Investigation Report

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

NIPSO Reference: 18943

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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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EXECUTIVE SUMMARY

I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust).

I accepted the following issues of complaint for investigation:

- Whether the care and treatment provided to a patient at the Emergency Department (ED), Antrim Area Hospital on 8, 12 and 23 July 2017 was appropriate and reasonable?
- Whether the patient ought to have been assessed by a cardiologist when an in-patient in Antrim Area Hospital between 23 and 27 July 2017?
- Whether the patient was appropriately discharged from Antrim Area Hospital on 27 July 2017?

The investigation of the complaint identified a failure by the Trust to seek a cardiology opinion in relation to the patient before deciding to discharge him from hospital on 27 July 2017. I recommend that a fulsome written apology be provided to the patient by the Trust Chief Executive for this failure in clinical care and treatment.

THE COMPLAINT

1. The patient stated that he attended Antrim Area Hospital (AAH) Emergency Department on three separate occasions: 8, 12 and 23 July 2017. He complained that ED clinicians failed to accurately diagnose and admit him to hospital following his first two attendances. The patient further complained that the ED clinicians ought to have been aware sooner that, because he had type 2 diabetes, his symptoms were indicative of heart problems.

2. Further, the patient complained that although he was admitted to hospital on the third occasion, and received treatment for heart failure, he was discharged a few days later despite his case not having been reviewed by a cardiologist.

3. The patient believed it is a failing of the Trust that he attended the ED three times in 15 days and (though he was admitted for a few days on the third visit) he ended up being sent home despite having a heart issue. He noted his cardiologist's comments (quoted in the Trust's written response of 5 March 2018) that *'diabetic patients often present with breathlessness instead of chest pain and this may not be obvious to non-cardiology specialists.'* The patient feels *'this is something that every non-cardiology specialist should be aware of'.*

Chronology

4. The patient, a type 2 diabetes sufferer in his 70s, stated he had no history of heart problems prior to July 2017. However, he did have a stent inserted into a blood vessel in his groin in November 2013, and again in March 2017, due to *'vascular problems'.*

5. In the first week of July 2017, he was in Portstewart, watching golf. He stated that he felt *'breathless, was struggling to breathe and had some pain in [his] leg.'* The patient stated that: *'On Saturday 8 July 2017 I felt no better.'* He described the sensation as *'chest discomfort'* but was clear that he had no chest pain. A nurse in an out-of-hours GP[1] service directed him to the ED, AAH. According to the patient, the nurse indicated that *'as a diabetic patient,*

[1] General Practitioner

breathlessness is an indicator of heart issues as pain does not tend to appear.' The patient presented at the ED on 8 July 2017 and informed the clinicians of what he had been told.

6. Tests were carried out and he was diagnosed with angina and sent home with a referral to the Rapid Access Chest Pain Clinic[2] (RACPC).

7. On 12 July 2017, while awaiting notification of a RACPC appointment, the patient *'really felt unwell'* and presented to the ED a second time. Tests were carried out and, again, angina was diagnosed. He was sent home to await his RACPC appointment, though he *'felt increasingly unwell'.*

8. On 23 July 2017 he *'became so breathless'* that he decided to attend the ED a third time. On this occasion he was admitted to a respiratory ward. Following treatment for heart failure he was discharged on 27 July 2017 to await his appointment for the RACPC.

9. On 3 August 2017 he attended an outpatients appointment with a cardiologist. The patient was feeling so ill and was so sure he needed imminent help that he took an overnight bag to that appointment. The cardiologist offered the patient treatment as an outpatient over a six to eight week period, or, immediate admission. The patient opted for immediate admission.

10. On 11 August 2017 he was given coronary angioplasty[3] in the Royal Victoria Hospital. He was then returned to AAH and discharged the following day.

Issues of complaint

11. The issues of complaint which I accepted for investigation were:
    - Whether the care and treatment provided to the patient at the ED, AAH on 8, 12 and 23 July 2017 was appropriate and reasonable?

