Investigation of a complaint against a Nursing Home

Report Reference: 202006260

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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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Case Reference: 202006260

Listed Authority: Massereene Manor Private Nursing Home

SUMMARY

This complaint was about the actions of Massereene Manor Private Nursing Home (the Home). The complainant raised concerns about the care and treatment his wife (the resident) received during the period 25 April 2020 to 16 May 2020. In particular the complainant was concerned that having contracted COVID-19 the resident's health deteriorated and her care was not considered for escalation to hospital. The complainant was also concerned about the administration of antibiotics and the loss of records relating to the period of his complaint. The complaint felt that the fact that a DNACPR was in place for the resident may have impacted on the decision making regarding her care.

The investigation established:

- It was appropriate for the resident's condition to be managed in the care home up until 16 May 2020 and that the care provided was generally appropriate. However, the Home should have spoken with the GP to seek input about whether the resident needed intravenous antibiotics specifically when it first recognised her swallowing difficulties;
- The Home handled the administration of the patient's first antibiotic appropriately;
- However, the Home failed to follow up with the GP when the script for the second antibiotic was for an antibiotic in capsule form. The resident had identified swallowing difficulties and the manor of administration of the second antibiotic without a developed care plan was not appropriate, which constituted a failure in the care and treatment provided to the resident;
- The Home failed to manage the resident's records appropriately, which constituted a failure in record-keeping. The effect of this was that key records relating to the period covered by the complaint were not available.
- There was no indication that the presence of a DNACPR order impacted the care provided to the resident as no such event occurred. However, it was identified that there had been no advanced care planning discussion with the resident's family

which would have assisted with decisions regarding the escalation of the resident's care and treatment. I made an observation to the Home regarding the importance of advance care planning and incorporating this into their practice.

I therefore partially upheld the complaint.

I recommended the Home provide the complainant a written apology for the injustice caused as a result of the failures identified. I made further recommendations to bring about service improvement and to prevent future recurrence. I recommended the Home provide this Office with evidence of its compliance with these recommendations.

The Home accepted the findings and recommendations of my report.

I offer through this report my condolences to the complainant for the sad loss of his wife.

THE COMPLAINT

1. This complaint was about the actions of Massereene Manor Private Nursing Home (the Home). The complainant raised concerns about the care and treatment the Home provided to his wife (the resident) during the period 25 April 2020 to 16 May 2020.

Background

2. The resident had fronto-temporal dementia [1]and lived in the Home at the relevant time. On 25 April 2020 the resident was tested for COVID-19 and the result received on 27 April 2020 confirmed she was positive for COVID-19. On 5 May 2020 the Home informed the complainant that the resident's condition was deteriorating. On 9 May 2020 an Out of Hours GP prescribed liquid antibiotics for the resident. A GP prescribed a second course of antibiotics, in capsule form, on 13 May 2020 when the Home again informed the complainant the resident's condition was deteriorating further.

3. On 16 May 2020 the Home informed the complainant it had spoken with the resident's doctors and she had sadly entered an end-of-life stage. It explained the resident would receive palliative treatment going forward. The resident's GP, the Home and complainant all agreed it was best for the resident to receive palliative care in the Home instead of in hospital. The resident sadly passed away on 4 June 2020.

Issue of complaint

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

Whether the care that the Home provided to the resident during the period 25 April 2020 to 16 May 2020 was reasonable, appropriate and in line with relevant standards. In particular this will consider:

- **Escalation of the resident's care**
- **Administration of the resident's antibiotics**
- **Record keeping during the relevant period**

[1] An uncommon type of dementia that causes problems with behaviour and language.

INVESTIGATION METHODOLOGY

5. To investigate this complaint, the Investigating Officer obtained from the Home all relevant documentation together with its comments on the issues the complainant raised.

Independent Professional Advice Sought

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

    - A Nurse, BA(Hons), MSc, PGCert(HE), RGN (to 2024) - with over 30 years' experience in care for older people across hospital, community and care home settings, including 20 years as hospital-based Consultant Nurse for Older People. (N IPA).

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

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

Relevant Standards and Guidance

8. 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[2]:

    - The Principles of Good Administration

9. 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.

