and his family. I wish to convey my heartfelt condolences to the complainant for the loss of her father.

I recommended the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment. For service improvement to prevent future reoccurrence, I recommended the Trust brings the contents of this report to the attention of staff so they can reflect on the learnings identified. I made further recommendations for the Trust to address under an evidence-supported action plan to instigate service improvement and to prevent further reoccurrence of the failings identified.

THE COMPLAINT

1. This complaint was about the actions of the Northern Health and Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her late father (the patient) from 2 to 4 April 2021 and 10 to 18 June 2021.

Background

2. The patient was a resident in Seabank Care Home (the Home). The patient attended the hospital on 2 April 2021 following an unwitnessed fall in the Home. The Trust discharged the patient on 4 April 2021. On 10 June 2021 the Home arranged an ambulance for the patient following symptoms of breathlessness, cough and sputum[4]. The patient attended Causeway Hospital Emergency Department (ED) and the staff admitted the patient on the same day. The patient remained in hospital until his discharge on 18 June 2021. The patient sadly passed away on 6 July 2021.

Issue of complaint

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

   Whether the Trust provided appropriate care and treatment to the patient from 2 April to 4 April 2021 and from 10 June 2021 to 18 June 2021.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

   - A Consultant Physician for over 40 and an accredited geriatrician since 2001 (C IPA); and

[4] A mixture of saliva and mucus produced by the lungs as a result of a viral or bacterial infection.

- A Senior Nurse with 21 years' experience across primary and secondary care (N IPA).

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

6. The information and advice which informed the findings and conclusions are included within the body of this report. The 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

7. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

The general standards are the Ombudsman's Principles[5]:

- The Principles of Good Administration

8. 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, updated April 2019 (the GMC Guidance);
- The Nursing Midwifery Council Standard for Nurses March 2018 (NMC Code);
- The National Institute for Health and Care Excellence's Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, Clinical Guideline 32, updated 4 August 2017 (NICE CG32);
- National Institute for Health and Care Excellence (NICE) Pressure

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

Ulcers: Prevention and management Clinical guideline [CG179] 23 April 2014 (NICE Pressure Ulcer Guidance);

- NICE Pressure Ulcers: Quality Standard [QS89] 11 June 2015 (NICE Pressure Ulcer Quality Standards);
- GMC Treatment and care towards the end of life: good practice in decision making July 2010 (GMC DNACPR[6] Guidance); and
- Northern Health and Social Care Trust Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy 11 February 2020 (Trust's DNACPR Policy); and
- British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing - Decisions relating to cardiopulmonary resuscitation, 2016 (Resuscitation Guidelines).

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

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

10. 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. My staff also met with the complainant and her husband. Both the complainant and the Trust provided extensive comments to the draft Investigation Report. I gave careful consideration to all the comments I have received, and where appropriate I included their comments in the body of this report.

[6] Do not resuscitate is a legally recongised order and means the patient is not to be resuscitated if they suddenly go into cardiac arrest or stop breathing.

THE INVESTIGATION

Whether the Trust provided appropriate care and treatment to the patient during the period 2 April 2021 to 4 April 2021 and to 10 June 2021 to 18 June 2021.

In particular this will consider:

- The patient's nutritional needs;
- The patient's pressure sores;
- Information provided to the Home about Covid 19 concerns; and
- DNACPR policy.

The patient's nutritional needs 10 June to 18 June 2021

Detail of Complaint

11. The complainant said the Trust let the patient *'waste away'* and did not refer the patient to a dietitian. She also said the Trust did not inform the patient's family of his *'poor oral intake'*.

Evidence Considered

Legislation/Policies/Guidance

12. I considered the following policies and guidance:
    - GMC Guidance;
    - NMC Code;
    - NICE CG 32 guidance; and
    - NICE Pressure Ulcer Guidance.

Trust's response to investigation enquiries

13. The Trust apologised its staff did not complete a MUST assessment[7] upon the patient's admission (10 June 2021). It stated its staff commenced the patient on a food chart and the nursing staff *'provided assistance and encouragement at mealtimes'*.

14. The Trust stated the Speech and Language Therapists (SALT) reviewed the patient and advised *'a level 0 fluids, and level 4 diet, only when upright and*

[7] Malnutrition Universal Screening Tool is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. It includes management guidelines which can be used to develop a care plan.

alert'. It stated the patient was on a daily food chart and the Consultant (Consultant A) referred the patient to a dietician on 16 June 2021, *'however he was discharged before being seen by them'*. Following his discharge the Trust stated Consultant A did not refer the patient to the community dietician as the Home had a dietetic plan in place.

Relevant Trust records

15. The Trust provided this Office with the patient's medical and nursing records for 10 June to 18 June 2021. This Office also obtained the patient's relevant Home records. I enclose a summary of these records to Appendix five of this report.

Relevant Independent Professional Advice

C IPA

16. The C IPA advised *'the records show that referral was made to SALT who are competent to assess swallow and they made recommendations for consistency of diet/food in order to achieve safe swallow'*. He advised SALT assessed the patient *'on various occasions'* and made appropriate recommendations for the patient to have a soft diet with normal fluids.

17. He advised Consultant A referred the patient to a dietitian on 16 June 2021 at 9.50, however the reasons for the referral *'at that time is not clear from the notes'*. He advised the hospital dietitian did not see the patient prior to his discharge however *'the plan to use the residential home's facilities [..] was appropriate'*.

