Investigation Report

Investigation of a complaint against

NIPSO Reference:

The Northern Ireland Public Services Ombudsman
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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: 202000354
Listed Authority: South Eastern Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) at the Ulster Hospital (the Hospital) following the patient's admission on 6 December 2019 until the patient sadly passed away on 15 December 2019. The complainant said that she considered her father ought to have been more appropriately prioritised for surgery in the Hospital's theatre list, given his age, medical history and level of pain. In addition, the complainant said that her father did not receive sufficient pain relief at appropriate times, which resulted in him being "*left to suffer*" in pain.

The investigation examined the details of the complaint, the Trust's response, and relevant local and national guidance. I obtained independent professional advice from a Consultant Orthopaedic and Trauma Surgeon and a Consultant in Pain Medicine.

Having considered the advice of the independent advisors, the medical records, and relevant standards and guidance, the investigation did not find a failing in the care and treatment the Trust provided to the patient. However, it was identified that the Trust's communication with the complainant regarding the factors taken into consideration when prioritising the patient for surgery could have been clearer. It was also identified that the Trust could have communicated with the complainant about why a syringe driver was not going to be used as part of the management of the patient's pain.

Therefore whilst the complaint was not upheld, it was nonetheless highlighted that the Trust ought to reflect on these points of learning.

THE COMPLAINT

1. This complaint is about the care and treatment the South Eastern Health and Social Care Trust (the Trust) provided to the complainant's father (the patient) at the Ulster Hospital (the Hospital) from 6 December 2019 until the patient sadly passed away on 15 December 2019. The first aspect of the complaint relates to the Trust's prioritisation of the patient for surgery. The complainant said that she considered her father ought to have been more appropriately prioritised given his age, medical history and level of pain. The second aspect of the complaint relates to the Trust's management of the patient's pain. The complainant said that her father did not receive sufficient pain relief at appropriate intervals during his time in Hospital.

Background

2. The patient, a gentleman aged in his 90s, had been living with Alzheimer's disease[1]. The patient resided in a nursing home. On 6 December 2019 the patient was admitted to the Hospital after falling in the nursing home. At the Hospital it was determined that the patient had broken his hip and would require surgery. The patient's surgery took place on 11 December 2019. The patient sadly passed away on 15 December 2019.

3. The complainant raised a complaint to the Trust on 28 December 2019 about the care and treatment the Trust provided to the patient. The Trust responded by letter dated 6 August 2020. The complainant was dissatisfied with this response, and so the Trust re-opened the complaint on receipt of an email from the complainant dated 6 September 2020.The Trust provided its final reply to the complainant on 30 September 2020.

[1] A progressive neurologic disorder, and the most common form of dementia, which results in a continuous decline in thinking, behavioural and social skills that affects a person's ability to function independently.

Issue of complaint

4. The issue of complaint accepted for investigation was:

Was the care and treatment provided to the patient by the Trust following the patient's admission to the Ulster Hospital on 6 December 2019 reasonable, appropriate and in line with relevant standards?

This issue will consider;

- Whether the patient was appropriately prioritised for surgery; and
- Whether the patient was given appropriate pain relief at appropriate intervals.

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues raised by the complainant. Documentation gathered included information relating to the Trust's handling the complaint.

Independent Professional Advice Sought

6. Independent professional advice was obtained from the following independent professional advisors (IPAs):

- **Consultant Orthopaedic and Trauma Surgeon (OT IPA)**, MB, ChB, FRCS, FRCS (Tr/Ortho), with over 25 years' experience in the role.
- **Consultant in Pain Medicine (PM IPA)**, with extensive experience in pain management.

The clinical advice received is enclosed at Appendix three to this report.

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

Relevant Standards and Guidance

8. 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. I also make reference to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[2]:

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

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 those individuals whose actions are the subject of this complaint.

   The specific standards and guidance relevant to this complaint are:

   - The National Institute for Health and Care Excellence (NICE) Quality Standard for Hip Fracture in Adults, March 2012 (NICE Quality Standard);
   - South Eastern Health and Social Care Trust Guideline on the Management and Prescribing of Analgesia in Adult Patients presenting with a Fractured Neck of Femur (NoF); SET/Guide (12) 2017, April 2017 (2017 Trust Guideline);
   - South Eastern Health and Social Care Trust Guideline on the Use of the T34 Syringe Pump for Adult Palliative Patients; SET/Guide (83) 2019, November 2019 (2019 Trust Guideline); and
   - Acute Pain Service's Acute Pain Microguide App, published by 'MicroGuide' in 2018 (MicroGuide App).

10. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that I took into account everything I consider to be relevant and important in reaching my findings.

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

11. 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. Both the complainant and the Trust responded to my Office to confirm that they had no further comments to make. These positions were taken into consideration when I finalised this report.

THE INVESTIGATION

Was the care and treatment provided to the patient by the Trust following the patient's admission to the Ulster Hospital on 6 December 2019 reasonable, appropriate and in line with relevant standards?

Detail of Complaint

12. The complainant raised the following concerns regarding the care and treatment the Trust provided to the patient following the patient's admission to the Hospital on 6 December 2019:

    - That the patient had not been appropriately prioritised for surgery by the Trust, which resulted in a delay in the patient receiving his surgery. The complainant explained that during the period 6-11 December 2019, the patient's family took steps to find out why there was a delay in the patient receiving his surgery. The complainant said that the family were told there had been an unexpectedly high number of admissions with fractures around the same time as the patient's admission. The complainant said that when the family asked how the patients were being prioritised, they were given conflicting information – being told on the one hand that prioritisation was based on order of admission to the hospital, whilst being told on the other hand that prioritisation was based on clinical need. The complainant's position was that given the patient's age, his Alzheimer's disease, and level of pain, he ought to have been prioritised higher in the surgery list, irrespective of the order of admission.

- That the patient was not provided with suitable pain relief at appropriate intervals during his time in the Hospital – both before and after surgery. The complainant explained that she felt the medication dosages administered to the patient ought to have been increased at an earlier stage, given the patient's continued pain. The complainant queried why the dosage of Longtec[3] in particular was not increased more quickly when the patient continued to be in pain. The complainant also considered that a syringe driver[4] ought to been considered for the patient, given the level of pain being experienced.

Evidence Considered

Legislation/Policies/Guidance

13. I refer to the following policies and guidance which were considered as part of investigation enquiries:
    - NICE Quality Standard
    - 2017 Trust Guidance;
    - 2019 Trust Guidance;
    - 'MicroGuide' App.

    Relevant extracts from the above are enclosed at Appendix four of this Report.

The Trust's response to investigation enquiries

Prioritisation for Surgery

14. The Trust stated in its response to the original complaint that the surgery was "*unable to be carried out earlier*" due to the "*unusually high number of patients admitted with fractures, who also required an operation*". The Trust subsequently stated this number to be seven individuals, excluding the patient – and that the average number of patients to be admitted with a fracture in a given day was usually four.

[3] A pain-reducing drug belonging to the opioid family designed to relieve moderate to severe pain over a period of 12 hours.
[4] Also known as a syringe pump – small infusion pump used to gradually administer a steady stream of medication through a small plastic tube under the skin – often used in palliative care for cancer patients.

15. The Trust went on to state that there are only a certain number of theatre slots available each day, and that the Trust "*tries to allocate these sessions in a fair manner according to the needs of individual patients, the type of surgery required and the length of time each patient has to wait*". The Trust said that there were 31 individuals awaiting surgery at the time the patient was admitted, six of whom had injuries "*similar*" to the patient. The Trust went on to say that it typically treats 30 individuals for fractures each month, but that in December 2019 the total was 48 – and that 18 of those were admitted during the period 1-6 December 2019. The Trust stated that "*all fracture injuries are considered urgent and therefore must be prioritised to ensure surgery is carried out as timely as possible*". In terms of how individuals are prioritised, the Trust said that "*patients are prioritised in chronological order and also by clinical need*" – and that some patients require "*optimisation*" to ensure they are as "*fit as possible*" to undergo surgery. The Trust stated that "*this preoperative work*" can impact upon surgical priority. The Trust said that the patient "*was taken to theatre on the first available slot*".

16. The Trust went on to say that the patient was initially listed and prepared for surgery on the afternoon of 10 December 2019, but was not attended to that day in the end due to other operations taking longer "*than expected*". The Trust acknowledged during the internal complaints process that its communication with the patient's family in this respect had been "*poor*". It also acknowledged during the internal complaints process that the wait the patient endured was not the standard the Trust wishes to "*aspire*" to – but stated this was due to the high volume of patients admitted with fracture issues at the time of the patient's admission.