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

The specific standards and guidance relevant to this complaint are:

- The National Institute for Health and Care Excellence's COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community, Clinical Guideline 163, updated 30 April 2020 (NICE CG163);
- The National Institute for Health and Care Excellence, COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community, Clinical Guidance 165, April 2020 (NICE CG165);
- The National Institute for Health and Care Excellence, Managing medicines in care homes, SC1, March 2014 (NICE SC1)
- Association of Palliative Medicine and NHS Northern Care Alliance, COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care, 27 March 2020;
- Regional Palliative Medicine Group and Public health Agency, Guidance for the management of Symptoms in Adults in the Last Days of Life, 2018;
- Regional Palliative Medicine Group and Public Health Agency, COVID-19: Symptom Management in Last Days of Life (For use in Secondary and Primary Care Settings), April 2020;
- The Department of Health Social Services and Public Safety, Care Standards for Nursing Homes, April 2015;
- The Nursing and Midwifery Council Code for Registered Nurses; and
- Massereene Manor Private Nursing Home Records Management Policy, 2019.

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

10. 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.

11. A draft copy of this report was shared with the complainant and the Home for comment on factual accuracy and the reasonableness of the findings and recommendations. In response to the draft report comments were received from the complainant and the Home. All comments received were fully considered before finalising this report.

THE INVESTIGATION

Issue 1: Whether the care that the Home provided to the resident during the period 25 April 2020 to 16 May 2020 was reasonable, appropriate and in line with relevant standards. In particular this will consider:

- **Escalation of the resident's care**
- **Administration of the resident's antibiotics**
- **Record keeping during the relevant period**

Escalation of the resident's care

Detail of Complaint

12. The complainant said he was concerned the Home should have arranged for the resident to be admitted to hospital for treatment when her condition first started to deteriorate in week two of her COVID-19 infection. He said instead the Home waited to make a decision on hospitalisation when she entered her end-of-life phase on 16 May 2020, in week four of her infection. The complainant questioned whether a Do Not Attempt Cardiopulmonary Resuscitation[3] (DNACPR) Notice in place for the resident contributed to this decision.

Evidence Considered

The Home's response to investigation enquiries

13. The Home stated the resident's family and her GP agreed on 16 May 2020 the resident had entered an end-of-life stage. It confirmed those parties discussed hospital admission on that date, but ultimately decided it was in the resident's best interests to receive end of life care in the Home.

14. The Home stated prior to that it spoke with an Out of Hours GP and the resident's own GP about her condition on four occasions. It accepted it did not consider hospital admission as an option for the resident on those occasions, or at any other time prior to 16 May 2020. It stated that prior to this date, it did not consider it necessary to do so. It denied the DNACPR in place had any bearing on its decisions in this respect.

[3] A notice documenting an advanced decision that medical staff will not attempt to re-start a patient's heart in the event a patient's heart or breathing stops.

Relevant Home records

15. The Home provided this Office with a copy of the resident's Home records.

Relevant Independent Professional Advice

16. The N IPA advice is attached at Appendix 2 and I will address the key elements of this advice in the analysis and findings section below.

Analysis and Findings

17. The complainant was concerned the Home should have spoken to the resident's doctors to discuss whether she needed to go to hospital for care at an earlier stage of her infection.

18. I reviewed the RQIA Standards for Nursing Homes and note it does not state precisely when a Home should discuss potential hospitalisation of a resident during a period of illness. I note, therefore, the decision about when such a discussion should take place is within the professional judgement of staff. The N IPA's advice echoes this position.

19. I reviewed the Home records and note the Home sought GP input about the resident's care on 25 April, 7 May, 9 May and 13 May 2020. There is no record of the Home raising the issue of admission to hospital specifically during the calls on the dates listed.

20. The N IPA advised '*The Nursing Home monitored the resident's observations and oxygen saturations correctly and records indicate that they were stable up to 13 May. On that day the resident's oxygen sats dropped to 91%, she was reviewed by the GP service who prescribed antibiotics, and available records state that medication was administered as prescribed. Her sats recovered and observations otherwise remained stable.*' The N IPA further advised *'there was therefore no clinical indication for the Nursing Home to call an ambulance or ask further whether hospital would have been appropriate*' prior to 16 May 2020. The N IPA advised the GP had made an entry after the resident had passed away '*the GP entry for 19/06 states that there was no indication for hospital transfer during this period'*, which I note the N IPA agreed with.

21. I note the N IPA having reviewed the Home's records advised that there were occasions during the relevant period that it was documented that the resident had difficulty swallowing capsule medication. She advised when the Home first became aware of this, it '*should*' have contacted a GP to discuss whether '*hospital treatment with IVs was indicated*'. Having advised that consultation with the GP regarding the need for hospitalisation and IV antibiotic treatment should have occurred, ultimately it was the IPA's view that there was '*no indication*' for hospitalisation during the relevant period.

