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

Report Reference: 202004541

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

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: **202004541**
Listed Authority: **Western Health & Social Care Trust**

SUMMARY

I received a complaint about care and treatment the Western Health & Social Care Trust (the Trust) provided to the complainant's late mother (the patient) between 3 December 2021 and 27 January 2022.

The complainant said the Trust did not assist the patient to use the toilet on the day it discharged her from hospital. This resulted in the patient sitting in soiled clothing for an extended period of time. I upheld this issue of complaint. The investigation identified that the patient took fluids and a diuretic prior to her discharge. Despite this, there was no evidence to suggest the Trust ensured or assisted the patient to use the toilet in the hours before she left the hospital. The investigation identified this as a failure in care and treatment as the Trust did not deliver the fundamentals of care effectively. In not doing so, the Trust did not give sufficient consideration to the patient's human rights and did not adhere to the FREDA principle of dignity.

The complainant also said the Trust did not provide Acute Care at Home for the patient for the appropriate duration and that it prematurely ended its treatment of intravenous antibiotics and clinical oxygen. Furthermore, the complainant said she had to arrange palliative care for the patient when the Trust discharged her from its Acute Care at Home service. The investigation did not identify any failures in the care it provided to the patient at home.

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failure in care and treatment. I also made recommendations for service improvements to prevent recurrence of the failings identified.

I extend my deepest condolences to the complainant and her family for the loss of her mother.

THE COMPLAINT

1. This complaint was about the care and treatment the Western Health & Social Care Trust (the Trust) provided to the patient from the date of her discharge from hospital on 3 December 2021 until her passing on 27 January 2022. The complainant was the late patient's daughter.

Background

2. The patient was a 91-year-old female diagnosed with type 2 diabetes[1], chronic kidney disease[2] and osteoarthritis[3]. The Trust admitted her to hospital on 12 November 2011 with atrial fibrillation[4], tight chest, shortness of breath, and low blood pressure.

3. On 3 December 2021, the Trust discharged the patient and transported her home. When she arrived home, the complainant saw the patient's clothing was soiled.

4. The Trust provided the patient with Acute Care at Home (ACAH)[5] provision from 14 January - 17 January 2022. The complainant had concerns about aspects of this care. She was concerned about the way the Trust discharged the patient from ACAH and left it to family to arrange palliative[6] care.

5. The patient sadly passed on 27 January 2022.

Issue of complaint

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

   Whether the Western Health & Social Care Trust provided the patient with the appropriate care and treatment subsequent to her discharge from hospital on 3 December 2021.

[1] Formally known as adult-onset diabetes, type 2 diabetes is characterised by high blood sugar and resistance to insulin.
[2] Long-term kidney disease in which there is a gradual loss of kidney function.
[3] Inflammation of the joints.
[4] Fast, irregular heart rate.
[5] A short-term service to support elderly patients within the home.
[6] Care given to a patient to provide relief from symptoms of illness.

INVESTIGATION METHODOLOGY

7. 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

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

- A Consultant Physician and accredited geriatrician with over 23 years' experience in geriatric medicine (G IPA), holding the following qualifications: MB, MSc, MD, FRCP. FRCPEdin, FRCPGlasg, FRCP(I), Dip Card, RPMS Lond; and

- A Senior Nurse with 23 years' experience of providing primary and secondary care (N IPA), holding the following qualifications: RGN, MSc, BSc, MA, Dip in adult nursing.

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

9. 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

10. 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[7]:

- The Principles of Good Administration

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

11. 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 2014 (the GMC Guidance);
- The Nursing & Midwifery Council (NMC) The Code, updated 10 October 2018 (the NMC Code);
- The Nursing & Midwifery Council (NMC) Standards of Proficiency for Registered Nurses, 28 March 2018 (NMC Standards);
- Western Health & Social Care Trust (WHSCT) Acute Care at Home Service for Older People (ACAH) Operational Policy, July 2016 (ACAH Policy);
- National Institute for Health and Care Excellence (NICE) Shared Decision-Making Guidance, 17 June 2021 (NG197);
- Western Health & Social Care Trust (WHSCT) Acute Care at Home Service for Older People (ACAH) Guide for Patients and Families, November 2017 (ACAH Guide);
- National Institute for Health and Care Excellence (NICE) Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, 18 August 2015 (NG15);
- National Institute for Health and Care Excellence (NICE) British National Formulary (BNF) Treatment summary for oxygen, undated (BNF guidance on oxygen);
- Journal of Pain and Symptom Management (JPSM) Oxygen is Nonbeneficial for Most Patients Who are Near Death, 27 August 2012, (JPSM article on oxygen provision);
- National Health Service (NHS) fact sheet about furosemide, 21 February 2019 (NHS fact sheet on furosemide);
- NIDirect factsheet on End of Life and Palliative Care, undated, (NIDirect factsheet);
- Western Health and Social care Trust (WHSCT) patient information on District Nursing (DN) Service, September 2017 (WHSCT patient information on DN); and

- Foyle Hospice services guidance, undated (Foyle Hospice services guidance).