Pain Management

17. The Trust stated that the patient received Paracetamol[5], Codeine Phosphate[6] and Shortec[7] regularly during his time in Hospital - in accordance with a "*stepwise approach*[8]", which recommends that "*simple analgesics are routinely*

[5] A medication used to treat fever and mild to moderate pain.
[6] A drug in the opioid family used to treat pain, cough and diarrhea.
[7] A medication used to treat moderate to severe pain in patients with cancer, but also for post-operative pain.
[8] Therapy in which the dose and number of medications and frequency of administration are increased as necessary and decreased when possible in order to achieve and maintain control.

administered every six hours for pain relief in elderly patients with hip fractures". The Trust said that the aim of this approach is to avoid "*serious side effects of opioid use*" in elderly patients.

18. In addition, the Trust stated that the patient was reviewed for pain relief on 7 December 2019 at 16.45 following the complainant's query to a nurse. The Trust said that upon review, 5mg of Longtec was administered to the patient. The Trust said that the dosage was kept to 5mg due to concerns regarding the impact of the drug on the patient's kidneys. The Trust went on to say that a doctor reviewed the patient again on 8 December 2019, at the request of a nurse who noted the patient was in "*severe pain*". On this occasion, a 5mg dose of Shortec was administered to the patient, followed by a 5mg dose of Oxynorm[9] later that day. The Trust said in its reply that the doctor noted his concerns regarding potential opioid toxicity[10], and that this had been explained to the family. The Trust stated that elderly patients are at "*greater risk*" of opioid toxicity – which can affect the function of organs, cause a person to stop breathing or cause a person to lose consciousness. The Trust stated that it was on this basis that the dosage of Longtec was gradually increased.

19. The Trust went on to say that on 9 December 2019 staff noted the patient remained in pain, and a doctor recommended that the patient be referred to the Acute Pain Team. The Trust acknowledged during the internal complaints process that the referral was not made until the 10 December 2019, and apologised for that delay. The Trust stated that learning from this failing contributed to the development and introduction of the MicroGuide App (please see Appendix four for details). The Trust said that on 10 December 2019 the dosage of Longtec was increased to 10mg, and was administered to the patient at 22.00.

20. In terms of pain medication for the surgery, the Trust said that the patient was given a "*regional nerve block*", and was then given a combination of Paracetamol, Shortec and Longtec in the immediate aftermath. The Trust said

[9] A strong liquid painkiller containing Oxycodone, belonging to the opioid family designed to relieve moderate to severe pain.
[10] Side-Effect of opioid drugs which can lower the breathing rate to a dangerous level

that on 12 December 2019 the dosage of Longtec was increased to 15mg. The Trust acknowledged during the internal complaints process that a doctor discussed with the complainant pain relief via syringe driver – but that this option was not proceeded with on the basis that they are "*not routinely used for patients awaiting hip fractures. They are most commonly used for patients receiving palliative care, particularly where patients have multiple, complex symptoms*". The Trust further stated that not all painkillers can be administered via syringe driver.

21. The Trust's chronological breakdown of the medication administered to the patient is contained as Appendix five to this Report.

Relevant excerpts from medical records

22. Relevant excerpts from the patient's medical records are enclosed at Appendix six to this Report.

Relevant Independent Professional Advice

Prioritisation for Surgery

OT IPA

23. I referred the OP IPA to the Trust's position that it bases its decisions regarding priority for surgery on several factors – these being the time of the patient's admission to hospital, clinical need, and optimisation for surgery. The OT IPA advised that adopting these factors to determine surgical prioritisation is "*consistent with accepted procedure and guidance*".

24. In terms of clinical need specifically, the OT IPA advised that when assessing this, the Trust ought to take into consideration if the patient is medically fit for surgery, if they have been admitted to the "*appropriate ward*", and have been "*optimised*" for surgery. The OT IPA advised that the assessment of the patient's clinical need in this case had been reasonable, appropriate and in line with relevant standards.

25. In terms of optimisation for surgery, the OT IPA advised that optimisation includes considering if a patient is medically fit from a "*cardio-respiratory (heart*

and lungs) viewpoint with normal blood tests and hydration". The OT IPA further advised that "*I have no concerns about the patient's optimisation for surgery*".

26. The OT IPA advised that in addition to assessing clinical need and optimisation of the patient themselves, the Trust must also consider the availability of a theatre and staff for the surgery itself, and the availability of a ward place post-surgery for the patient to return to.

