Northern Ireland Public Services Ombudsman

Investigation Report

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

NIPSO Reference: 18545

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) concerning the care and treatment received by the complainant in Causeway Hospital, Accident & Emergency between January 2015 and May 2017.

I accepted the following issue of complaint for investigation:

- Whether the complainant received appropriate care and treatment for management of his pain relief in Accident & Emergency between January 2015 and May 2017?

The investigation of the complaint did not find any evidence of a failure in the care and treatment provided by the Trust. I therefore do not uphold the complaint.

THE COMPLAINT

1. The complainant said that he was not being treated in accordance with a note placed in his medical file dated 19 June 2014 advising that he should be provided with Diamorphine intravenously if he presents to CCU or A&E. In particular, he referred to numerous A&E attendances between January 2015 and May 2017 and complained he had been discharged to his GP without appropriate pain relief. Furthermore, he specifically complained with respect to an A&E attendance on 17 December 2015. During this admission, the complainant believed he was not adequately assessed. He also believed that he should be receiving Diamorphine when attending A&E for prolonged chest pain.

Issue of complaint

2. The issue of the complaint which I accepted for investigation was:

Issue 1: Whether the complainant received appropriate care and treatment for management of his pain relief in Accident & Emergency between January 2015 and May 2017?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised by the complainant. This documentation included information relating to the Trust's handling of the complaint and relevant medical records.

Independent Professional Advice Sought

4. After further consideration of the issues, I obtained independent professional advice from a Consultant in Emergency Medicine. The IPA has worked over 11 years as a Consultant in a District General Hospital and his familiar with assessment of

suspected cardiac chest pain and also management of patients with long term care plans.

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPA has provided me with 'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case.

   The general standards are the Ombudsman's Principles[1]:

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

7. The specific standards are those which applied at the time the events occurred and which governed the exercise of the administrative and professional judgement functions of those organisations and individuals whose actions are the subject of this complaint.

8. The specific standards relevant to this complaint are:

   - Manchester Triage management of chest pain
   - NICE Pathways: Chest pain overview
   - NICE Pathways: The assessment and immediate management of suspected Acute coronary syndrome

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

- Causeway ED Algorithm of Treatment of Acute Pain in Adults June 2015
- NHSCT Controlled Drugs Policy and Procedures for In-Patient Areas February 2015

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

10. As part of the investigation process, a draft of this report was shared with the Trust and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Detail of Complaint

11. The complainant suffered from a number of significant conditions, including angina. He was involved in a serious RTA in 1991 and underwent coronary by-pass surgery in 2004. He had a spinal cord stimulator fitted in 2015. As a result of his history and medical conditions, the complainant has stated he had built up a tolerance to pain relief. As a result of this, there has been a note placed in the complainant's medical file dated 19 June 2014 from a Consultant Physician. The complainant stated that according to this note, he should be provided with Diamorphine intravenously if he presents to the Coronary Care Unit (CCU) or Accident and Emergency (A&E). He complained he was not being treated in accordance with this note. In particular, he referred to numerous A&E attendances between January 2015 and May 2017 and complained he was discharged to his GP without appropriate pain relief.

12. Furthermore, he specifically complained with respect to an A&E attendance on 17 December 2015. During this admission, the complainant believed he was discharged without adequate pain relief and Dr A did not examine him. He believed that he should be receiving Diamorphine when attending A&E for prolonged chest pain

however he was not receiving this. The Trust have stated that the prescription of Diamorphine is a clinical decision and it will be determined on clinical presentation.