22. Having reviewed all relevant evidence, including the N IPA's advice, I am satisfied the resident did not require hospitalisation during the relevant period. Therefore, for the most part, I consider the Home did not fail in the care and treatment it provided when it did not proactively discuss escalation of care in hospital for the resident with a GP before 16 May 2020. However, I consider the Home's failure to consult with a GP about whether the resident may have required hospital attendance for intravenous antibiotics when it identified a swallowing difficulty does constitute a failure in care and treatment for this particular aspect of her care. The NMC Code requires nurses to work within the limits of their competence and make '*timely referrals*' to other practitioners when '*action, care or treatment is required*'. I find the Home staff failed to adhere to this aspect of the NMC Code in this respect. I therefore partially uphold this element of the complaint. This failure caused the resident to lose the opportunity for her GP to consider hospitalisation and intravenous antibiotics as part of her treatment plan.

23. Regarding the impact of the DNACPR in place, I note the IPA's advice that the existence of the DNACPR did not have any bearing on the Home's ability to consider hospitalisation at an earlier stage. She advised the DNACPR was specific to resuscitation decisions and is independent from decisions about transfer to hospital for treatment. Although I acknowledge the complainant's concerns, having considered the N IPA's advice, and the Home records available, I am satisfied there is no evidence to suggest the DNACPR influenced decision making about hospital transfer. On this basis I do not uphold this element of complaint.

Observation

24. Although outside the scope of this investigation, I nonetheless note the N IPA observed in her advice that the Home's advance care planning[4] for the resident could have been to a higher standard. She suggested if the Home had been more proactive with this planning, it may have clarified the complainant's concerns about hospitalisation options for the resident.

25. The N IPA referred to NICE CG163 and NICE CG165, which both recommend Homes '*put escalation and treatment plans in place'* for residents.

26. The N IPA observed the Home missed several opportunities to offer and appropriately record advance care planning discussions with the resident's family. However, she recognised it was unlikely any advanced plans would have overwritten any GP advice obtained on hospitalisation.

27. Whilst this issue did not form part of this investigation, I nonetheless strongly encourage the Home to reflect on the N IPA's observation in its practice going forward.

Administration of the resident's antibiotics

Detail of Complaint

28. The complainant said he was concerned about how the Home handled the courses of antibiotics prescribed for the resident. He was concerned the first course of antibiotics the GP prescribed the resident on 9 May 2020 was for five days, but it appears the Home only administered them for three days before seeking a new course. In addition the complainant is concerned the second course was for capsule antibiotics instead of liquid antibiotics. The resident was on a stage three liquid diet and the complainant was concerned the resident was unable to swallow the tablets.

Evidence Considered

The Home's response to investigation enquiries

29. The Home stated the GP record indicated 500mgs BD for five days. It explained, however it does not have a record of the GP's script as during the pandemic the GP brought medication himself when he visited the Home to see residents. The Home

[4] An advance care plan can include people's wishes such as their preferred place of care in the event of their condition deteriorating and their wishes for refusing life sustaining treatment.

stated the staff nurse completed the Kardex as 500mgs BD, and its staff administered this from 9 May 2020 pm to 12 May 2020 am. It explained the nurse on 12 May 2020 recorded she had administered the last dose. The Home explained this indicated the supply the GP left was only meant to last three days.

30. The Home stated the resident remained unwell on 12 and 13 May 2020. Therefore it contacted the GP, who prescribed a further antibiotic. The Home explained there is no record its staff questioned whether the first course had finished early. It stated the GP was happy to prescribe a further course of treatment.

Relevant Home records

31. The Home provided this Office with a copy of the resident's Kardex. However, the Home informed this Office it lost some of the resident's medication records from 25 April until 17 May 2020 and from 26 May until 4 June 2020.

Relevant Independent Professional Advice

32. The IPA advice is attached to Appendix two of this report.

Analysis and Findings

First Course of Antibiotics

33. According to Out of Hours GP records a GP prescribed the resident a five day course of clarithromycin, an antibiotic, on 9 May 2020, to be taken twice a day. In response to enquiries from this Office the Home stated '*the antibiotic was prescribed by a doctor who visited the resident in the nursing home prescribing a three-day course of antibiotics.'*

34. I reviewed the Kardex and note the Home recorded administering this medication once on 9 May 2020, twice on 10 and 11 May 2020, and once on 12 May 2020. This demonstrates the Home administered a three day course of the medication to the resident. This does not align with the five day course noted in the out of hours GP records. However, in the absence of the GP's original script, I am unable to determine exactly how much medicine the Home in fact received. I note when the resident required additional antibiotics on 13 May 2020, the Home sought another course from her own GP, which that GP provided. There is no evidence to suggest or

infer the Home lost or misplaced any of the medication. Therefore, on the balance of probabilities, I find it is more likely than not the Home received a three-day course of the medication, which it duly administered.