27. The OT IPA advised that the Trust had "*optimised the patient quite early after his admission*" and that the delay in the patient receiving surgery was "*related to other factors such as high volume of admissions and difficulty with available theatre time*". The OT IPA further advised that it had been difficult for the Trust to "*fit this patient in*" given the other individuals requiring surgery, and who required surgeons with a "*particular speciality*". However, the OT IPA also advised that "*placing this patient earlier or indeed first on a theatre list would not have been unreasonable*".

28. The OT IPA advised that "*most of the management of the patient including optimisation and the actual surgery itself seems to have occurred most satisfactorily*". The OT IPA clarified this by advising that despite the Trust's management of the patient being in line with relevant standards, "*a prioritisation early on the theatre lists on the Monday or Tuesday (3 and 4 days after admission) should have been considered*". On this point, the OT IPA also advised that, having reviewed the theatre lists for the Monday and Tuesday (included in this report at Appendix seven), he felt it was "*very likely*" that the patient would "*fall off the end of the list*" due to delays in other surgeries. Nonetheless, the OT IPA advised that "*a prioritisation earlier on one of these lists may have been desirable*" for the patient.

29. The OT IPA advised that irrespective of when the surgery took place "*it is likely the outcome would have been the same*", and that "*the situation is unlikely to have been helped by earlier intervention*". However the OT IPA advised that

"*earlier surgery would have helped in pain relief for the patient and allowed easier and more effective nursing care*".

30. The OT IPA subsequently clarified that consideration of prioritising the patient for surgery on the Monday or Tuesday was "*optional*" and a matter of "*discretion*" for the Trust. The OT IPA further clarified that deciding not to exercise that discretion did not result in a failure to meet relevant standards on the Trust's part.

Pain Management

P IPA

31. The P IPA advised that the patient's medical history included "*dementia, chronic kidney disease and alcohol abuse*" – and that this history was an important factor to be considered when administering analgesia - being pain relief medication.

32. The P IPA advised that "*there was a significant clinical input*" regarding "*assessment of pain*" and "*attempts at pain relief*" with "*the use of various agents including various forms of Oxycodone (which is a powerful oral analgesic) and Paracetamol*". The P IPA further advised that drugs administered included IV Paracetamol, PR codeine, Shortec, and Longtec, which the IPA advised were administered at various stages and, at times, within the same day.

33. The P IPA referred to 8 December 2019 specifically and advised that on that day, the Trust administered Paracetamol and Longtec and that there was "*repeated administration of various analgesic agents along with evidence of continual assessment of* [redacted]*'s condition through this period*".

34. The P IPA advised that "*at times, analgesics seemed to cause a reported relief of symptoms and at other times it was reported that the relief was short-lived*" or that the patient "*remained restless and agitated*".

35. In terms of the administration of analgesia, the P IPA advised that there is a "*wide variation in analgesic response*" between patients, and that how a

particular patient will respond to a drug is "*not predictable*". The P IPA went on to advise that factors such as a patient's "*age*", "*co-morbid conditions*", and their "*history of drug tolerance*", including alcohol, can impact upon a patient's response to analgesia.

36. The P IPA advised that "*older patients are more likely to be very sensitive to drugs, especially if they have co-morbid conditions such as Dementia*". The P IPA further advised that for patients who live with conditions such as Dementia, the administration of analgesia, together with the side effects of treatment "*may make them difficult to assess as whether they are responding*". The P IPA went on to advise that "*the side effect of confusion from dementia can mean an inadequate dose in the day time can lead to respiratory depression and confusion in the evenings and night time*". The P IPA advised that, as a result, "a*chieving the ideal dose can be very difficult, and at times impossible*".

37. The P IPA advised that patients who have a high tolerance to alcohol may be "*unexpectedly more resistant*", or that their "*bodily systems cannot cope with the drugs and they become more sensitive*" depending on their circumstances.

38. The IPA advised that as a result of these factors "*the correct clinical approach to follow when somebody is in pain following an acute injury is to assess their response to smaller doses of opioid*". The P IPA went on to advise that "*this can be done by firstly giving short acting agents, lower strength and then subsequently slowly increasing*". The P IPA further advised that "*the presence of chronic kidney disease*" in the patient "*will delay the metabolism and excretion of such analgesics*". As a result, administration of analgesia "*has to be done slowly and over a number of days due to build up in the body which can cause late side effects*". The P IPA advised that "*a typical course of action is to initially provide short acting analgesic agents and slowly (and cautiously) increase the strength and convert the short acting into longer acting agents*".