Evidence Considered

The complainant's clinical records

The Consultant Physicians' Care Plan dated 19 June 2014

13. The care plan stated the following:

'[The complainant] has a very long history of coronary artery disease. In the past he has had a surgical bypass grafting and stenting. He has a permanent cardiac pacemaker. He has a past history also of pulmonary embolism and he is on lifelong warfarin oral anticoagulation. He has ***severe recurrent angina****. Despite full anti angina medication his symptoms of upper chest pain are very frequent and severe. [The complainant] and his primary care practitioners usually try to manage his angina at home but on occasion when he has protracted chest pain he requires admission.*
He should be admitted to CCU where the staff are aware of his severe coronary disease. Intravenous opiate analgesic is usually effective if given in appropriate dosage for his build. Analgesic should be administered as soon as possible after admission to CCU or A&E. *It should not be withheld if [the complainant] is in pain.*
When [the complainant] requires opiate analgesia it is appropriate to administer Diamorphine 2.5mg intravenously. This is a small initial dose and if his pain does not settle after 5 minutes a further dose of Diamorphine 2.5mgs should be given. If after this pain still persists contact the senior SHO/SpR on duty or if necessary contact the consultant physician on call.'

14. I have reviewed the complainant's medical records, including his A&E records. The following table indicates the occasions in which the complainant attended A&E and whether or not he received Diamorphine. It also indicates whether or not he was subsequently admitted to the CCU.

Date	Triage Details	Diamorphine given in A&E? (Y/N)	Trust Comments	Outcome	Admitted to CCU? (Y/N)
4 January 2015	Chest pain, cardiac pain, Pain score 6	N	Not felt to be clinically indicated. Received alternative analegesia	Received GTN and paracetamol. Morphine given by NIAS pre hospital	Y
25 January 2015	Chest pain, cardiac pain, pain score 7	N	Not felt to be clinically indicated.	Not happy to go home. Referred to cardiology. Morphine given by NIAS pre hospital. Morphine given in CCU.	Y
4 April 2015	Chest pain, cardiac pain, pain score 7	Y	Felt to be clinically indicated.	Morphine given by NIAS pre hospital	Y
4 June 2015	Chest pain, significant cardiac history	N	Not given by emergency department staff, diamorphine given by cardiology	Morphine given by NIAS pre hospital	Y
19 August 2015	Chest pain, significant cardiac history,	N	n/a	Morphine given by NIAS pre hospital Referred to	N

	pain score 2			cardiology	
17 December 2015	Chest pain, moderate pain 6	N	Not felt to be clinically indicated. Received alternative analegesia	Morphine given by NIAS pre hospital, subsequently discharged home	N
1 November 2016	Cardiac pain, chest pain, pain score 6	N	Not felt to be clinically indicated. Received alternative analegesia	Given paracetamol and codeine	Y
7 January 2017	Cardiac pain, chest pain, pain score 6	N	Not felt to be clinically indicated. Received alternative analegesia	Given oral morphine 'Oramorph'	Y
10 May 2017	Cardiac pain, chest pain, pain score 6	N	Not felt to be clinically indicated. Received alternative analegesia	Offered IV morphine, refused. Had 10mg with NIAS pre hospital.	Y

Trust response to investigation enquiries

15. The Trust provided statements from the Consultant Physician and the Lead Nurse who signed the care plan dated 19 June 2014. The Consultant Physician stated he

has treated the complainant on many occasions over the past 12 years, mostly in connection with his coronary artery disease recurrent angina and pacemaker. The Consultant Physician explained that the A&E department of Causeway Hospital works as a discreet unit and its officers work under the direction of the Consultant Emergency Physicians. As a physician, his team are only involved if the A&E staff have made a referral to the medical team for consultation or admission. He recalled that in 2014 in response to a complaint made by the complainant, he drafted a letter to A&E staff indicating that if the complainant presented to A&E with protracted chest pain then he recommended that he should be admitted to CCU where staff are aware of his severe coronary artery disease. The Consultant Physician added that *'in keeping with good medical practice we did stress to [the complainant] that we would advise small doses of opiate analegesic initially. It was made clear that large doses would be inappropriate initially as they could have serious unwanted side effects primarily on his respiration. Additionally the Clinical Services Manager explained clearly that at times when the hospital was experiencing high occupancy, [the complainant] might be admitted to another ward such as a medical ward if a CCU bed was unavailable. It is my recollection that he accepted that this could happen.'*

16. The Lead Nurse stated that as a nurse, she would not be responsible for prescribing analgesia as this is a medical decision taken by the doctor. She stated she was aware of the medical plan agreed by the Consultant Physician in an attempt to resolve the complainant's concerns regarding his pain relief. She stated she discussed this plan with the complainant on a number of occasions and advised him that the analgesia is a medicial decision. She also told him that the Consultant Physician agreed a plan for analegesia for admission to CCU if admission to hospital was required for cardiac pain.