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

12. I also referred to the following publication:
    - Northern Ireland Ombudsman Human Rights Manual, 2015 (the NIPSO Human Rights Manual).

13. 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.

14. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Whether the Western Health & Social Care Trust provided the patient with the appropriate care and treatment subsequent to her discharge from hospital on 3 December 2021

The toileting of the patient upon discharge from hospital on 3 December 2021.

Detail of Complaint

15. The complainant said the Trust discharged the patient from hospital on 3 December 2021. She said staff dressed the patient "*first thing*" but waited until *"early evening*" before staff transported her home. She said the patient "*was not toileted*" during this wait and when she arrived home, her incontinence pad was "*soaking wet*" and had leaked through her clothes. The complainant said this left the patient feeling "*very distressed*".

Trust's response to investigation enquiries

16. The Trust said it had "*looked at the documentation in relation to toileting on the day of discharge*" and was "*unable to comment if the patient had been toileted prior to getting into the ambulance*". It apologised the patient "*had been incontinent*" and such was not what it wished for the patient "*or any patient*."

Relevant Trust records

17. I completed a review of the documentation the complainant submitted in support of the complaint; the documentation the Trust provided in response to my investigation enquiries; and the patient's clinical records relating to her discharge from hospital.

18. Based on my review of the documentation and records, I compiled a chronology of key events. This chronology is at Appendix Four to this report.

Relevant Independent Professional Advice

19. I considered the advice I obtained from the N IPA. The advice related to nursing care the Trust provided to the patient on the day of her discharge from hospital. I enclose the N IPA advice at Appendix Two to this report.

Analysis and Findings

20. I reviewed the patient's medical notes on the date of discharge. They evidence the patient took fluids on five occasions between 08:00 and 15:00. Records also document nursing staff gave the patient furosemide at 10:00. The NHS fact sheet on furosemide describes it is a diuretic[8] which starts to work *"within"* one hour. It states "*most people need to pee about 30 minutes after taking furosemide, and again within a few hours*".

21. Given the patient's fluid intake on that day, and the administration of furosemide, I would have expected to see evidence that nursing staff at least checked with the patient if she needed to visit the toilet. However, I could find no evidence of this or of any visits to the toilet for the patient on the date of her discharge. In the absence of this evidence, I cannot be satisfied that nursing staff considered the patient's toileting needs on 3 December 2021.

22. The NMC Code identifies bladder care as one of the fundamental aspects of nursing care and it states that staff should make sure those receiving care are kept in clean and hygienic conditions. Section 1.2 of this Code also requires staff to deliver the fundamentals of care "*effectively*". Based on the information available, I cannot be satisfied that nursing staff did everything within their remit to look after the patient's toileting needs on 3 December 2021. Based on the evidence available, I uphold this element of the complaint. I consider this a failure in the patient's care and treatment.

[8] Medicine which increases urine production.

23. The N IPA advised this adversely impacted on the patient's "*comfort and dignity*" and exposed her to the risk of skin lesions. I considered the human rights principles of fairness, respect, equality, dignity and autonomy (FREDA) in my consideration of this element of the complaint. Express findings of a breach of any relevant laws are a matter for the courts to consider. However, I am satisfied the failure identified demonstrated that the Trust did not give sufficient consideration to the patient's human rights. This also demonstrated a lack of regard for the patient's dignity, causing her to sustain the injustice of discomfort and upset. Furthermore, I consider the complainant sustained the injustice of upset and concern for her mother.

The care and treatment provided to the patient by the Acute Care at Home (ACAH) team

Detail of complaint

24. The complainant said she was "*unaware*" ACAH would "*only*" be supporting the family for a period of seven days. She also said the Trust removed all care *"without notice within a few hours of a confrontation with the consultant over care planning*".