18. In response to the draft Investigation Report the complainant said Consultant A should have referred the patient to a dietician upon the development of a pressure sore on 13 June. She referred to NICE Pressure Ulcer Guidance which recommends: *'offer adults with a pressure ulcer a nutritional assessment by a dietitian or other healthcare professional with the necessary skills and competencies'*. The C IPA emphasised that the guidance recommends *'other healthcare professional with the necessary skills and competencies'* and advised *'the consultant having the competency/skill/training on pressure ulcers was competent to treat/advice without referring to a dietitian, as cited and*

clarified in [NICE Pressure Ulcer Guidance]'. He also advised *'it cannot be said that a multidisciplinary team was not involved* [in the patient's care and treatment] *because doctors, nurses, and therapists and AHPs[8] participated in his management'*.

N IPA

19. The N IPA advised nursing staff only monitor the intake of those patients at risk of malnutrition and should complete a nutrition assessment (MUST[9]) on these patients' admission to hospital to assess their risk. She advised the patient did not have a MUST assessment and *'therefore it is not possible to say what his level of risk was'*. She advised as per local and national guidance the nursing staff should have completed a MUST for the patient on admission or one week after. As the nursing staff did not complete a MUST for the patient, she advised the patient's risk of malnutrition could not be assessed. .

20. However the N IPA advised the patient was taking nutritional supplements prior to his hospital admission and *'therefore food charts would be indicated regardless of MUST score'*. She advised the nursing staff started food charts for the patient on 12 June and therefore the nursing staff's monitoring of the patient's food intake *'was appropriate'*.

21. The N IPA reviewed the patient's nursing records and advised his food charts demonstrated *'poor oral intake throughout'*. She advised the Trust prescribed the patient's existing nutritional supplements, but the nursing staff rarely administered these supplements *'due to patient refusal…therefore, there were nutritional concerns from admission'*. She advised the nursing staff discussed the patient's difficulties in encouraging oral intake with the patient's daughter during his admission.

22. On 13 June 2021 the records document the patient developed a Stage 1 pressure ulcer to his sacrum. The N IPA advised *'it is very difficult to link the pressure ulcer development to the patient's poor nutritional intake given that poor intake was noted from 12th'*. She advised *'there was no evidence, from the*

[8] Allied health professions
[9] MUST – Malnutrition Universal Screening Tool.

records available, that the stage 1 pressure ulcer impacted on the patient's nutrition'.

23. On 15 June 2021 the records document the patient's Stage 1 pressure ulcer developed into a Stage 2 pressure ulcer. The N IPA advised that pain from pressure damage can affect appetite. However the assessments document that the patient's pain scores were marked as 0 and his co-codamol was stopped because pain was adequately controlled with paracetamol *'making uncontrolled pain unlikely; thus, making any impact on nutrition also unlikely'*.

24. The N IPA advised there was no additional interventions that the nursing staff should have been taken in relation to the patient's nutrition upon the development of the pressure sores. However *'the patient should have been referred to a dietitian independent of his pressure damage because of his poor dietary intake'*. She advised the dietitian's assessment and advice would include nutritional advice to improve skin integrity.

25. She advised Consultant A referred the patient to the dietitian and SALT, however *'more should have been done to improve the patient's intake'*. The N IPA advised the patient *'should have had a nutritional care plan outlining his needs'*. This would have identified his individualised nutritional needs and his calculated calorie intake. She advised the nursing records documented that the patient needed assistance with eating but it is unclear what this meant as assistance can mean a number of things such as cutting up a patient's food, or allowing the patient more time to eat.

26. The N IPA advised the nursing staff should have weighed the patient on admission and weekly thereafter. This also would have been done during a MUST. The nursing records document the nursing staff were *'unable to weigh'* the patient and the N IPA advised in such circumstances *'MUAC can be used (mid upper arm circumference)'* which gives an indication of body mass index. However there was no documented MUAC within the records and as such she advised it is unclear if the patient's intake resulted in weight loss. She also advised she is not able to conclude if the patient lost weight based on his food charts.

27. The N IPA advised the Trust included the patient's need for normal fluids, level 4 diet and eating 'upright' within the patient's discharge letter. She advised the dietician did not visit the patient prior to his discharge and the patient did not have a nutritional plan. Therefore *'there was no nutritional plan to include'* within his discharge letter. However she advised she did not consider a dietetic plan should have been included if there was one, *'as the patient would be reassessed by the community dietitians on discharge if dietary advice was needed'*.

Analysis and Findings

(i) Medical

28. The records document Consultant A referred the patient to the SALT team who visited the patient on 10 June, 11 June and twice on 16 June. The records document the SALT team made recommendations to Consultant A and the nursing staff to provide the patient with a soft diet with normal fluids in order to achieve safe swallow. The records also document Consultant A made a referral to a dietician on 16 June; however the Trust discharged the patient on 18 June to the care of the Home. The hospital's dietitian did not visit the patient prior to his discharge.

29. In response to the draft Investigation Report the complainant raised concerns that Consultant A should have referred the patient to a dietician upon the development of his Stage 1 pressure ulcer on 13 June, which developed to a Stage 2 pressure ulcer on 15 June. She said this was in accordance with NICE Pressure Ulcer Guidance. This guidance recommends *'offer adults with a pressure ulcer a nutritional assessment by a dietitian or other healthcare professional with the necessary skills and competencies.'* I note in his advice the C IPA emphasises *'healthcare professional with the necessary skills and competencies'*. He advised *'the consultant having the competency/skill/training on pressure ulcers was competent to treat/advice without referring to a dietitian, as cited and clarified in* [NICE Pressure Ulcer Guidance]'.