[2] This service provides urgent assessment for patients suffering from symptoms suggestive of angina (chest pain). (Taken from the Trust's website)
[3] The term "angioplasty" means using a balloon to stretch open a narrowed or blocked artery. However, most modern angioplasty procedures also involve inserting a short wire-mesh tube, called a stent, into the artery during the procedure. The stent is left in place permanently to allow blood to flow more freely.

- Whether the patient ought to have been assessed by a cardiologist when an in-patient in AAH between 23 and 27 July 2017?
- Whether the patient was appropriately discharged from AAH on 27 July 2017?

INVESTIGATION METHODOLOGY

12. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant medical documentation together with the Trust's comments on the issues raised.

Independent Professional Advice Sought

13. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPAs):
    - An ED Consultant (ED IPA)
    - A Consultant Respiratory Physician (RP IPA)

14. The information and advice which have informed my findings and conclusions are included within the body of my report. The IPAs have 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

15. 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.

16. The general standards are the Ombudsman's Principles[4]:
    - Principles of Good Administration (see Appendix two)
    - Principles of Good Complaints Handling

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

- Public Services Ombudsmen Principles of Remedy

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

18. The specific standards relevant to this complaint are:
    - NICE guidance Ref: CG95 - *Chest Pain of recent onset,* March 2010 (reviewed November 2016).

19. 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. As part of the NIPSO process, a copy of this report was previously shared in draft form with the patient and the Trust for comment on factual accuracy and the reasonableness of any findings and recommendations.

THE INVESTIGATION

Issue 1: *Whether the care and treatment provided to the patient at the ED, AAH on 8, 12 and 23 July 2017 was appropriate and reasonable?*

Detail of Complaint

20. The patient presented at the ED on three occasions: 8, 12 and 23 July 2017. On each of those occasions, a referral to the RACPC was deemed appropriate by the clinicians. Focusing on the issue I have decided to investigate, the patient complained that: *'it was only on [his] 3rd attendance to A&E with [his] symptoms that [he] was admitted and had heart failure confirmed. [He] queried this as [he] believed [he] should have been admitted earlier as [his] diabetes means that heart failure / issue pain can be masked.'*

Evidence Considered

21. I considered relevant extracts from the patient's medical records which cover his three visits to the ED, in particular, ED clinical records.

22. The relevant aspects of the Trust's written responses to the patient's complaint were also considered.

Legislation/Policies/Guidance

23. NICE (CG95). *Chest Pain of recent onset,* March 2010 (reviewed November 2016). The RP and ED IPAs both highlighted the relevance of this guidance in their advice.

The Trust's response to the investigation enquiries

24. The Trust stated that *'the target for urgent referrals to the RACPC is approximately 2 weeks from the date of referral.'* However, in July 2017 the target *'had extended to 6 weeks'* because: *'The key person running the clinic at that time had changed and the new doctor was in the process of recruitment and selection'.*

25. The Trust stated that *'an appointment had been booked for the Rapid Access clinic for 16 August. However, [the patient] had contacted the booking office seeking an earlier appointment. [A cardiac consultant] had arranged an additional clinic and [the patient] was added to this for 3 August.'*

26. The Trust stated that, as part of the complaints process, a senior consultant in emergency medicine reviewed the patient's complaint and, in particular, his three attendances to the ED and, advised that the treatment given was appropriate on each occasion. The senior consultant believed there was nothing specifically on the first attendance (8 July 2017) '*that would have mandated a cardiology admission'* and the patient was appropriately referred to the RACPC.

27. The ED consultant noted that the patient's '*chest x-rays were reported as normal on the first two attendances'* to hospital (8 and 12 July 2017); specifically, '*there was no mention of heart failure by the reporting radiologist'*. The consultant referred to the patient's history of '*chest discomfort'* prior to 8 July 2017 and ongoing '*chest heaviness'* which he noted as being described by the clinicians who cared for the patient as '*exertional only'* and, '*did not appear to be increasing in frequency or intensity and fitted with a working diagnosis of stable or exertional angina.'*

28. Referring to the third attendance (23 July 2017) the ED consultant noted that, on '*minimal exertion'*, the patient had been '*more short of breath than he had been previously along with chest discomfort'*, with '*no relief despite rest'*. He was admitted to hospital.

