Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 17755

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
@NIPSO_Comms

Publication date: November 2018

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. She may also investigate and report 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.

Where the Ombudsman finds maladministration or questions the merits of a decision taken in consequence of the exercise of professional judgment she must also consider whether this has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. The Ombudsman may recommend a remedy where she finds injustice as a consequence of the failings identified in her report.

The Ombudsman has discretion to determine the procedure for investigating a complaint to her Office.

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

EXECUTIVE SUMMARY

I received a complaint from a patient of the Southern Health and Social Care Trust. I accepted the following issues for investigation:

- Whether the care, treatment and discharge of the complainant from the Emergency Department of Craigavon Area Hospital on 18 March 2017 was appropriate and in line with accepted standards and guidelines?

Findings and Conclusion

I have investigated the complaint and have found failings in relation to the following matters:

i. The patient's discharge ought to have been delayed
ii. The patient ought to have been moved to an observation ward and not to the waiting room
iii. The ED doctor ought to have established that the patient was well enough to tolerate oral fluids and a light diet.
iv. The patient ought to have been provided with advice to return to the Emergency Department if her nausea persisted and this ought to have been recorded.

I have not found any failings in relation to the patient's complaint that the Emergency Department staff did not know that she had been administered morphine earlier in the day.

I am satisfied that the failures in care and treatment that I identified caused the patient to experience the injustice of discomfort and distress and the time and trouble in bringing her complaint to this Office.

Recommendations

I recommend that the Trust apologies to the patient for the injustice suffered as a result of the maladministration I have identified, and makes a solatium payment of £500 within one month of the date of my report.

THE COMPLAINT

1. The patient complained about the actions of the Southern Health and Social Care Trust (the Trust). The complaint relates to her dissatisfaction with the manner of her discharge from the Emergency Department of Craigavon Area Hospital on 19 March 2017.

2. The patient suffered from migraine headaches. On the morning of 18 March 2017, she was seen by an 'out of hours' doctor. She was taken by ambulance later in the day to the Emergency Department (ED) at Craigavon Area Hospital complaining of a migraine headache, vomiting and diarrhoea. She was registered in the ED at 19.04 hours and, following examination, was prescribed paracetamol and anti-sickness medication and kept under observation before being discharged at 00.40 hours on 19 March 2017.

3. The patient believes she was unfit for discharge because she was still under the influence of morphine which had been prescribed earlier in the day by the out of hours' doctor. She also states that a doctor told her '*she would try to find me a ward to recover in'.* She states she was ordered out of bed by an unnamed male doctor, and that she was wheeled into the waiting area of the ED where she lay sleeping across chairs. When she later took a taxi home, she states she continued to vomit during the journey and was unsteady on her feet. She believes that the Trust failed in its duty of care to her.

ISSUE OF COMPLAINT

4. The following issue of complaint was accepted for investigation:

- **Whether the patient's care, treatment and discharge from the Emergency Department of Craigavon Area Hospital on 18 March 2017 was appropriate and in line with accepted standards and guidelines?**

INVESTIGATION METHODOLOGY

5. 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.

Independent Professional Advice Sought

6. After further consideration of the issues I obtained advice from an Independent Professional Advisor (IPA), a consultant in emergency medicine.

7. 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

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.

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

- The Principles of Good Administration
- The Principles of Good Complaint's Handling
- The Public Services Ombudsman's Principles for Remedy

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

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

The specific standards relevant to this complaint are:

- The General Medical Council (GMC) Good Medical Practice guidance for doctors.
- NICE guidelines 'Headaches in over 12s: diagnosis and management' https://www.nice.org.uk/guidance/cg150 (CG150)

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

MY INVESTIGATION

Detail of Complaint

12. On the morning of 18 March 2017, the patient states that she was suffering from a severe migraine. She was seen by an out of hours' doctor at 11.04. The doctor's record shows that he examined her and administered 10mg diamorphine and 50mg cyclizine. The patient does not believe she received cyclizine at that time because her sickness did not abate.

13. The patient's condition did not improve and she called the emergency services at 17.49 hours and was brought by the Northern Ireland Ambulance Service (NIAS) at 18.12 hours to the ED of Craigavon Area Hospital. The ambulance service staff took a history from the patient which records that a doctor had visited her at home and administered Cyclimorph at 11.30 hours.

14. The patient arrived at the hospital at 19.04 hours. The typed ED notes 'triage text' records 'GP gave cyclomorph at 11 vomiting since' while a handwritten note below adds 'cyclomorph and oral cyclizine 11am'. She was initially examined and treated with paracetamol (for pain relief) and ondansetron (for

sickness) at 19.45 hours. She was seen by an ED doctor at 21.45 hours and given further anti-emetic medicine at regular intervals. Intravenous fluids were administered at 22.00 hours. I note that the doctor has recorded in the notes '*no diarrhoea'*. The patient was discharged at 00.40 hours.