30. I note the Home's records document diet plans in place for the patient upon his hospital discharge. In response to this Office's enquiries the Trust stated there

was no need for Consultant A to refer the patient to a community dietician upon his hospital discharge as the Home had a dietetic plan in place. The C IPA advised this *'was appropriate'*.

31. In her response to the draft Investigation Report the complainant referred to NICE CG 32 which indicates health care professionals should ensure that all people who need nutritional support receive coordinated care from a multidisciplinary team. The complainant said this did not happen for the patient. I note this guidance also states *'the composition of this team may differ according to setting and local arrangements'.* The C IPA advised *'it cannot be said that a multidisciplinary team was not involved because doctors, nurses, and therapists and AHPs participated in* [the patient's] *management'*.

32. Overall, I accept the C IPA's advice and I am satisfied Consultant A provided the patient with the appropriate care and treatment for his nutritional needs. I do not uphold this element of the complaint.

33. However I must note the C IPA advised the Consultant A's records are not clear regarding the reason for the patient's referral to a dietitian. Upon my review of Consultant A's records I note Consultant A did not document a reason for the patient's referral to a dietician. Although in this instance I do not consider this a failure in the patient's care and treatment as the nursing records document the reasoning, I would highlight this record keeping to the Trust.

(ii) Nursing

34. I refer to NICE CG23 which states *'all hospital in-patients should be screened on admission and screening should be repeated weekly or when there is cause for clinical concern'*. The records do not document the patient's weight or MUAC during his hospital admission. The N IPA advised the nursing staff should have weighed the patient upon admission and weekly thereafter, and if this was not possible *'MUAC should have been used'.* I also note the documents do not contain a record of a completed MUST assessment for the patient. The N IPA advised as the nursing staff did not complete a MUST assessment for the patient upon his admission or one week after, the nursing staff were unaware of the patient's risk of malnutrition. I refer to the NMC Code

which requires nursing staff to *'use contemporary nutritional assessment tools'*. I am critical nursing staff did not follow national guidelines and consider this a failure in the patient's care and treatment.

35. I note the nursing records contain food charts for the patient during the period 12 June to 18 June. The Trust stated its nursing staff used these food charts to monitor the patient's food intake. The N IPA advised as the nursing staff commenced food charts for the patient on 12 June, their monitoring of his intake *'was appropriate'*. She advised his food charts demonstrated a poor oral intake throughout his hospital admission. I note the nursing records document the nursing staff informed the complainant on 12 June of their difficulties in encouraging oral intake. I am satisfied the complainant was aware of the patient's poor oral intake.

36. In response to the draft Investigation Report the complainant raised concerns about the patient's pressure ulcers and the impact on the patient's nutrition. The N IPA advised it is difficult to link the pressure ulcers to the patient's poor nutritional Intake. She did acknowledge that pressure damage can affect appetite *'which can further impede nutritional intake'*. She advised upon her review of the records the patient's pain scores were 0 and the staff stopped his co-codamol because *'pain was adequately controlled with paracetamol'.* She advised uncontrolled pain was unlikely *'making any impact on nutrition also unlikely'*. She advised there was no additional interventions that the nursing staff should have taken in relation to the patient's nutritional care upon the development of his pressure ulcers. I accept this advice.

37. The medical records document Consultant A referred the patient to a dietician (16 June) and the SALT team visited the patient on at least 4 occasions. However the N IPA advised *'more should have been done [by the nursing staff] to improve the patients' intake'*. She advised the patient did not have a nutritional care plan in place *'despite a very poor intake throughout his admission'*. I refer to NMC Code which requires nursing staff to *'Use evidence-based, best practice approaches for meeting needs for care and support with nutrition and hydration'*. The N IPA advised *'patients with a poor nutritional*

intake should have a nutritional care plan, with clear, individualised interventions aimed at improving intake'. I accept this advice and I am satisfied the nursing staff failed to provide the patient with a nutritional care plan in accordance with national guidelines. I consider the lack of a nutritional care plan a failure in the patient's care and treatment.

38. I note the nursing records document that the patient *'needed assistance with eating'*. However the N IPA advised from the records it is not clear what type of assistance the patient needed. She advised *'assistance can mean lots of things'* like cutting up food or allowing additional time for the patient to eat. I refer to the NMC Code which requires nursing staff to make clear and accurate records. I am critical the nursing staff did not document the type of assistance the patient required within his nursing records. Nursing staff should record this type of detail to ensure clarity for other nursing staff when providing care and treatment to the patient. I consider this a failure in the patient's care and treatment.

39. In response to the draft Investigation Report the complainant raised concerns that the nursing staff did not include a dietic plan within the patient's hospital discharge letter. As the dietician did not attend with the patient prior to his discharge, there was no dietetic plan to include. However the N IPA advised she did not consider *'that a dietetic plan should have been included even if there was one, as the patient would be reassessed by the community dietitians on discharge if dietary advice was needed'*. I accept this advice.

40. Overall, in relation to the nursing care and treatment, I am satisfied the nursing staff monitored the patient with food charts, and advised the patient's family of his difficulty eating. I am also satisfied that the patient's development of pressure sores did not affect his nutritional care. However I must note my concern of the absence of the following within the patient's nursing records: the patient's weight/MUAC, a MUST assessment, nutritional care plans and a lack of clarity of the type of assistance the patient required. I partially uphold this element of the complaint.