Trust's response to investigation enquiries

25. The Trust said:

- The ACAH team does "*not*" have a set length of admission or duration of treatment for any patient. Such duration is dependent on each patient's clinical situation, progress and response to treatment with updates discussed and agreed with patients and families throughout the period of admission.

- Written information provided to all patients and families on the initial visit advises on the role and purpose of the service with no specific time frames mentioned. This is reinforced verbally at the time of all admissions and would have been the case with [the patient] and her family. Further, the average length of stay is around 4.5 days, so in the unlikely event of a specific duration being mentioned to family, it would not have been 7 days.

Relevant Trust records

26. I completed a review of the documentation the complainant submitted in support of the complaint; the documentation the Trust provided in response to my investigation enquiries; and the patient's clinical records relating to treatment the ACAH team provided.

27. Based on my review of the documentation and records, I compiled a chronology of key events. This chronology is at Appendix Four to this report.

Relevant Independent Professional Advice

28. I considered the advice I obtained from the IPAs. The advice related to the care the ACAH team provided to the patient. I enclose the IPA advice at Appendix Two to this report.

Analysis and Findings

29. Records show the patient's GP made an ACAH referral to the Trust on 13 January 2022. The Trust provided ACAH care from 14 January 2022. Although the complainant told my office the Trust provided ACAH for seven days, records document it discharged the patient after three days, on 17 January 2022.

30. The ACAH Guide describes its service as a consultant-led community scheme which the Trust "*may*" offer for "*up to"* seven days. Records document the Trust provided the patient's family with a copy of the ACAH Guide and said the family understood "*the role*" played by ACAH.

31. The ACAH policy states nursing staff will "*keep patients informed*" of any plans for discharge. This undertaking is in accordance with the NMC Standards requiring nurses to *"share information"* about the patient's health, care and ongoing treatment. Records document nursing staff informed the patient in the presence of family it would discharge her from its care if she showed *"no improvement*." The N IPA advised the records show ACAH staff "*did explain the criteria for discharge during initial assessment and then reiterated this on final visit*".

32. The ACAH guide explains the consultant will review care on a "*daily*" basis and discharge the patient when "*medically able*". Records document a consultant assessed the patient on 17 January 2022 and noted the prognosis as *"guarded*"[7]. Although records evidence the consultant noted an intention to discharge the patient over the next "*1-2*" days, he discharged her from ACAH care later that same day.

33. I found no evidence documented of a confrontation between the complainant and the consultant. Therefore, I did not view any evidence to suggest the decision to discharge was based on this interaction. In this case, I can only establish if the decision to discharge was

[7] A guarded prognosis means the outcome is uncertain and its challenging to predict the response to treatment.

appropriate and based on the patient's clinical need.

34. The G IPA advised the consultant recognised there was "*no more*" he could offer to improve the patient's health and advised discharge was the "*correct*" approach. The G IPA further advised ACAH is an "*extension*" of hospital care and once the patient is "*optimised"* for discharge, there is "*no"* mandated notice period required.

35. Having reviewed the relevant records and guidance, I accept the advice of the G IPA that the timing of discharge was appropriate. Although the complainant's concerns about the duration of ACAH provision are inconsistent with the records, I consider the guidance provided does not set any expectations that the Trust would provide ACAH for a set time, or that it would extend beyond seven days. I therefore do not uphold this element of the complaint.

IV treatment given to the patient whilst at home

Detail of complaint

36. The complainant said the consultant told family on 17 January 2022 that ACAH would administer IV antibiotics for a *"further 24 hours".* However, a nurse removed the IV equipment later that day. She was concerned ACAH did not provide the "*proper*" care by doing so.

Trust's response to investigation enquiries

37. The Trust said it is "*usual" practic*e to transition to oral treatment of antibiotics and such would be *"a trigger"* for a patient's discharge. It said this course of action was "*completed*" that afternoon and was "*within"* the timeframe discussed with the patient.

Relevant Trust records

38. I completed a review of the documentation the complainant submitted in support of the complaint; the documentation the Trust provided in response to my investigation enquiries; and the patient's clinical records relating to the ACAH team's administration of IV antibiotics.

39. Based on my review of the documentation and records, I compiled a chronology of key events. This chronology is at Appendix Four to this report.

Relevant Independent Professional Advice

40. I considered the advice I obtained from the G IPA. The advice related to the care the

ACAH team provided to the patient. I enclose the G IPA advice at Appendix Two to this report.