17. In relation to this care plan and the administration of morphine, the Trust stated this guideline states that the complainant should be given an analgesic if required. It suggested a dose of intravenous morphine as an example. The Trust added *'however prescribing morphine is a clinical decision based on this guideline; it does not mean that morphine will be indicated on every attendance.'* In relation to why the complainant was not always admitted to CCU, the Trust stated this is a clinical decision taking into account the history, relevant investigations and the requirement

for a CCU bed is made on this basis. The Trust added that CCU beds are allocated to patients with conditions including but not restricted to evidence of a myocardial infarction, serious heart arrhythmias, severe heart failure and unstable blood pressure. A CCU bed is also kept for the immediate care of patients who have undergone stroke lysis. The Trust stated although the complainant had multiple attendances with chest pain, few of them exhibited evidence of any of these conditions.

18. The Trust acknowledged the creation of the care plan is not usual practice. However in difficult clinical situations a care plan is useful in guiding decision making particularly for junior medical staff out of hours. The care plan arose from a meeting with the complainant in 2013 at his request and was an attempt to resolve some of his issues. The Trust acknowledged *'on hindsight an attempt to put in place guidance for staff in managing a complex clinical situation created as many problems as it solved. This care plan created an expectation in [the complainant] of the care he would receive in attending the hospital. (Intravenous opiates and a bed in CCU) his subsequent behaviour appears to be driven by frustration when these expectations were not met and created what to him were inconsistencies in his care from attendance to attendance. The care plan did not override the need to assess [the complainant's] attendance on its merits. There are many causes of chest pain. If the care plan was followed rigidly this would have created risk to him. There is evidence that in 2014 it resulted in opiate toxicity. The administration of powerful analgesia should be based on clinical judgment. This has been explained to him on many occasions. There is limited capacity in CCU. Patients must be admitted to this high dependency area based on clinical need. To create an expectation of direct admission is wrong.'* The Trust confirmed there was no review of the care plan or examination of its efficacy.

19. In relation to the guidelines for administration of Diarmorphine, the Trust stated it is used in cardiac chest pain including angina and acute myocardial infraction. It is given in 2-3mg doses until effective and it is used in patients with high pain scores for any reason in A&E. The Trust stated the main side effect is central nervous system depression with respiratory compromise. Once given patients are monitored closely for a period of time to assess for this complication. The Trust added that as a

powerful opiate there are long term risks of developing tolerance and addiction. The Trust confirmed that a patient's pain score is a consideration when prescribing analgesia. There is a ladder of analgesia based on pain scores starting with simple analgesia such as oral paracetamol working up to intravenous opiates. The Trust referred to a departmental guideline which was last updated in 2015.

20. The Trust stated there was an awareness of the complainant's reliance on morphine and in March 2014 there was a concern he had been given opiates to the point of overdose. In the past he was prescribed low doses of oral opiates (Oramorph) to help with his symptoms. The Trust stated an action arising out of this was the introduction of the guidelines by the Consultant Physician and one of the reasons he was referred for a nerve stimulator was to reduce his reliance on opiates as a form of analgesia. The Trust clarified that there was no active decision to stop administering diamorphine after October 2015 when the spinal cord simulator was introduced and the care plan remained in place.

21. In relation to Dr A's examination on 17 December 2015, I noted a letter from the Trust dated 10 February 2016 in response to the complaint. The Trust acknowledged to the complainant that Dr A had not recorded his examination in his notes and he personally apologised if this was the case. The Trust indicated it will speak to the doctor in this respect. In response to further enquiries seeking clarification on this issue, the Trust acknowledged there is not a detailed examination recorded in the records available however there is a list of vital signs. The Trust stated Dr A appears to not have documented listening to the heart sounds or lungs or an examination of the abdomen etc. The Trust added this would be considered good practice and would have been expected to be recorded in the notes.