41. I consider the identified failings above caused the patient a loss of opportunity to receive an assessment, a measurement of his weight/MUCA and a nutritional care plan to monitor his risk of malnutrition. I consider the lack of records in relation to the type of assistance the patient required may have caused the patient a loss of opportunity to receive the correct type of assistance when trying to eat. I also consider the identified failings caused the complainant to sustain the injustice of uncertainty. This is because the complainant was uncertain of what actions the nursing staff were taking to care for the patient's poor nutritional intake and what steps they were taking to improve his intake. I also consider the identified failing in the patient's weight/MUCA measurement caused the complainant uncertainty and a loss of opportunity. The complainant said it took away an opportunity for the family to assess how the patient deteriorated.

42. Whilst I have identified failings in the care and treatment it is difficult to conclude the impact of these failings. This is because the nursing staff did not measure the patient's weight/MUCA during his hospital admission, which would have been done as part of a MUST assessment. I acknowledge the nursing staff used food charts to monitor the patient's intake and documented their concerns within the nursing records. I also note the records document the nursing staff escalated their concerns about his intake to a Doctor who referred the patient to a dietician. Although the Trust discharged the patient prior to receiving a visit from the dietician, the Home had a dietetic plan in place. The C IPA advised this *'was appropriate'*.

The patient's pressure sores 10 June to 18 June 2021

Detail of Complaint

43. The complainant said the patient acquired pressure sores from his hospital stay. She said the hospital attributed these sores as *'pre-existing, not secondary as was the case'*.

44. In response to the draft Investigation Report the complainant raised concerns that Consultant A did not inform the community dietitian of the patient's development of a Stage 1 and Stage 2 pressure ulcer.

Evidence Considered

Legislation/Policies/Guidance

45. I considered the following policies and guidance:
    - NICE Pressure Ulcer Guidance; and
    - NICE Pressure Ulcer Quality Standards.

The Trust's response to investigation enquiries

46. The Trust stated it refutes this allegation. It stated the ED records document the patient *'had a skin tear and blanching erythema[10] to the sacrum[11] and heels'*. It also stated these records document the patient had a laceration on his head.

47. It stated the nursing staff repositioned the patient and encouraged him to lie on his side *'to relieve pressure but preferred and was obviously more comfortable on his back'*. It stated the ward discussed the patient's skin condition during the handover to the Home and the ward staff provided the Home with the patient's full body map. It further stated it ordered a pressure relieving mattress for discharge.

Relevant Trust records

48. The Trust provided this Office with the patient's ED, medical and nursing records for the period 10 June 2021 to 18 June 2021. This Office also obtained the patient's Home records for the period 10 May 2021 to 10 June 2021.

Relevant Independent Professional Advice

C IPA

49. The C IPA advised the Trust's discharge letter to the patient's GP does not reference the patient's pressure ulcer. However *'if there was deemed to have been an issue or critical concern, it would anyway have been for the GP to advice* [sic] *the district nurses in the community because they would be involved with the care and dressing of the pressure ulcer'*. He advised if the

[10] Redness on the skin that disappears with pressure and then returns.
[11] A single bone located at the base of the spine.

district nurses considered the patient's pressure ulcer was an issue for his nutrition *'it would be open for them to inform the dietitian'*.

N IPA

50. The N IPA advised the nursing staff assessed the patient's risk of pressure damage using the Braden Scale[12] on 11 June 2021. The patient scored 12, which the N IPA advised meant *'he was at high risk'*.

51. The N IPA advised the nursing staff checked the patient's skin upon admission. She advised the patient's body map (completed on admission) documents that the patient had blanching erythema to the sacrum and dry heels, bruising to his arm and hand, and dry, red, scaley skin on his lower legs. She advised the records do not document the patient had a skin tear or pressure damage.

52. She further advised the nursing staff placed the patient on a daily SKIN bundle[13]. She advised as the patient was high risk the patient *'should have had his position changed every four hours and nursed on a pressure redistributing surface'*. She also advised the frequency of positional changes was not indicated on the SKIN bundle charts until 16 June when 'four hourly' was ticked.

53. The N IPA advised it is not clear from the records what type of mattress the Trust used on the patient's bed until 15 June when it used an auto logic mattress[14]. In response to the draft Investigation Report the Trust informed this Office it used an AtmosAir[15] mattress upon the patient's admission. The N IPA advised *'this is considered a 'high specification mattress'* and would have been suitable.

54. The N IPA advised the SKIN bundle charts document the patient developed *'a stage 1 pressure ulcer[16] to his sacrum'* on 13 June 2021, *'which deteriorated further to a stage 2 pressure ulcer[17]'* on 15 June 2021. She advised the

[12] Braden Scale for Predicting Pressure Ulcer Risk is a tool that purpose is to assist health professionals and nursing staff assess a patient's risk of developing a pressure ulcer.
[13] Care used to prevent the development of pressure ulcers on a patient. It consists of surface, keep moving, incontinence, and nutrition.
[14] A medical pressure mattress for medical use to prevent pressure injury.
[15] Non-powered hybrid mattress used to provide reactive pressure redistribution.
[16] Stage 1 ulcers have not yet broken through the skin.
[17] Stage 2 ulcers may appear as a shallow, crater-like wound or blister containing a clear or yellow fluid.

patient's *'positional changes were not consistent'*. The N IPA acknowledges the records document there were frequent occasions when the patient refused positional changes. However she advised *'there does not appear to have been any attempt to revisit and attempt again in a timely manner…when the patient refused, it would be hours after that repositioning would be encouraged again'*.

55. The N IPA advised there were failings in the patient's pressure area prevention and management: the patient did not receive four-hourly positional changes and the nursing staff did not consistently maintain the patient's positional changes. The N IPA advised these failings caused the patient to develop a stage 2 pressure ulcer to his sacrum.