35. I understand the complainant's concerns surrounding this contradiction in records. However, having reviewed all available evidence, I am satisfied the Home's handling of the first antibiotic was appropriate and reasonable. I therefore do not uphold this element of complaint.

Second Course of Antibiotics

36. I note when the Home sought the second course of antibiotics, it received them in capsule form on 13 May 2020. At this time the resident was on a non-solid food diet. The Home recorded on 7 May 2020 the resident was having difficulties swallowing. On 8 May 2020 the resident received paracetamol as a suppository. The Home records document the resident received her antibiotics. However, it is unclear from the records how the Home administered the medication.

37. I note the N IPA's advice that it is more likely than not the Home administered this medication to the resident in whole capsules. I reviewed the Home records, which state '*medication given as prescribed including new antibiotic*'. There is nothing in the records to demonstrate or infer the Home split the medication, or crushed it, before administering it to the resident. I therefore accept the N IPA's advice in this respect. It is important to note however that some key records relating to this period were not provided as they were lost by the Home.

38. I note the N IPA's advice that the Home should have documented how it administered the medication in more detail in its records. She advised the standard of record-keeping in this respect did not adhere to the NMC Code. I reviewed the NMC Code and note it states nurses must ensure '*contemporaneous nursing records are kept of all nursing interventions, activities and procedure carried out in relation to each resident.'* Having reviewed the Home records, I accept the N IPA's advice, and find staff failed to adhere to these standards in this respect. I consider this to be a failure in record-keeping.

39. I also note the N IPA's advice that, given the resident's swallowing difficulties, the Home should have conducted a risk assessment and developed a medicines

administration care plan before it administered the capsules. The N IPA advised it was inappropriate for the Home to have administered whole capsules of this antibiotic to the resident in the absence of these plans. She advised '*this would not be appropriate for someone with swallow difficulty who requires a puree/liquid diet because capsules can lodge in the oesophagus or obstruct the airways if not swallowed effectively.'* She advised the Home failed to adhere to RQIA Standards, NICE Guidance and the NMC Code as a result. I accept this advice.

40. NICE SC1 states '*Care Home providers should determine the best system for supplying medicines for each resident based on the resident's health and care needs and the aim of maintaining the resident's independence where possible. If needed they should seek the support of health and social care practitioners.'* In addition, standard 4 of the RQIA Standards for Nursing Homes requires Homes to reassess its resident's needs on a daily basis, and record any changes in a resident's care plan. I find that in failing to complete a risk assessment and develop a medicines administration care plan before it administered capsule medication to the resident in these circumstances, the Home failed to adhere to these standards.

41. In terms of impact, I note the N IPA advised it would not have been appropriate for the Home to administer capsules of this medication to a resident with a recognised swallowing difficulty, and who required a puree/liquid diet, without first completing these plans. She advised *'capsules can lodge in the oesophagus or obstruct the airways if not swallowed effectively.'* She further advised '*there was potential harm to the resident from administration of capsule form of medication. The potential harm includes choking, incomplete swallow and absorption of the medication and possible consequences of medication lodged in the oesophagus.'* I refer to the N IPA's advice that in these circumstances the Home should have spoken with the resident's GP to ask about changing the capsule medication for a liquid equivalent, but it failed to do so. I accept the N IPA's advice on these aspects of the resident's care.

42. I am pleased to note there is no evidence to demonstrate or infer that the resident suffered the potential consequences the N IPA outlined. Nonetheless, I consider the Home's actions in administering the capsules to the resident in these circumstances, and its failure to seek GP input for a liquid equivalent, constitute failures in the care and treatment it provided. They also constitute failure to adhere to relevant standards. The NMC Code requires nurses to act in the best interests of patients at

all times. It also requires nurses to work within the limits of their competence and make '*timely referrals*' to other practitioners when '*action, care or treatment is required*'. It requires nurses to only administer medicines within the limits of their training and competence and to take measures to reduce, as far as possible, '*any potential for harm*'. I find the Home staff failed to adhere to these aspects of the NMC Code in this respect. I therefore uphold this element of the complaint.