Relevant Independent Professional Advice (IPA) (including the Trust's response to IPA)

22. In relation to the A&E staff's approach to the care plan, the IPA advised that *'For patients with complex medical conditions or where symptom management is difficult*

or requires a specific protocol it is reasonable for the specialist team, in discussion with the patient and other clinicians involved in the care of the patient, to provide a care plan. This may be for emergency presentations or as a general guide on the management of an uncommon or difficult to control symptoms or condition. It is a guidance documents and should be considered in association with the clinical findings of the patient assessment on each presentation. Whilst those doctors and clinical staff should be made aware of such protocols for individuals, it does not remove the need for a thorough clinical assessment and evaluation on each occasion which will inform the most appropriate course of treatment.' The IPA referred to the Consultant Physician's complete statement in the care plan which states *'<u>When</u> the complainant requires opiate analgesia it is appropriate to administer diamorphine…'* which implies that an appropriate opiate to use, in the Consultant Physician's opinion, is diamorphine. The IPA advised the statement indicates *'Should he be in severe pain and require opiate medication 2.5mg would be a suitable does to start treatment, it does not state that it is the only analgesia suitable for his statement though earlier in the guidance document the Consultant Physician states that an appropriate dose of opiate analgesia is usually effective'…*

23. The IPA noted there are several occasions where the arrival pain score reported by the complainant was 6/10 and the A&E guidance document recommends oral paracetamol/ibuprofen and codeine as appropriate first line analegesia for such a pain score. The IPA advised *'On this basis staff would appear to be following the Emergency department guidance on pain relief – this protocol is in common use in emergency departments. (WHO pain ladder).'* In relation to the recommendation for admission to CCU, the IPA advised *'Admission is based on the clinical need of the individual and a patient who has a long-standing condition but presents without acute features of concern would not displace another patient from the bed on coronary care simply because of a guidance note. It appears that [the complainant] has taken very literally the guidance for the clinical teams prepared by the Consultant Physician and has not accepted the clinical assessment of those treating him the during acute episodes.*
    I consider the Trusts interpretation and response to have been reasonable.'

24. In relation to the complainant's various attendances to A&E when he did not receive diamorphine, the IPA advised *'I would agree with the trust that it is a clinical decision for each presentation as to what analgesia is felt to be appropriate. Whilst pain and pain scores are somewhat subjective and do vary between individuals the Emergency department pain management protocol does give staff a safe method to manage painful symptoms that patients are experiencing. From my review of the medical records provided and based on the pain scores recorded it appears that 'appropriate' analgesia was initially offered for the level of pain reported at the time (the analgesia offered was in accordance with the WHO analgesia ladder). On occasion some medications were unavailable (e.g. 19/8/2015 Tramadol not available in the emergency department but patient reported pain as 'bearable' and offered co-codamol instead. On another occasion (4/6/2015) it is noted that [the complainant's] pain had eased at the time of assessment thus no additional analgesia was prescribed. Whilst on these attendances the analgesia provided was not diamorphine as [the complainant] had expected, in my opinion and based on the documentation in the medical notes it does follow reasonable standards in so far as pain score were generally documented or there was a comment about level of pain being experienced at the time of assessment with subsequent prescription for analgesia in keeping with the pain management document previously referred to.'*

25. The IPA further advised *'In general [the complainant] has been prescribed analgesia in accordance with the trust pain management protocol which is in line with WHO pain ladder standards. I can find no suggestion that medication has been actively withheld. NICE guidance on the immediate management of suspected acute coronary syndrome recommends that patients are offered pain relieve as soon as possible. The advice suggests GTN may be adequate but offer Intravenous opioids if an acute myocardial infarction is suspected. If the attending clinician did not suspect an acute MI it is not unreasonable that they considered other analgesia first, of note NICE does not specify diamorphine as the appropriate drug of choice for chest pain.'*