56. The N IPA advised details on the patient's development of a Stage 1 and then Stage 2 pressure ulcer should have been included on the discharge letter to enable continued pressure area care within the community. However the records document a wound map identifying the Stage 2 pressure ulcer was handed to the Home upon the patient's hospital discharge which was in line with the NMC standards *'to work with colleagues to preserve the safety of those receiving care… share information to identify and reduce risk'.*

Analysis and Findings

(i) Medical Care

57. I note the Trust's discharge letter to the patient's GP (dated 18 June 2021) does not make reference to the patient's diagnosis of a Stage 1, which later developed into a Stage 2 pressure ulcer. In response to the draft Investigation Report the complainant raised concerns that the community dietician was unaware of the patient's pressure ulcer. The C IPA advised *'if there was deemed to have been an issue or critical concern, it would anyway have been for the GP to advice* [sic] *the district nurses'*. He advised if the district nurses felt nutrition was an issue *'it would be open for them to inform the dietician'*. I accept the C IPA's advice and I am satisfied it is not the role of Consultant A to inform the community dietician of the patient's pressure ulcer. I do not uphold this element of complaint.

(ii) Nursing Care

58. The records document on the patient's admission (10 June 2021) he suffered from blanching erythema to the sacrum and dry heels, bruising to his arm and hand, and dry, red, scaley skin on his lower leg. However I note the records do not document the patient presented with pressure damage upon his admission to hospital.

59. The Braden Scale completed on 11 June 2021 documents the patient was at high risk of developing pressure ulcers. The NICE Pressure Ulcer Guidance states when a patient is of high risk of developing a pressure ulcer, nursing staff should develop and document an individualised care plan. The records document the nursing staff put in place a SKIN bundle care plan for the patient on 11 June 2021 until his discharge on 18 June 2021.

60. However I note the N IPA advised a SKIN bundle should identify the type of mattress the patient had. She advised as the patient was high risk, the nursing staff should have nursed the patient on a *'pressure redistributing surface'* upon his admission. She advised it is not clear from the SKIN bundle care plans what type of mattress the patient had during the period 11 June to 14 June and the SKIN bundle plans document on 15 June *'an auto logic mattress was used'*. The N IPA advised *'the patient should have been nursed on a high specification mattress from admission* [on 10 June]*'*. In response to the draft Investigation Report the Trust stated all mattress within the hospital are Atmos Air which his suitable for and including Grade 2 pressure damage. The N IPA advised this mattress is considered a *''high specification' mattress and would have been suitable'*. I accept this advice.

61. The N IPA advised SKIN bundles should also identify how frequently the patient is to be repositioned. The NICE Pressure Ulcer Guidance documents that adults at risk of developing a pressure ulcer should change their position frequently and *'at least every 6 hours'*. The N IPA advised as the patient was at high risk of developing pressure ulcers, *'he should have had his position changed every four hours'*. The nursing staff documented the patient's repositioning from 11 June to 18 June within the SKIN bundles. The N IPA

advised the SKIN bundle did not indicate the frequency of repositioning until 16 June when 'four hourly' is ticked. I consider the nursing staff did not meet the NICE standards in repositioning the patient and I consider this a failure in the patient's care and treatment.

62. I note the N IPA also advised the patient's *'positional changes were not consistent'*. I acknowledge the records document on occasions the patient refused repositioning. However the N IPA advised, following the patient's refusal *'there does not appear to have been any attempt to revisit and attempt again in a timely manner'*. I would have expected the records to document the nursing staff reattempting to reposition the patient at a later stage. Due to the absence of these records I am satisfied the nursing staff did not attempt to reposition the patient in accordance with the guidelines. I consider this a failure in the patient's care and treatment.

63. In response to the draft Investigation Report the complainant said the nursing staff did not record the details of the patient's pressure sores within his discharge letter. The N IPA advised the nursing staff should have included details on the patient's development of a Stage 1 and then Stage 2 pressure ulcer on the patient's discharge letter to enable continued pressure area care within the community. However the records document that a wound map identifying the Stage 2 pressure ulcer was handed to the Home upon the patient's hospital discharge. The N IPA advised this was in line with the NMC standards *'to work with colleagues to preserve the safety of those receiving care… share information to identify and reduce risk'.* I accept this advice.

64. Overall I am satisfied the patient did not suffer from pressure sores prior to this hospital admission. I am concerned the nursing staff's management of the patient's risk of developing pressure ulcers was not in accordance with national guidelines. I uphold this element of the complaint.

65. I consider the identified failings in care and treatment caused the patient to sustain the injustice of a loss of opportunity to receive the appropriate pressure care management. I accept the N IPA's advice and I am satisfied that this failure in his care and treatment led to the patient developing a stage 2

pressure ulcer. Clearly a stage 2 pressure sore is painful and I consider the development of this ulcer would have caused the patient pain and distress. I also consider the development of this ulcer would have caused the complainant upset as she observed her father receiving treatment for the pressure sore which he unfortunately developed due to a lack of appropriate care by nursing staff.

Information provided to the Home about Covid 19 concerns 10 June to 18 June 2021

Detail of Complaint

66. The complainant said the Trust did not inform the Home of the patient's Covid 19 diagnosis.

67. In response to the draft Investigation Report the complainant said the Trust should have informed the Home that the patient was showing possible Covid 19 symptoms upon his admission to the hospital.

Evidence Considered

Legislation/Policies/Guidance

68. I considered the following guidance:

- GMC Guidance.

Trust's response to investigation enquiries

69. The Trust stated the nursing notes document the nursing staff completed a verbal handover of the patient to the Home. It stated the handover documentation pack which accompanied the patient to the Home upon his hospital discharge *'clearly documents [the patient] was Covid positive and that infection control measures were required'*.