39. The P IPA advised that "*one has to be mindful that during this period, chances of opioid induced depression and cognitive dysfunction are always present*" and that "*risks are higher in the elderly and at night*" and in those "*limited by cognitive impairment*" such as dementia.

40. Regarding the administration of Longtec specifically, the P IPA advised that "*there is always going to be variation on how quickly one reviews after one gives oral agents such as Oxycodone, in the form of Shortec or Longtec*". The P IPA went on to advise that this is because the drugs can build up in a patient's body, and effects can vary between patients. The P IPA further advised that *"it is typical to wait, in an older patient, up to half a day to a day before considering increasing a dose of a short acting opioid and up to two days before considering the dose of a long acting opioid*". The P IPA advised that in making a decision regarding an increased dosage, clinicians ought to consider whether the patient had "*responded appropriately*" to a previous dose, if the patient had any history of "*not responding to a particular level of analgesic administration*" and whether there had been any "*variability*" in previous responses. The P IPA advised that where there had been variability, a clinician should proceed more cautiously. The P IPA further advised that variability is a "*significant problem*" when treating "*the elderly*" and "*those suffering from dementia*".

41. The P IPA advised that "*there were times*" when the patient "*seemed to respond to the doses given and other times he did not*". The P IPA went on to advise that he did not think in the patient's circumstances, "*including the history of dementia, his age and kidney disease*" that the "*dose of analgesics given, could have been given any quicker*". The IPA further advised that "*the drugs chosen, were in my view entirely appropriate*". The P IPA advised that "*the only way to safely administer*" pain relief to the patient was to "*assess repeatedly and administer increases in doses cautiously and slowly*". The P IPA went on to advise that "*the record suggests that this approach was carried out in a clinically appropriate manner*".

42. Regarding the use of a syringe driver specifically, the P IPA advised that a syringe driver "*gives a fixed continuous dose of analgesic*" to a patient. The P IPA went on to advise that pain levels in the perioperative period vary from "*a lot of pain initially, then settling and then an increase in pain when an operation has occurred*". The P IPA advised that the fixed and continuous dose administered by a syringe driver does not "take into account what is happening

to the patient", and that it will "*continue to administer opiates*" irrespective of physical changes in the patient. The P IPA further advised that this happens even if the patient becomes comatose, or develops "*poor breathing*". As a result, inappropriate use of a syringe driver can lead to "*very dangerous situations and death by overdose*". The P IPA went on to advise that as a result, "*syringe drivers are unlikely to be used in this type of setting*", and that it would be "*considered clinically inappropriate*" to do so. Instead, they are used "*in the palliative care setting*" where "*considerations of relative overdose are considered to be clinically of less or no concern*".

43. The P IPA advised that a syringe driver "*should not have been used in this case*", and that it would have been "*inappropriate*" to have done so. The P IPA further advised that "*clinicians providing syringe drivers in these settings have been criticised*". The P IPA advised that he would have been "*very critical*" if a syringe driver had been used to treat someone who it was hoped *"would recover*", such as the patient.

44. Regarding the Trust's management of the patient's pain, the P IPA ultimately advised that "*there does seem to be from the medical notes regular assessments and administration of analgesia, which in my view is appropriate, given his age, injury and medical background*". The P IPA further advised that "*I have no clinical concerns in this case*" and that "*I do not find any clinical failings on the part of the Trust in management of this patient's pain*".

Analysis and Findings

Prioritisation for Surgery

45. The complainant was concerned that the Trust had not appropriately prioritised the patient for surgery. The complainant's position was that given the patient's age and his Alzheimer's disease, that he ought to have been listed for surgery at an earlier date than he was. The complainant also considered that the Trust had given her conflicting rationales regarding how patients are prioritised for surgery when she raised concerns about this whilst the patient awaited surgery. The complainant's position was that at times she was told that prioritisation was based on clinical need, and at other times on order of hospital admission.

46. The Trust's position was that the patient was correctly prioritised and underwent surgery at the earliest opportunity, given the number of patients admitted to hospital before the patient who also required urgent surgery. The Trust identified and acknowledged during the internal complaints process that the patient's wait for surgery was not the standard the Trust wished to "*aspire*" to, and apologised for this.