26. In relation to whether the complainant ought to have been admitted to CCU on 19 August 2015 and 17 December 2015, the IPA advised *'There is nothing in the medical notes documented by the emergency department team or the cardiology team to suggest that his care was in any way compromised by not being on the*

coronary care unit. Whilst the Care plan initiated by the Consultant Physician suggests coronary care was an appropriate location for admission as the team there know [the complainant's] case well, this is not an absolute requirement during any admission. The limited number of beds within any coronary care unit means that the clinical need of patients is the determinant on who is admitted to the unit. On 17 December 2015 the attending clinician felt that [the complainant's] symptoms did not require admission and subsequently discharged him home from hospital directly from the emergency department. This is not an unreasonable course of action if there is no acute clinical reason to admit him to hospital at that time. Whilst [the complainant] may feel admission was needed, based on the clinical assessment, examination and investigation findings the attending doctor did not think admission was required. This is reasonable.'

27. In relation to the treatment the complainant received on 17 December 2015, the IPA noted his pain score was 6/10 and he was seen by the doctor within the recommended timeframe. The IPA noted the complainant was prescribed Codeine 60mg orally at 1.05. The IPA advised *'If using the Trust pain management guideline then codeine is appropriate analgesia to offer [the complainant] as his arrival pain score was recorded as 6/10. However, of note this analgesia was prescribed around 2 hours after the assessment on arrival. It is not clear what his pain score at the time the medication was prescribed or whether he remained in moderate pain. The doctor was aware that he had received morphine and IV paracetamol with the ambulance crew and that there was a longstanding cardiology agreed plan when the complainant had severe pain. On this basis it would suggest that Dr A did not consider [the complainant] to be in severe pain thus prescribed analgesia appropriate for 'moderate pain.'*

28. In relation to Dr A's examination on 17 December 2015, the IPA advised *'On 17 December 2015, [Dr A] has not recorded the details of his physical examination of the complainant. A set of observations have been documented in the medical notes but there is no information about the findings of the examination which took place. It would be normal practice for the attending doctor to record the findings of their physical examination even if they were normal as this is equally as important to record as abnormal findings.The findings from the ECG, Chest radiograph and blood*

investigations have been recorded and were not suggestive of an acute cardiac problem.' The IPA further advised *'As a result of there being no record of the physical examination findings it is impossible to comment as to whether the examination was conducted to a reasonable standard. More significantly, as medical notes are considered to be recorded contemporaneously many consider that not documenting something is the same as not doing it. Whilst this may not be true, there is no record of the physical examination that took place as a result there is no written evidence that [Dr A] assessed [the complainant's] heart or chest. I would have expected more details of the physical examination to be recorded in any patient presenting with chest pain. I therefore cannot conclude that the record of the clinical assessment is of an acceptable standard.'*

29. The IPA further advised *'However, from the information that is recorded in the medical notes – the repeat Troponin investigations as part of the assessment to exclude significant cardiac disease. It appears that [Dr A] had evaluated [the complainant] to a level that he was able to identify that an acute cardiac event needed to be excluded. This was done with appropriate investigations and as the results were normal it was not unreasonable to consider discharge from hospital as an option for a patient with a recurrent condition provided symptoms were now controlled and ongoing treatment/ medication could be administered out of hospital. As a result, I do not consider that the failure to record physical findings of the clinical examination following assessment impacted on the outcome of the attendance or the ongoing management of [the complainant].'* The IPA was therefore satisfied that the decision to discharge the complainant home was not unreasonable and concluded the care and treatment on 17 December 2015 was of a reasonable standard.

30. In relation to learning arising from this complaint, the IPA advised *'The trust should ensure that any such documents are clearer and ensure the patient has had an adequate explanation of why the advice has been put in place. Medical staff should ensure documentation of medical records is adequate and include examination findings (positives and negatives) to demonstrate the complete assessment to their patients. In addition, where patients who present with pain are being discharged it is important to document a reassessment of the pain score to ensure symptoms have*

been effectively managed prior to discharge. Similarly, if discharging a patient who has presented with painful symptoms there should be documentation of the advice given to the patient about ongoing symptom management, analgesia advised of prescribed etc.'