Relevant Trust records

70. The Trust provided this Office with the nursing and medical records for the patient from 10 June to 18 June 2021. This Office also obtained the patient's Home records following his hospital discharge. I enclose a summary of these records at Appendix four to this report.

Relevant Independent Professional Advice

71. The C IPA advised the patient's POCT[18] and PCR[19] results were both negative for Covid 19. He advised the onus of the Consultant is to treat the patient as he presents with Covid 19. There was no obligation to notify the Home upon his admission on 10 June 2021 and *'there was nothing to be gained by informing the Home'*.

72. The C IPA advised the patient's discharge letter *'states clearly that Covid tests were negative…the [chest x-ray] report said that pulmonary oedema or Covid were to be suspected'*. He advised the Trust's letter to the Home was *'extremely cautious'*, and the transfer information *'said that infection control was required and that Covid was the infection suspected'*. He advised *'nothing more needed to be done'*.

Analysis and Findings

73. The complainant said the Trust should have informed the Home that the patient was showing possible Covid 19 symptoms upon his hospital admission on 10 June 2021. The clinical records document, upon his admission, he received both POCT and PCR tests for Covid 19. These were both negative.

74. However the patient presented with symptoms of Covid 19 during his hospital admission. The clinical notes provided do not contain a record of the Trust informing the Home of the patient's suspected Covid 19 symptoms prior 18 June 2021. The C IPA advised *'the onus of the consultant is to treat the patient as he presents with Covid-19. There is no obligation to notify the Home on admission…there was nothing to be gained by informing the Home'*.

75. I note Consultant A's discharge letter dated 18 June states the patient's Covid 19 tests were negative, however his chest x-ray indicated a possible Covid 19 pneumonia. The transfer documentation the Trust provided to the Home upon his hospital discharge instructs the Home to ensure there is infection control as

[18] POCT – Point of Care Testing is clinical laboratory testing conducted close to the site of patient care where care or treatment is provided. It provides for rapid turnaround of test results.
[19] PCR – Polymerase Chain Reaction is a test to detect the presence of a virus.

the Trust suspected the patient had a Covid 19 infection. The C IPA advised *'nothing more needed to be done'*.

76. I am satisfied there was no requirement for the Trust to inform the Home of the patient's suspected Covid 19 symptoms prior to the patient's hospital discharge. I am satisfied upon the patient's discharge the handover documentation and the discharge letter informed the Home of the Trust's suspicion of the patient's Covid 19 diagnosis and the need for infection control. I do not uphold this element of the complaint.

DNACPR Policy 2 April 2021 to 4 April 2021 and 10 June to 18 June 2021

Detail of Complaint

77. The complainant believed Trust staff did not follow its DNACPR policy from 2 April 2021 to 4 April 2021, and 10 June 2021 to 18 June 2021. She said the patient's DNACPR forms did not adhere to the DNACPR policy in relation to incomplete patient identifiers and did not contain senior sign off. She also said medical staff did not completely explain the DNACPR policy to her, and did not take into consideration the patient's ability to give informed consent.

Evidence Considered

Legislation/Policies/Guidance

78. I considered the following guidance:
    - GMC DNACPR Guidance;
    - Resuscitation Guidelines; and
    - Trust's DNACPR Policy.

Trust's response to investigation enquiries

79. The Trust acknowledged its staff did not include the patient's address on the DNACPR[20] forms dated 2 April and 10 June 2021. It also acknowledged a Consultant did not countersign the DNACPR form dated 10 June 2021. However it stated the on call doctor signed the 10 June form following *'thorough discussion with a consultant who provided guidance and oversight*

[20] DNACPR – Do not attempt cardiopulmonary resuscitation. Cardiopulmonary resuscitation (CPR) is a procedure which can be initiated on any patient who has stopped breathing.

throughout the process…the on call Doctor who completed the form did so under the direct supervision and guidance of the consultant'. The Trust apologised a Consultant did not countersign the 10 June form but stated *'this did not affect any part of the decision making or management plan for* [the patient].*'*

80. The Trust stated in cases where a patient lacks capacity to make decisions, healthcare professionals carefully consider whether to implement a DNACPR order. It stated on 10 June a team of three doctors made the decision to implement a DNACPR order. It stated these doctors *'carefully assessed the situation and made the decision in the best interest of the patient'*. It recognised *'the patient was confused'* and its staff discussed the subject of resuscitation with the patient *'but the decision was largely a medical one that involved additional staff members'*.

81. The Trust stated its healthcare team *'takes great care to ensure that all patients are fully informed of any medical decisions or procedures that are being made and that their ability to provide informed consent is taken into consideration'*. It acknowledges DNACPR orders *'can be a difficult and emotional decision, and we take great care to ensure that patients and their families fully understand the nature and implications of the order'*.

82. The Trust stated it held discussions with the complainant during his second hospital stay regarding the patient's DNACPR status, explaining the risks and associated benefits. It stated *whilst* [the complainant] *was reluctant, she agreed to discuss with family. It was explained that ultimately it is a medical decision with family involvement…we take great care to ensure that patients and their families fully understand the nature and implications of the order*'.

Relevant Trust records

83. I obtained the Trust's medical and nursing records for the periods 2 April to 4 April 2021 and 10 June to 18 June 2021. These records included two DNACPR orders dated 2 April and 10 June 2021.

Relevant Independent Professional Advice

2 April to 4 April 2021

84. The C IPA advised a DNACPR only 'comes into play' when there is a cardiac/respiratory arrest and advised *'even if a DNACPR order is made, the patient will be provided all medical care and any necessary interventions, short of resuscitation'*.