The patient's clinical records

29. I have reviewed the ED Clinical Record in respect of the patient's three visits to the ED. The record includes the following notes:

    8 July 2017
    ED doctor – *'chest discomfort when walking for 10 days, last episode 10am. Feeling fatigued and discomfort. Very SOB[5] when walking 100 yards. No pleuritic chest pain[6].'*

    12 July 2017
    ED doctor – *'Has been having pain in chest on exertion. Last week – walking up incline when chest pain. Gets heaviness in chest. No pain at rest. . . . Pain is <u>not</u> pleuritic.'*

    23 July 2017
    ED doctor – *'3rd attendance this month - SOB / chest discomfort – diagnosed stable angina + ref RACPC*
    Today SOB after minimal exertion, ongoing from 6pm + no relief despite rest.

[5] Short of breath
[6] Sharp chest pain experienced by the patient when breathing deeply

No chest pain / palpitations.'

The ED IPA's advice

30. The ED IPA reviewed the patient's medical notes and provided advice to assist my investigation. The ED IPA set out in detail what had happened to the patient using the material contained within the medical record. The ED IPA stated that the patient's *'history of chronic kidney disease, diabetes, diverticulitis and stents of the superficial femoral artery*[7] *were noted'* by clinicians [my underlining].

31. The ED IPA concluded *that 'the care given [to the patient] by the ED staff on 8, 12 and 23 July 2017 was reasonable.' There were no indications on the first two occasions for immediate assessment by a cardiologist and referral was made to cardiology through the RACPC. On the third attendance, [the patient] was referred to the in-taking medical team which is the usual route for accessing in-patient cardiology by the ED team.'*

32. The ED IPA stated: *'[The patient] presented with chest pain as well as breathlessness, ischaemic heart disease was considered on each occasion he presented and it is my understanding of the records that he did not present with an acute myocardial infarction to the ED.'*

33. Referring to the cardiologist's comment that '*diabetic patients often present with breathlessness instead of chest pain',* the ED IPA stated that: '*Whilst this might not be in the knowledge base of all ED doctors, it would be standard practice to take an ECG from patients presenting with breathlessness and this was done.'*

[7] The main blood supply to the thigh and leg. In this context, superficial means near the surface of the skin.

Analysis and Findings

34. The locus of the patient's complaint is that he was not provided with an adequately urgent pathway to care and treatment for the heart condition with which he presented at the ED in July 2017. He is suspicious that *'non-cardiology professionals'* in the ED did not realise the seriousness of his condition because [his] '*diabetes means that heart failure / issue pain can be masked.'* Shortly afterwards, the following month, the patient underwent a coronary angioplasty procedure in the Royal Victoria Hospital. Understandably, the necessity for this procedure may be viewed by the patient as further justification for feeling something was amiss in respect of the Trust's handling of his three earlier visits to the ED.

35. I note the ED IPA found that on each occasion, clinicians identified the symptoms experienced by the patient as possibly being related to cardiac issues. Of particular note is the fact that, at his first visit, 8 July 2017 he was *'referred to the Rapid Access Chest Pain Clinic (RACPC).'* I accept the advice of the ED IPA.

36. I note that the patient's RACPC appointment (16 August 2017) was booked prior to him obtaining an earlier appointment (3 August 2017). I also note that the RACPC appointment was within six weeks of his initial visit to the ED (8 July 2017). While I acknowledge that the Trust was taking steps to address issues regarding resources available to the RACPC, I am concerned about the effect of a six-week wait on patients who are very concerned about their condition. If the patient had been seen quickly at the RACPC, in line with the Trust's two-week target, it may have prevented the patient presenting to the ED on 23 July 2017 and spending four days in hospital.

37. Although the patient denies presenting with chest pain on any of the three occasions, the ED IPA is satisfied the ED team considered cardiac issues on each of those occasions. In my view this has been established irrespective of whether the patient exhibited chest pain or not. I note the term chest pain is used throughout the NICE guidance (CG95) to mean *chest pain <u>or discomfort</u>* (my underlining). I consider this to be relevant because my review of the

patient's medical records reveals 'chest discomfort' as a recorded symptom by ED clinicians.