47. I note the OT IPA's advice that a Trust can adopt a number of factors which together influence a patient's place on a priority list for hip surgery. I also note the OT IPA's advice that the factors the Trust put forward – namely, the time of a patient's admission to hospital, their clinical need, and optimisation for surgery - was "*consistent with accepted procedure and guidance*".

48. Having reviewed all relevant evidence, I am satisfied that the multi-factor approach the Trust adopted for the prioritisation of patients requiring urgent hip surgery, including the patient, at the prevailing time was reasonable, appropriate, and in line with relevant standards. I accept the OT IPA's advice in this respect. However, I consider that the Trust's communication with the complainant regarding how the patient was being prioritised for surgery could have been clearer at the time. If the Trust had been more clear with the complainant at the time that prioritisation was based on a combination of factors, this may have prevented the complainant from feeling that she was being told conflicting information by different staff members. As the patient had been optimised for surgery, the date of surgery was determined by the Trust on the basis of clinical priority and then chronological order was applied to patients of the same clinical priority.

49. In terms of whether the Trust applied these factors in a manner that was appropriate given the patient's age, condition, and medical history, I note the advice of the OT IPA. The OT IPA advised that the Trust's assessment of the patient's clinical need was reasonable, appropriate and in line with relevant standards. The OT IPA was satisfied that the patient had been assigned to the correct ward, been assessed as being medically fit for surgery, and been optimised for surgery – at the relevant time. I accept the OT IPA's advice in this respect.

50. I note the IPA's advice that the patient's wait for surgery was not related to clinical need or optimisation, but was related to the "*high volume of admissions and difficulty with available theatre time*". This advice supports the position the Trust advanced in both the internal complaints process, and in its responses to this Office. I reviewed the data the Trust provided regarding admissions to the Hospital that required hip surgery in the days leading up to the patient's admission, and noted the OT IPA's interpretation of that data. I accept the OT IPA's advice in this respect. I am therefore satisfied that the reason the patient had to wait for his surgery was due to pressures on the surgeons and on theatre availability as a result of the high number of patients also requiring urgent surgery who had been admitted prior to the patient's admission. I also refer in this respect to my previous finding in this report that the Trust's use of order of admission after clinical priority as a factor to determine the order of surgery was in line with relevant standards.

51. The OT IPA's ultimate advice was that the Trust's prioritisation of the patient for surgery was "*satisfactory*". I considered his view that the Trust could, in its discretion, have chosen to place the patient higher on the surgical priority list – so that the patient's surgery could have taken place on Monday 9 or Tuesday 10 December 2019. I share this view given the patients age and pain status. However, I accept that it was a matter for the Trust to choose whether to exercise this discretion – and that there was no policy, guidance or standard in place at the time to require the Trust to use such discretion.

52. I note the OT IPA's advice that, having reviewed the surgical theatre lists for those two days, it was "*very likely*" that the patient would have "*fallen off the end of the list*" on those days due to delays in other surgeries, even if the Trust had exercised its discretion. The use of the discretion to place the patient at the end of the list for the 9 or 10 December 2019 may have led to disappointment for the patient and his family if the Trust was unable to perform the surgery on either of those dates.

53. I reviewed the surgical theatre lists for these two days. I note that only individuals who were admitted earlier than the patient received their surgeries before the patient received his.

54. On this basis, I am satisfied that the Trust did not breach relevant standards when it opted not to exercise its discretion to place the patient higher on the surgical priority list - though I accept this is a very difficult situation for all concerned when an elderly patient in pain has to wait for surgery. I am satisfied that, at the time, the Trust had to balance the competing demands of a high volume of patients, all of whom required urgent surgery of a similar type.

55. I therefore find that the patient was appropriately prioritised for surgery in line with relevant standards in place at the prevailing time. I do however consider that a five day wait for urgent surgery for an elderly patient who was in pain was unacceptable – and I note the Trust's comment that it is not the standard that it would wish to provide for its patients. Unfortunately the patient's experience is not unique and will require concerted effort over a period of time to address the lack of theatre capacity.

Pain Management

56. The complainant was concerned that the Trust had not appropriately managed the patient's pain – both before and after his surgery. The complainant's position was that pain relief had not been administered at appropriate intervals, and that dosages had not been increased as quickly as they could have been. The complainant also considered that the Trust ought to have used a syringe driver to administer pain relief to the patient as he continued to be in pain despite pain medication being given to him.

57. The Trust's position was that the patient received appropriate pain relief at appropriate intervals –and that it would have been potentially harmful for the patient if dosage had been increased at any faster pace. Regarding the syringe driver, the Trust's position was that it would not have been appropriate for this to have been used in the patient's case.