85. He advised the Consultant (Consultant B) correctly completed and signed the form on 2 April 2021 and as Consultant B signed the form *'no further sign off is required'*.

86. The C IPA advised the form recognised the patient had dementia and *'it is not necessary for the patient to give consent, as this purely a medical decision'*. In response to the draft Investigation Report the complainant said dementia is not grounds to enact DNACPR or to decide not to discuss or seek arrangement from the patient. The C IPA advised the DNACPR form documents the reasons for its enactment is *'multiple significant co-morbidity, it was unlikely to be successful and significant frailty'*. He advised *'dementia is not cited as being a cause'*.

87. He advised the decision to apply DNACPR order rests with the clinician and the clinician can make this decision even if the family do not agree. However the C IPA advised it is a requirement for clinician staff to inform the family that a DNACPR is in place for a patient. He advised the box on the DNACPR form *'to indicate discussion took place with the patient as well as the family is left blank…the reasonable conclusion then is that such discussion did not take place'*. However the C IPA advised the clinical records do document the F2 Doctor (F2 Doctor A) attempted to telephone the complainant and her husband on three occasions to discuss the DNACPR order and failed to make contact.

88. The C IPA advised the Trust followed the DNACPR policy during the period 2 April to 4 April 2021.

10 June 2021 to 18 June 2021

89. The C IPA advised the F2 Doctor (F2 Doctor B) completed a DNACPR form on 10 June 2021 for the patient. He advised the Trust's guidance states a DNACPR form must be completed by *'the senior most professional immediately available'*. He advised it was appropriate for the F2 Doctor B to sign the form as it *'was Trust policy…The form states the consultant contributed to the decision. That makes the form to be valid and properly in order'*.

Analysis and Findings

2 April to 4 April 2021

90. The GMC DNACPR Guidance states clinicians should undertake discussions about DNACPR with the patient with sensitivity and should include information about the risks and benefits of cardiopulmonary resuscitation. This guidance also requires the clinician to do this with the patient's family, when either discussions with the patient are not possible or where the patient wants their involvement.

91. I note the medical records document the patient had dementia. The clinical records document the Trust enacted the DNACPR due to *'multiple significant co-morbidity, it was unlikely to be successful and significant frailty'*. The C IPA advised *'dementia is not cited as being a cause'* for the patient's DNACPR during this period. However as the patient had dementia, and cited as not having decision-making capacity, the GMC DNACPR Guidance requires the clinician to contact the patient's family to discuss the DNACPR. The records document the F2 Doctor A attempted to contact the patient's family on three occasions within a very short space of time on 2 April 2021. The purpose of his contact was to discuss the DNACPR order but unfortunately he was unable to speak with someone. The records document F2 Doctor A's intention to follow up on his contact with the family that same afternoon. However records of further contact are not contained within the clinical records. In the absence of such records I cannot be satisfied that F2 Doctor A made any further attempts to contact the family.

92. The C IPA advised F2 Doctor A should have informed the family of the DNACPR decision. He advised as F2 Doctor A tried to contact the family three times and could not get through, *'to that extent, the Trust does not bear blame for family not being informed'*. However, I do not accept the IPA's advice. I acknowledge the complainant's reasonable concerns that these three attempts of communication occurred within a 28 minute period. Whilst I recognise the pressure clinicians faced at the time of the patient's admission, I consider it entirely unreasonable to expect the family to answer within such a short timescale and then not make any further attempt to follow up contact, particularly given the significance of the matter to be discussed.

93. In response to the draft Investigation Report the complainant raised concerns about the completion of this form. Whilst the C IPA advised Consultant B correctly completed the DNACPR form, I disagree. Upon my review of this form, there are several sections of the form which are incomplete. These incomplete sections include the patient's address and date of birth which is critically important personal information used to distinguish one patient from another. These sections of the form are used to identify the patient and I consider accuracy in their completeness a necessity. This incomplete form constitutes a failure in the patient's care and treatment. This is because it risks the DNACPR not being attributed to the right patient and I find it highly concerning that such important information could be omitted.

94. Both the Resuscitation Guidelines and the GMC End of Life Guidance clearly state that for those patients who lack capacity, clinicians are required to '*consult with those close to the patient…take account of their views about what the patient would want and aim to reach agreement with them'*. Upon my review of the clinical records, I do not consider the Trust correctly followed relevant guidance during this period. This is because it did not consult the patient's family regarding the DNACPR decision. This removed an opportunity for the family to be properly informed about the decision, to provide their views, or to request another clinical opinion, as the guidance allows. I consider this a failure in the patient's care and treatment.

95. The C IPA advised the failure to communicate did not impact the patient or family as the DNACPR '*was not invoked'*. I note the advice but do not consider it to be relevant to the circumstances. It is my firm view that the impact of not following the guidance, and not involving the family in such decisions about the patient's care and treatment, cannot be ignored. This is especially the case given the patient could not make these decisions himself.

96. I consider the identified failures in care and treatment caused the patient to sustain the injustice of a loss of opportunity for his family to have input into his care. I also consider it caused the complainant to sustain the injustice of loss of opportunity and upset. This is because the family were unaware of the presence of the DNACPR and unable to be involved fully in their father's care.

97. I uphold this element of the complaint.

10 June 2021 to 18 June 2021

98. The medical records contain a DNACPR form dated 10 June which the F2 Doctor B completed. The Trust's DNACPR Policy states an DNACPR *'In circumstances where the DNACPR order is made by the most senior doctor immediately available, it should be reviewed and endorsed by the consultant or general practitioner responsible for the patient's care as soon as possible'.* I note the form documents the Consultant (Consultant C) endorsed the order along with one other F2 Doctor. The C IPA advised the form was *'valid and properly in order'* as it followed the Trust's policy and Consultant C contributed to the decision.