43. I consider these failures had the potential to have put the resident at risk of harm, and caused the resident to sustain the injustice of loss of opportunity to have her needs properly assessed and to receive her medication in the appropriate form.

Record-keeping during the relevant period

Detail of Complaint

44. The complainant said during the complaints process he sought access to the resident's notes and records. During the internal process the Home was unable to locate certain records relating to food and fluid intake and medication prescribed. The complainant said these records were directly relevant to his concerns about the antibiotics the resident received at the Home. The complainant was therefore concerned about the standard of record keeping at the Home.

Evidence Considered

The Home's response to investigation enquiries

45. The Home stated it accepts it has lost these records. It stated it has carried out extensive searches of its records, including historical document files, but has been unable to locate them. The Home also stated the Home Manager and Managing Director who were in post at the time are no longer employed by the company and have no record of actions taken to retrieve the missing documents.

Analysis and Findings

46. The complainant said the Home lost some of the resident's records, namely dietary intake and medications records which were relevant to the issues he complained about. In particular:

- The resident's dietary intake for 11, 13, 14, 16 and 17 May 2020
- The resident's medications record from 25 Apil 2020 until 17 May 2020 and from 26 May 2020 until 4 June 2020

47. I note the Home's Records Management Policy 2.1 details the retention and disposal of records. It states '*it is the management's responsibility to ensure that all records created internally, and those received from external organisations will be used, stored, retained and disposed of in line with best practice. These will be retained for not less than 6 years from the date of last entry.'* While this policy details how records should be stored and disposed of, it is of concern that there is no guidance what to do when a resident's records have been lost.

48. In response to my enquiries the Home has not provided any explanation as to why or how this loss of the resident's records occurred. Of further concern is that the Home has also not outlined any learning it has adopted from losing these records or any steps put in place to prevent future recurrence.

49. In considering this case the N IPA advised the Home '*have failed to supply sufficient records of an important period of the resident's care, which indicates a record keeping failure.'*

50. I was concerned to learn of the loss of the resident's Home records and to note the N IPA's comments on the records provided to be inconsistent. I consider it a fundamental principle of information governance that all public sector bodies, especially those responsible for providing health and social care services, can easily identify, locate and retrieve a complete set of records relating to each of their service users. Ensuring a complete set of records are available is an essential element for the delivery of evidenced based health and social care and to enable openness and transparency about events that occurred including being able to effectively respond to complaints. The loss of contemporaneous records often diminishes the level of trust and raises concerns as to what may have occurred.

51. I acknowledge why the complainant would be so concerned about the loss of the resident's records as it indicates a lack of care and attention by the Home towards the resident*.' The Home's Records Management Policy states 'All records must be kept securely within a designated space. Collect, treat and store all data appropriately. All records in use are kept securely in designated areas within the home. Only staff working in the home and visiting members of the multidisciplinary team will have access to these,'* I consider the Home has failed to follow this policy for the reasons outlined above. The First Principle of Good Administration 'Getting it Right' requires a public body act '*in accordance with the public body's policy and guidance (published or internal)'.* I am satisfied this constitutes maladministration. As a consequence of this failing the complainant sustained the injustice of uncertainly, concern and distress as the Home could not provide the complete records directly related to his concerns. Therefore, I uphold this element of complaint.

CONCLUSION

52. I received a complaint about the care and treatment the resident received from the Home during the period 25 April 2020 to 16 May 2020.

53. I partially upheld the complaint for the reasons outlined in this report. I found failures in the care and treatment the Home provided to the resident, as well as a failure in record-keeping, the latter of which constituted maladministration.

54. I recognised the failures caused the complainant and the resident to sustain injustice, as discussed in the report.

55. I offer through this report my condolences to the complainant for the sad loss of his wife.

Recommendations

56. I recommend the Home 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 the final report.

57. I further recommend for service improvement and to prevent future recurrence that the Home:

i. Brings the contents of this report to the attention of all Home Nursing staff emphasising the importance of keeping appropriate records, appropriately filing and storing of records, conducting appropriate risk assessments, and producing appropriate care plans for administration of medications.

ii. Discusses the findings of the report at Senior Management Level and the Home reflects on the comments about the importance of fully recording of information.

iii. Create guidance on what steps the Home should take if it cannot locate a resident's notes and records.

iv. I recommend the Home 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 Home 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 relevant policies).

58. I also made an observation for the Home to consider regarding the importance of advance care planning in practice going forward.

SEAN MARTIN **March 2025**

Deputy 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 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.