Analysis and Findings

41. Records evidence the ACAH team commenced treating the patient with the IV antibiotic co-amoxiclav at 16:00 on 14 January 2022. The G IPA advised ACAH administered the antibiotic intravenously to achieve a "*higher*" blood level[8]. This is the concept of the "*loading dose*"[9] which prompts a "*faster*" clinical response.

42. The records do not evidence that clinicians told the complainant on 17 January 2022 they would continue IV antibiotics for a further 24 hours. In the absence of corroborative evidence, I can only establish if the decision to replace the IV antibiotic with an oral antibiotic was appropriate.

43. Records show ACAH administered the final IV treatment at 08:30 on 17 January 2022 and replaced it with a liquid antibiotic at 15:40 on that same date. NG15 states clinicians should review intravenous antimicrobial[10] prescriptions after "*48-72 hours*". This is to determine if clinicians *"can"* switch to an oral antimicrobial.

44. The G IPA advised ACAH acted "*appropriately*" when it discontinued the IV co-amoxiclav as it was "*within*" the recommended timeline. He advised the liquid suspension form of the antibiotic is "*well absorbed*" and its administration did not adversely impact the patient's treatment. He advised this was "*appropriate*" as the cessation of the IV administration "*prevents damage*" to the patient's veins. Having reviewed the records and relevant guidance, I accept that advice. I do not uphold this element of the complaint.

The administration of clinical oxygen to the patient whilst at home

Detail of complaint

45. The complainant said the Trust removed "*all care*" from the patient when it ended ACAH provision. The complainant said this included oxygen which the family "*had to*" source a replacement from the GP.

[8] To administer an effective dosage of the antibiotic as quickly as possible.
[9] An initial large dose of medicine used to ensure a quick therapeutic response.
[10] A group of medicines, including antibiotics, used to treat infectious diseases.

Evidence Considered

Trust's response to investigation enquiries

46. The Trust said there was "*no clinical indication*" to provide the patient with oxygen. It said if there had have been then it would "*have arranged"* for supply of oxygen.

Relevant Trust records

47. I completed a review of the documentation the complainant submitted in support of the complaint; the documentation the Trust provided in response to my investigation enquiries; and the patient's clinical records relating to the ACAH team's administration of oxygen.

48. Based on my review of the documentation and records, I compiled a chronology of key events. This chronology is at Appendix Four to this report.

Relevant Independent Professional Advice

49. I considered the advice I obtained from the G IPA. The advice related to the care the ACAH team provided to the patient. I enclose the G IPA advice at Appendix Two to this report.

Analysis and Findings

50. BNF guidance states oxygen should be *"regarded"* as a drug and clinicians should only prescribe it for use in the home after "*careful*" evaluation. It states in most acutely ill patients, oxygen should be administered until they reach a saturation between "*94-98%".* However, it makes exception for those with respiratory conditions for whom a lower target of 88-92% is indicated.

51. Records show the patient's oxygen saturation level was 94% without supplemental oxygen on 14 January 2022. They also show she was "*not"* experiencing respiratory distress at that time. However, the Trust started to administer oxygen when the patient's saturation level reduced to 91-92%.

52. BNF Guidance states the administration of oxygen should be considered alongside the patient's carbon dioxide (CO_2) levels. The G IPA advised the patient was "*recognised as being a CO_2 retainer*". Therefore, the Trust reduced her levels in accordance with her CO_2 levels. The G IPA advised this was the "*right decision*". I accept this advice.

53. Records document ACAH removed oxygen for the patient on 17 January 2022. The

G IPA advised the patient had "*no clinical need*" for oxygen at that time given she had started palliative care. The G IPA further advised it is "*well recognised*" that oxygen is *"not*" required for a patient once the stage of palliation is reached. Therefore, ACAH acted "appropriately" by removing it. Having reviewed the relevant records and guidance, I accept that advice.

54. I appreciate the complainant's concern about the Trust's withdrawal of oxygen from the patient. However, this investigation has found the reasons for doing so were in accordance with relevant guidance and good practice. I therefore do not uphold this element of the complaint.

Care provision for the patient following her discharge from ACAH
Detail of complaint

55. The complainant said the Trust failed to arrange palliative care provision for the patient after it discharged her from the ACAH. She said it was "*family*" who arranged hospice care for the patient.