99. The complainant raised concerns about the incompletion of this DNACPR form also. Upon my review of this particular form, I note although F2 Doctor B did complete the patient's date of birth on the form, they did not complete the patient's address. Although the correct date of birth may go some way towards mitigating the risk of the DNACPR not being attributed to the correct patient, I consider the failure to complete this form accurately to be a service failure. I find this lack of accuracy in such an important medical form to be highly concerning, particularly as this occurred on two separate occasions relating to the same patient. I refer the Trust to my previous finding at para 93 and

reiterate my significant concern that an incomplete form risks the DNACPR not being attributed to the right patient. I ask the Trust to remind its staff about the proper completion of DNACPR forms and the risks if these are inaccurate or incomplete.

100. I note the DNACPR form documents that F2 Doctor B informed the complainant of the decision to enforce the order and the record states the complainant *'wants to speak with family however aware it is a clinical decision'*. I note in her complaint the complainant said the medical staff did not fully explain the DNACPR policy to her and her family. Although I note the C IPA's advice that the family *'could have sought and obtained clarification concerning this from the clinicians',* in my view the clinicians are responsible for providing a clear explanation to the patient's family and ensuring their understanding of the situation. This was clearly a worrying time for the family. I appreciate that they may not have had the opportunity to speak with the clinicians to seek further clarity and it is unfortunate the complainant's experience was that the DNACPR policy was not fully explained during this discussion.

101. Overall in consideration of all available evidence for both periods I am not satisfied the Trust followed the DNACPR policy in terms of appropriate communication with the family and accuracy of the both forms. Therefore I uphold this element of the complaint. I note on both hospital admissions the patient did not have a cardiac/respiratory arrest in hospital and the Trust did not invoke the DNACPR order. However, I acknowledge how sensitive and difficult it is for any family to be involved in discussions about a DNACPR order for a loved one and would emphasise the importance of such discussions being handled appropriately.

CONCLUSION

102. I received a complaint about the care and treatment the patient received from the Trust on 10 June to 18 June 2021. I also received a complaint about the Trust's application of a DNACPR policy on 2 April to 4 April 2021 and 10 June to 18 June 2021. I upheld elements of the complaint for the reasons outlined in this report.

The investigation established Consultant A and B provided the patient with the appropriate care and treatment, and informed the Home of the patient's suspected Covid 19 diagnosis upon his hospital discharge on 18 June 2021. It found the nursing staff appropriately completed food charts upon the patient's admission to hospital on 10 June 2021.

103. I was concerned that the investigation found the nursing staff failed to complete a MUST assessment and a measurement of the patient's weight/MUCA upon his admission to hospital on 10 June. The nursing staff failed to provide the patient with a nutritional care plan. It found the nursing records lack clarity on the type of assistance the patient required during feeding. The investigation also found there were failings in the nursing staff's pressure area prevention and management and that these failings led to the patient unnecessarily developing a painful Stage 2 pressure sore. The investigation also found the Trust's application of a DNACPR policy was not in line with the national standards on 2 April to 4 April 2021. There were also failures in the communication with the family and the accuracy of the information contained within the DNACPR forms.

104. I acknowledge these issues of complaint were of great concern to the complainant and her family. I hope the C IPA and N IPA's advice and the findings, and recommendations of this report provide her an element of closure. I offer through this report my condolences to the complainant for the loss of her father.

Recommendations

105. I recommend the Trust provides to the complainant a written apology in accordance with NIPSO's 'Guidance on issuing an apology' (July 2019), for the injustice caused as a result of the failures identified (within **one month** of the date of this report).

106. I recommend the Trust discusses the findings of this report with relevant staff and asks them to reflect on the failures identified and discuss it as part of their next appraisal.

107. I recommend the Trust undertakes an audit using a random sampling of nursing records over the last six months. The audit should assess if these records contain a completed MUST assessment for a patient upon their admission to hospital and whether a nutritional care plan is in place for a patient that has nutritional concerns. It should also assess what actions the nursing staff have taken to manage a patient's risk of developing pressure sores.

108. I recommend the Trust undertakes an audit using a random sampling of DNACPR forms and relevant clinical records over the last six months. The audit should assess if these forms are completed correctly and whether there has been a reasonable attempt to contact a patient's family to discuss the DNACPR, if the patient lacks capacity.

109. I recommend that following both audits, the Trust should take action to address any identified trends or shortcomings and report its findings and any recommendations to this Office within **six months** of the date of my final report.

110. I further recommend for service improvement and to prevent future recurrence that the Trust provides training to all relevant nursing staff to incorporate the following:
    i. Recording all details on the type of assistance patients require in accordance with the NMC guidance;
    ii. Completing a MUST assessment for a patient upon his admission to hospital;
    iii. Completing a nutritional care plan for a patient; and
    iv. Pressure area prevention and management.

111. I further recommend for service improvement and to prevent future recurrence that the Trust provides training to all relevant clinicians to incorporate the following:
    i. To make a reasonable attempt to contact a patient's family about DNACPR when a patient lacks the capacity to consent; and
    ii. To complete all relevant sections of a DNACPR form in accordance with national standards.

112. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **six** months of the date of my final report. The Trust should support its action plan with evidence to confirm it took appropriate action (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff read and understood any related policies).

Margaret Kelly
Ombudsman **July 2024**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and relevant guidance, 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.