38. I have established that ED medical staff identified that the patient's symptoms could be related to heart problems. I accept the advice provided by the ED IPA that the tests undertaken by the ED *'did not indicate an acute cardiac event'.* The records indicate that the patient did not experience an acute cardiac event and the ED IPA agrees that this was the case. I am therefore satisfied that a cardiology opinion was not required by ED staff on any of the occasions when the patient visited the ED in July 2017. In light of this fact, and in view of the follow-up RACPC appointment that had been arranged to investigate the patient's heart problems, I am satisfied that he was appropriately discharged from the ED on both 8 and 12 July 2017.

39. I note that, upon the patient's presentation to the ED on 23 July 2017, tests were conducted similar to those conducted on the first two occasions. I note that on this third occasion he was admitted to the hospital's respiratory ward due to his shortness of breath under minimal exertion with no relief despite rest. I note that the respiratory medical team was on duty that night as the in-taking medical team. I accept the ED IPA's advice that the patient was correctly referred to the in-taking medical team by the ED clinicians.

40. In light of the forgoing analysis, I have found no evidence of any failure in the care and treatment of the patient in the AAH ED. I have found that his care and treatment was appropriate and reasonable. **I therefore do not uphold this aspect of the complaint.**

Issue 2: *Whether the patient ought to have been assessed by a cardiologist when an in-patient in AAH between 23 and 27 July 2017?*

Issue 3: *Whether the patient was appropriately discharged from AAH on 27 July 2017?*

41. I consider Issues two and three of the patient's complaint to be linked and, as such, I have decided to consider both issues together.

Detail of Complaint

42. The patient complained that he was not seen by a cardiologist during his hospital admission from 23 to 27 July 2017, despite being diagnosed with heart failure. Neither was he given a more urgent pathway to receiving the cardiology care and treatment which he later received. Instead he was discharged from hospital and left to await his RACPC appointment; I note he had initially been *'offered an appointment in mid-August'*. Subsequent to his discharge from hospital on 27 July 2017 I note the patient sought an earlier appointment with a cardiologist on 3 August 2017.

Evidence Considered

43. I considered relevant extracts from the patient's medical records which cover his stay in hospital between 23 and 27 July 2017. These include hand-written notes made by the Medical Assessment Team on the patient's admission and those notes attributed to the respiratory consultant over the course of that period.

44. The relevant aspects of the Trust's written responses to the patient's complaint were also considered.

Legislation/Policies/Guidance

45. NICE (CG95). *Chest Pain of recent onset*. March 2010 (reviewed November 2016).

The Trust's response to the investigation enquiries

46. In response to my enquiries in relation to the patient's hospital stay, the Trust stated: '*Ideally patients with heart failure should be assessed by a cardiologist; this referral was already in place and the medical team was aware of an imminent outpatient appointment. The patient had improved clinically by the day of discharge. There had been no indication of unstable angina or poor response to treatment and therefore no strong indication to refer to Cardiology whilst an inpatient, particularly as a cardiology outpatient appointment was already being processed*.'

47. The Trust further stated that '*In applying the Bolam test[8], a reasonable body of general physicians (non-cardiologists) would likely have made the same decisions. The patient's acute event was in early July 2017 and was not typical (breathlessness instead of chest pain) and the delay of one week in being assessed by a cardiologist incurred by his discharge on 27 July 2017 did not lead to a prognostic difference in management. The patient's current status and outcome from the events of 2017 would be no different whether he had been seen by a cardiologist as an inpatient between 23-27 July 2017 and at outpatients on 3 August 2017*.'

48. '*The patient's condition improved significantly with diuretics and fluid restriction. The patient did not require oxygen, was mobilising and had no other episodes of shortness of breath or chest pain during the period of 23 July 2017 to 27 July 2017. The patient was allowed to go home appropriately as his symptoms were under control and he had returned to his baseline activities of daily living prior to admission. An urgent cardiology outpatient referral had already been made*.'

The patient's clinical records

49. I have reviewed the Medical Assessment Document and handwritten notes attributed to the respiratory consultant responsible for the patient's care during his stay in the Respiratory Ward at AAH. I have noted the following:

    24 July 2017 @09.00
    'Intermittent shortness of breath. Low exercise tolerance – 10m now. Last night 18.30 SOB when walking in house. SOB when walking up hills. Sudden worsening shortness of breath.'