Evidence Considered

Trust's response to investigation enquiries

56. The Trust stated its ACAH team made a referral to District Nursing (DN) at the point of discharge on 17 January 2022. It said it informed the patient's GP of the palliative nature of her condition via a discharge letter. It said this was "*standard*" for all hospital -to-GP correspondence.

Relevant records

57. I completed a review of the documentation the complainant submitted in support of the complaint; the documentation the Trust provided in response to my investigation enquiries; and the patient's clinical records relating to the provision of care following discharge from ACAH.

58. I also considered the patient's medical records from her GP Practice and Foyle Hospice[11].

59. Based on my review of the documentation and records, I compiled a chronology of key events. This chronology is at Appendix Four to this report.

[11] A charity based in Londonderry which provides specialist palliative care services for patients with cancer and other life-limiting illnesses across the Western health and Social Trust area.

Relevant Independent Professional Advice

60. I considered the advice I obtained from the G IPA. The advice related to the care the ACAH team provided to the patient. I enclose the G IPA advice at Appendix Two to this report.

Analysis and Findings

61. Records evidence that ACAH made a computerised referral to DN for palliative care for the patient when it discharged her at 15:32 on 17 January 2022. It marked the referral as “urgent”. Records show DN received that referral at 15:35.

62. The patient’s GP Practice confirmed with my office that its records evidence the complainant rang the GP to discuss end of life care for the patient at an undisclosed time on 17 January 2022. Records show the GP thereafter sent an electronic referral for palliative care to Foyle Hospice. Foyle Hospice confirmed it received that referral on 18 January 2022. Foyle Hospice stated DN is the “key worker” in palliative care provision. Its staff contacted DN on 18 January 2022 to discuss how it could provide specialist care to support them. Foyle Hospice confirmed DN was already aware of the requirement to provide palliative care for the patient at that time.

63. DN attended to the patient on 14 January 2022, prior to ACAH taking over provision of care. On that date, DN staff recorded “ACAH will contact district nursing when [the patient] is discharged from service.” Based on the evidence available, I am satisfied ACAH followed this instruction.

64. Records evidence DN commenced palliative care on 19 January 2022. DN confirmed with my office its attendance was as a direct consequence of the referral made by ACAH. Care notes recorded by DN staff at 13:30 on 19 January 2022 state “Attended [the patient] today post discharge from ACAH service”. Records show Foyle Hospice staff commenced care on 20 January 2022. The NIDirect factsheet states both community nurses [DN] and hospice staff “may” be involved in end-of-life care. I note that both DN and Hospice nurses provided concurrent care to the patient thereafter until she sadly passed on 27 January 2022.

65. Records show ACAH discussed end of life care with the patient’s family. The referral to DN also evidenced that family members were aware ACAH made that referral. Records reflect ACAH informed the patient’s family at the point of discharge that DN would “still be available”.

66. The G IPA advised family members are "*not"* required to arrange end-of-life care directly with the service provider. Having reviewed the available evidence, I am satisfied ACAH made those arrangements for the patient. In doing so, it fulfilled its obligation. I acknowledge the complainant spoke to the GP about palliative care and he made a separate referral. However, that was in addition to the referral ACAH made. The G IPA advised ACAH took the "*correct step*" when it made its referral to DN and I accept that advice. I therefore do not uphold this element of the complaint.

CONCLUSION

67. I received a complaint about the care and treatment provided to the patient by the Trust between 3 December 2021 and 27 January 2022.

68. Based on my consideration of all the evidence available, I partly uphold the complaint. The investigation established that the Trust failed to ensure it delivered the fundamentals of care effectively (in relation to bladder care) on the day of the patient's discharge from hospital.

69. I am satisfied the failure identified caused the patient to experience the injustice of upset and discomfort. I also consider it also caused the complainant to sustain the injustice of upset and concern for her mother.

70. I acknowledge how distressing the patient's death was for the family. I hope this report addresses the complainant's concerns and goes some way towards reassuring her that the Trust's efforts to care for the patient at home were reasonable and appropriate. I extend my deepest sympathies to the family for the loss of the patient.

Recommendations

71. 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 failure identified (within one month of the date of this report).

72. I further recommend for service improvement and to prevent future recurrence, the Trust:

- Shares this report with staff involved in the patient's care and asks them to reflect on the failure identified.
- Provides training to relevant staff reiterating the importance of attending to the toileting needs of patients and delivering the fundamentals of care in accordance with the NMC Code.

73. I recommend the Trust implements an action plan to incorporate these recommendations and should provide me with an update within **three** 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 **May 2025**

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.