31. The IPA concluded that *'[the complainant] has an extensive medical history with complex management problems. He has undergone specialist intervention to help manage his pain. The Emergency department has been provided a guidance document about his care from his long-term cardiologist. It is clear that [the complainant] has a very specific interpretation of this guidance, though I consider this is different to the intention in with which it was written by the Consultant Physician.'*

32. The IPA's advice was shared with the Trust for comment. The Trust stated the IPA was reasonable and balanced and broadly reflects correspondence to date. In response to the draft report, the Trust stated it welcomed the findings and acknowledged that there were no failings in the care provided to the complainant. The complainant stated all he wanted from the outset was a handshake and apology from the Trust for the failure of Dr A to record his examination. The Trust indicated it was willing to do so.

Analysis and Findings

33. This investigation has considered the complainant's various A&E attendances between January 2015 and 10 May 2017. In the majority of occasions the complainant did not receive diamorphine in A&E but was admitted to CCU. I also note that the complainant received morphine by the ambulance service on many occasions on route to A&E and upon arrival at A&E was given other forms of analgesia. I acknowledge that this has resulted in him obtaining the belief that there was an inconsistent approach to his care and treatment in contravention of the care plan.

34. The Trust has stated that although the care plan remained in place, the decision to administer morphine is a clinical decision based on clinical presentation on each attendance. However it accepted in hindsight that the care plan created more problems than it solved due to the complainant's interpretation of it which has caused him frustration. I accept the advice of the IPA that the Trust's interpretation and response to the care plan has been reasonable. The IPA has sought to explain that the intention behind the Consultant Physician's care plan was to provide advice on appropriate pain relief, when it was felt to be required. I am satisfied that it was therefore intended as a guide for junior A&E staff and was written by a doctor who knew the complainant and his symptoms very well.

35. In relation to his various A&E attendances, the IPA was satisfied that the complainant was prescribed analegesia in accordance with Trust protocols and NICE guidance, which does not specify diamorphine as the appropriate drug of choice for chest pain. The IPA has therefore not identified any failings in relation to the pain relief prescribed to the complainant at each of his attendances. The IPA was also satisfied that it was reasonable not to admit the complainant to CCU on 19 August 2015 and 17 December 2015. I therefore accept the advice of the IPA in this regard.

36. In relation to Dr A's examination on 17 December 2015, the IPA has advised that Dr A prescribed the complainant anagelsia appropriate for moderate pain and the decision to discharge him was not unreasonable. I therefore accept this advice. In relation to the record of his examination, the IPA has advised it would be normal practice to record the findings of a physical examination even if the results were normal. Due to the lack of record of such an examination, the IPA could not conclude that the record of the clinical assessment is of an acceptable standard. However the IPA did not consider that the failure to record physical findings of the clinical examination impacted on the outcome of the attendance or ongoing management of the complainant. As the Trust has acknowledged this failing, indicated that it would speak to Dr A, and apologised directly to the complainant in response to his complaint, I do not intend to make a finding on this issue.

37. In conclusion, I have not identified any failings in the care and treatment of the complainant during this period. However I would suggest the Trust considers the learning identified by the IPA, in particular regarding ensuring such care plans are

clear and an adequate explanation provided to the patient. The IPA also highlighted the importance of ensuring documentation of medical records are adequate and include relevant examination findings and also include a reassessment of pain scores. Overall I consider the care and treatment provided to the complainant by the A&E Department at Causeway Hospital was in accordance with good medical practice. I therefore do not uphold this issue of complaint. While I do not uphold the complaint, I would suggest the Trust also considers reviewing the care plan with the complainant so that there is a shared understanding of his treatment going forward.

CONCLUSION

I have investigated the complaint and have not found any evidence of a failure in the care and treatment provided by the Trust to the complainant. I do not uphold the complaint.

PAUL McFADDEN
Deputy Ombudsman

2 January 2020

Appendices

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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