    24 July 2017 @ 15.05
    'Small peripheral embolus[9] can't be entirely excluded.

[8] A **test** that arose from English tort law, which is used to assess medical negligence. Bolam holds that the law imposes a duty of care between a doctor and his patient, but the standard of that care is a matter of medical judgement.
[9] An embolus is an unattached mass that travels through the bloodstream and is capable of clogging arterial capillary beds at a site distant from its point of origin.

Compressive atelectasis[10] at lung bases.
Large bilateral pleural effusions[11].
Furosemide[12] – start now'

25 July 2017
'Passed 1100ml urine
Remains SOB. Slight improvement.
No CP [chest pain], no abdominal pain, no palpitations.
Patient due another dose furosemide in morning.'

25 July 2017
'Bilateral effusions
Diuretics
Feels breathing improved today.'

26 July 2017
'Feels much better.'

27 July 2017
'Referred to cardiology. [RACPC]
Home today.'

The RP IPA's advice

50. Referring to when the patient was admitted to hospital on 23 July 2017 and before any decision was taken to discharge him on 27 July 2017, the RP IPA stated that he should have been seen by a cardiologist, as suggested by the patient in his first letter of complaint dated 2 February 2018. However, the RP IPA added that it was also his view that *'it was perfectly reasonable for [the patient] to have been treated on a respiratory ward for heart failure as this is a common general medical condition and can be treated on any general ward*

[10] The collapse or closure of a lung resulting in reduced or absent gas exchange.
[11] Excess fluid that accumulates in the pleural cavity, the fluid-filled space that surrounds the lungs.
[12] Medication used to treat fluid build-up due to heart failure, liver scarring, or kidney disease

that treats unselected medical patients requiring admission to hospital.'

51. I note that the patient was concerned to learn of his cardiologist's comment that *'cardiologists often see diabetic patients who present with breathlessness rather than chest pain and this may not be obvious to non-cardiology specialists.'* However, the RP IPA advised that this view was not relevant in this case because *'the physicians looking after [the patient] did establish the correct diagnosis of cardiac failure right from the outset and made the appropriate referral'* (to cardiology). The RP IPA indicated that the relevant aspects of NICE guideline CG95 had been followed.

52. The RP IPA referred to a note made in the patient's medical notes on 10 August 2017 which records that he was offered the chance to go home and receive further tests as an outpatient[13]. The RP IPA stated: *'. . . not only was [the cardiologist] himself considering outpatient treatment . . . there was also apparently subsequent talk of [the patient] being discharged from the ward and returning for angiography as an out-patient . . .'* Noting this, the RP IPA concluded: *'It is therefore difficult to see how the doctors caring for [the patient] during the 23-27 July admission could have brought his angiogram forward.'*

53. As part of the investigation I obtained further advice from the RP IPA regarding his view that the patient's discharge was premature:
'Referring to the period of [the patient's] admission to hospital (23 to 27 July 2017) in my opinion, on the understanding that a cardiac service was available in Antrim Area Hospital, [the patient] should have been referred to that service before any decision was taken to discharge [him] from hospital. In accordance with good medical practice a cardiologist should have been spoken to so that the cardiologist could make a decision as to the appropriate course of action for [the patient's] care and treatment. I refer to paragraph 15 of the General Medical Council's standards document: 'Good Medical Practice' which includes the wording: '. . . you must refer a patient to another practitioner when this serves the patient's needs.' In my opinion, this standard was not met in this

[13] Note made on medical record by doctor (Senior House Office) on 10 August 2017 at 10.20 – *'No further chest pain or SOB, offered the chance to go home & get further tests as an O/P [outpatient] but would prefer to stay'*

instance. From the records provided to me, I have found no evidence that this had a clinical impact on the patient; I note he was seen by a cardiologist one week after being discharged from hospital.'