58. I note that P IPA's advice that there had been "*significant clinical input*" in terms of both the assessment of the patient's pain, and the pain medication the patient received. It is accepted by both parties, and identified by the P IPA, that the patient received a variety of medications to manage his pain. This included Paracetamol and Codeine, as well as opioids - being Shortec and Longtec.

59. In terms of the doses, I note the P IPA's advice that these should start small and be increased gradually over a period of hours or days. This is particularly the case where an individual is elderly, living with Alzheimer's disease and kidney disease, has historically had a high tolerance for alcohol, and exhibits varying degrees of responsiveness to prior doses – characteristics present in the patient. This is particularly the case with opioid drugs. I further note the IPA's advice that if doses of these drugs were to be increased too quickly, it could lead to increased confusion for an individual in the patient's position, and potentially further medical complications or even death.

60. I note the P IPA's view that the drugs administered to the patient were "*entirely appropriate*" - and that the interval of drug administration and the doses were "*clinically appropriate*". Having considered the records and the rationale provided by the P IPA I accept this advice.

61. In terms of the syringe driver, I am satisfied that this was discussed with the complainant by a staff member. I am also satisfied that it was not ultimately used in the patient's care. I note the IPA's advice that it would have been "*clinically inappropriate*" for a syringe driver to have been used in these circumstances. I accept this advice. Therefore, whilst I acknowledge that it was the Trust that initially identified the potential of using a syringe driver, I am satisfied that it was the correct decision not to make use of it in this case. However, I consider that the Trust ought to have followed up with the complainant at the time in terms of why the syringe driver was not going to be used. This may have prevented the complainant from feeling that there was an available option that was not being explored to manage the patient's pain.

62. During the internal complaints process, the Trust identified and acknowledged that its referral of the patient to the acute pain team for further analysis could have been more efficient. The Trust apologised for this. I agree with the Trust's assessment, and I commend the Trust for recognising room for learning and improvement in this respect, and for apologising to the complainant for the delay. However, having reviewed the P IPA's advice in detail, and apart from the delay in the referral to the acute pain team, I am satisfied that the Trust's overall management of the patient's pain was reasonable and appropriate. This

is not in any way to undermine the complainants concerns, as it is clear that the patient was in pain and that this was difficult to manage for the clinical team - as outlined in the P IPA's advice. I acknowledge that this would have been very distressing for the patient and the complainant.

Summary of Findings

63. I have found that the patient was appropriately prioritised for surgery by the Trust, and that the Trust's management of the patient's pain, apart from the delay in referral to the acute pain team, was appropriate given his age and medical history. I find, therefore, that the care and treatment the Trust provided to the patient following his admission to the Hospital on 6 December 2019 was reasonable, appropriate and in line with relevant standards.

CONCLUSION

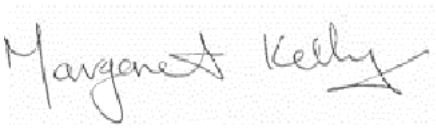
64. I received a complaint about the care and treatment provided by the Trust to the patient following his admission to Hospital on 6 December 2019.

65. The Investigation established that, apart from the delay in referral to the acute pain team accepted by the Trust during its consideration of the internal complaint, the management of the patient's pain and prioritisation for surgery were in line with relevant standards.

66. Therefore, the complaint is not upheld.

67. Nonetheless, I consider that the Trust should reflect on the learning identified in this report regarding the identified elements of its communication with the complainant at the time the patient was in Hospital.

68. Finally, I wish to pass on my condolences to the complainant, and her family, on the death of her father. Throughout my examination of this complaint I fully recognise the evident care and devotion shown by the complainant to ensure that her father received appropriate care and attention. I hope that my report has gone some way to address the complainant's concerns and provide some reassurance for her and her family.



MARGARET KELLY
Ombudsman
19 July 2022

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. **Getting it right**

- Acting in accordance with the law and with regard for the rights of those concerned.

- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.

- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.

- Including complaint management as an integral part of service design.

- Ensuring staff are equipped and empowered to act decisively to resolve complaints.

- Focusing the outcomes for the complainant and the public body.

- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. **Being customer focused**

- Having clear and simple procedures.

- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.

- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.

- Listening to complainants to understand the complaint and the outcome they are seeking.

- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. **Being open and accountable**

- Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.