15. The patient complained that she was discharged prematurely. She believes that, because of inaccurate descriptions of the drugs administered, the doctor was not aware that she had received morphine earlier that day and might still be under the influence of it.

Evidence Considered

16. The Investigating Officer obtained the patient's medical notes and records, documenting her care and treatment on 18 and 19 March 2017. This was referred to an Independent Professional Advisor (IPA).

17. The IPA summarised the patient's care and treatment as follows:

'19:04 - arrived in the ED, Set of observations completed, which are normal

19:45 - prescribed and given 1g paracetamol and 4 mg of ondansetron iv [intravenous]

21:45 - seen by an ED doctor

22:05 - Cyclizine 50 mg iv given (an antiemetic)[2]

23:05 - patient own 'imigran' 100 mg charted and given IM [intramuscular] by patient

23:15 - metoclopramide 1 mg iv and ondansetron 4 mg IV charted and given (both are antiemetic)

00:25 - further antiemetic given, 12.5 mg of iv stemetil (Prochlorperazine)

00:40 -home with prescription of ondansetron [antiemetic] 4 mg twice daily for 3 days.'

[2] Antiemetic drugs are prescribed to help with nausea and vomiting that are side effects of other drugs

18. The IPA advised that the observations, investigations and the medication administered on the patient's arrival in ED were appropriate and in line with NICE CG150. He also advised that '*none of the medications given in the ED would have potentiated the effect of the Diamorphine or interacted with it significantly'*.

19. As part of investigation enquiries, and explanation was sought from the IPA as to the differences between the various drugs documented in the patient's notes and records. He explained that Diamorphine and morphine are opiates[3] and should be termed as such. Further, he advised that a maximum of 10mg, three times a day would be a reasonable dose. He explained that Cyclomorphine is 10mg of morphine with 10mg of Cyclizine. Cyclizine is an antiemetic. He also advised '*It is not acceptable to use the term morphine generically, it would be more appropriate to have used the term opiates. Although this lack of rigor in terminology has not helped it has not led to any harm or patient safety issues in [the patient's] care.'*

20. The IPA advised that the out of hours' doctor's records are 'quite clear' and that the patient received 10mg Diamorphine and 50mg of Cyclizine on the morning of 18 March 2018. He advised that the patient therefore received 10mg of Diamorphine and 100mg of Cyclizine in total on 18/19 March 2018, which he has advised is within the maximum reasonable dose.

21. The Investigating Officer asked the IPA if the patient's discharge at 00.40 hours was appropriate and timely given the ED Senior House Officer's (SHO's) note that she complained of 'feeling terrible' and that she had told the patient that '*this is a side effect of morphine and will take some time but appears to get better'.* The IPA advised that '*the opiate would have worn off by the time of*

[3] Opiates are derived from the poppy plant. They are potent analgesic (pain relieving) drugs. Opiates work by altering the perception of pain rather than eliminating the pain. First, they attach to the molecules that protrude from specific nerve cells in the brain, called opioid receptors. Once connected, these cells send messages to the brain with much lower pain levels, and severity than the body is actually experiencing. Consequently, the drug user feels less pain, physically and emotionally.

discharge at 00.40 hours' and the antiemetics '*have no significant side effects if used in the correct dose – as they were'*.

22. However, the IPA further advised that the ED SHO *'may not have given adequate concern to the fact that [the patient] had not eaten or drunk for probably more than 24 hours'.* He also advised '*it would have been wiser to have kept her until she was able to tolerate fluids and a light diet'.*

23. I note that antiemetic medicine was administered intravenously to the patient at 23.15 hours and again at 00.25 hours.

24. In response to investigation enquiries, the Trust provided a copy of the patient's fluid balance sheet which indicates that she was given 1 litre of normal saline. This was started at 22.00 hours and was to run over the course of 1 hour. The IPA advised that '*the timing and amount of fluids [she] received was not crucial (as she did not have evidence of an acute kidney injury [as evident by her blood results] and because IV fluids are not mandated in the NICE guidelines for the treatment of migraine). However what is important is whether [her] nausea was sufficiently improved for her to tolerate oral fluids'.*

Analysis and Findings

25. In deciding whether care and treatment was appropriate and reasonable, I consider the applicable standards and guidelines. I will then assess whether the relevant care and treatment provided met those standards. In this case I refer to the GMC Good Practice Guidance which outlines the duties of a doctor into four discrete areas:

i. Knowledge, skills and performance
ii. Safety and Communication
iii. partnership and teamwork
iv. Maintaining trust

26. In relation to Communication, partnership and teamwork, the GMC guideline states that doctors should:

- ‘Treat patients as individuals and respect their dignity.
- Treat patients politely and considerately.
- Respect patients’ right to confidentiality.
- Work in partnership with patients.
- Listen to, and respond to, their concerns and preferences.
- Give patients the information they want or need in a way they can understand
- Respect patients’ right to reach decisions with you about their treatment and care.
- Support patients in caring for themselves to improve and maintain their health.
- Work with colleagues in the ways that best serve patients’ interests.’

27. In this case the ambulance service’s notes record that the patient was administered Cyclimorph at 11.30 hours. This record was based on a history taken from the patient. The ED notes and records record that the patient had been administered Cyclomorph and oral Cyclizine at 11.00 hours. I consider that it is highly likely that the confusion about the type of opiate administered may have arisen from the history provided by the patient in the ambulance.

28. The out of hours’ doctor’s records clearly evidence that he administered 1mg Diamorphine and 50mg Cyclizine on the morning of 18 March 2017. It is clearly documented that on arrival at the ED that the patient had been administered a type of opiate between 11.00 and 11.30 hours on 18 March 2017. The medical staff have recorded that the opiate administered was morphine, which is less potent than diamorphine. In giving weight to this evidence I am mindful of the closeness in time to the events which are recorded.

29. I have carefully considered the IPA advice. I accept the opinion of the IPA that it is likely that the diamorphine would have worn off by 00.40 on 19 March 2017. Therefore the patient’s drowsiness was probably due to the combination of a severe migraine which had begun on 17 March 2017 as well as a sustained period of nausea and vomiting from early morning on 18 March 2017.

30. The patient recalls that the doctor had told her she would try to find her a ward to recover. However she also recalls that a male doctor (who has not been identified) ordered her out of bed.

31. I accept the advice of the IPA that the key issue is whether the patient's nausea was properly addressed at the point of discharge, given her complaint to the doctor of '*feeling terrible'*. I consider that observations ought to have been carried out by Trust staff and her discharge delayed until the ED doctor was able to determine whether she was well enough to tolerate oral intake of fluids and food (a light diet).

32. I am concerned that staff in the ED did not listen to and act upon the patient's concerns in a timely way, in line with the GMC Good practice Guidelines, in relation to communication with her, when she was moved to the waiting room. I consider her concerns were not adequately dealt with and she ought not to have been discharged so hastily and without any documented advice to return should she continue to feel nauseous.

33. I shared my draft report with the Trust and with the patient. The Trust disagreed with my findings. The Clinical Director for Emergency Medicine argues that it was '*perfectly reasonable to discharge the patient to let her go home to sleep'*. He '*apologises that she did not feel well enough to go home and has emphasised that how she feels about her care is very important to him as Clinical Director'*.

34. The doctor recalls that the patient '*appeared comfortable in the cubicle'* and *'was agreeable for discharge' and* recalls telling her *'to re-attend if her symptoms were to return or worsen',* however this is not recorded. The patient refuted the Trust's statements.

35. I concluded in my draft report that there were failings in the care and treatment provided to the patient. I shared my draft report with the Trust and the patient. I have considered the Trust's comments, the patient's response and the IPA advice and my conclusion remains unchanged. **I therefore uphold these issues of her complaint.**

CONCLUSION

36. I have investigated the patient's complaint and have found failures in care and treatment in relation to the following matters:

    i. The patient's discharge ought to have been delayed
    ii. The patient ought to have been moved to an observation ward and not to the waiting room
    iii. The ED doctor ought to have established that the patient was well enough to tolerate oral fluids and a light diet.
    iv. The patient ought to have been provided with advice to return to ED if her nausea persisted and this advice ought to have been recorded by the doctor.

37. I am satisfied that the ED staff were aware that the patient had been administered morphine earlier in the day, therefore I do not uphold this element of the complaint. The clinicians in the ED department believed the drug administered by the out of hours' doctor was cyclomorph, as this is the history taken by NIAS staff from the patient. The drug cyclomorph contains morphine. I note that the IPA is critical that the term morphine has been used generically. The Trust may wish to consider his advice that use of the term opiates would be more appropriate.

    The failures that I have identified as part of my investigation have caused the patient to experience the injustice of discomfort and distress and the time and trouble in bringing her complaint to this Office and I uphold her complaint.

Recommendations

I recommend that the Trust apologies to the patient for the injustice suffered and makes a solatium payment of £500 within one month.

Marie Anderson

MARIE ANDERSON
Ombudsman **November 2018**

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.