Analysis and Findings

54. Clearly the patient had serious concern for his health when he returned to hospital on 23 July 2017 seeking help. The medical records, and the Trust's response to enquiries, confirm that heart (or cardiac) failure was apparent, something which had not been apparent previously. The RP IPA has confirmed that it was therefore correct that the patient should be admitted to hospital to receive treatment for that condition. I accept the RP IPA's advice that, if a cardiac service was provided in the hospital, then, it was consistent with good medical practice that he should have been reviewed by a cardiologist who could have provided advice on the appropriate course of action in relation to his care and treatment.

55. I note that the patient was seen by a cardiologist on 3 August 2017, one week after his discharge from hospital, as a result of his contact with the Trust. There is no doubt that he remained greatly concerned for his health since he brought an overnight bag to that appointment, expecting to be admitted immediately for urgent treatment. According to the patient, the cardiologist confirmed that he should have been seen sooner than the 3 August appointment he had managed to obtain. I note this led him to conclude that a cardiac specialist should have been asked for an opinion, or, seen him when he was an inpatient the previous month. This is borne out by the RP IPA's advice.

56. By way of balance, I have also reflected on the fact that, according to the patient, the cardiologist offered him the option of immediate admission to hospital on 3 August 2017 or, treatment as an outpatient over a six to eight week period. I note the patient has since alleged that the cardiologist 'agreed' that this alternative was *'not very good'*. However, I note the fact remains that such an offer was made. I consider this fact points to the likelihood that the cardiologist did not view the patient's condition to be so serious as to require

immediate in-patient treatment.

57. I am further persuaded of this view given the evidence that, on 10 August 2017, the patient was offered the chance of being sent home from the Cardiology Ward with the prospect of having further tests as an outpatient. The RP IPA made the point that *'it is therefore difficult to see how the doctors caring for [the patient] during the 23-27 July 2017 admission could have brought his angiogram forward.'* I also consider the following comments of the RP IPA to be relevant: '*I cannot see that not referring him to the cardiology service as an in-patient during the 23-27 July admission has had any adverse impact on the patient.'* From this I conclude that the outcome would have been no different had he been seen by a cardiologist during his stay in hospital at the end of July 2017.

58. Having carefully considered the evidence gathered, I am satisfied that the Trust's decision to discharge the patient on 27 July 2017, without first seeking the opinion of a cardiologist, is a failure in the care and treatment provided to him. **I therefore uphold issues two and three of the complaint.** I have not found that this caused any detriment to the patient. I note the RP IPA was clear that, while in the respiratory ward he received the treatment he needed (diuretics) and *'the documentation provided would suggest that his condition improved as would be expected.'*

59. Nonetheless, I acknowledge the significant stress and anxiety which the patient and his immediate family experienced as a result of his concerns that he was not reviewed by a cardiologist at any point until his appointment on 3 August. By way of remedy, I recommend that the patient be given a fulsome written apology by the Trust Chief Executive.

Response to draft investigation report

60. Both parties to the complaint were given the opportunity to comment on a draft of the investigation report. The Trust indicated an acceptance of the report and offered no further comments. Having carefully reflected on the comments submitted by the patient, I wish to add the following analysis.

61. The patient stated that during his visits to the ED on both 8 and 12 July 2017, he had been informed he would be seen in approximately two weeks. The patient therefore queried whether the six-week extended waiting time had been passed on to ED staff. The Trust has conceded the possibility that the ED may not have been aware that waiting times were longer at that stage and have offered an apology to the patient, through this office, if he was misinformed. The patient wondered whether the ED medics would have been 'happy' with him waiting six weeks to be seen by the RACPC. The Trust has stated that referrals received by the RACPC are triaged by a cardiologist. In light of this triage procedure, I am satisfied that the timescales considered in ED had less relevance.

CONCLUSION

62. The patient submitted a complaint to me about the actions of the Trust.

63. I have investigated the complaint and have not found evidence of any failure in relation to the care and treatment provided to the patient during his three visits to the Antrim Area Hospital Emergency Department on 8, 12 and 23 July 2017.

64. I have found there to be a failure by the Trust in not obtaining a cardiology opinion prior to discharging the patient on 27 July 2017. However, I am satisfied that he did not suffer any detriment to his health as a result of this decision.

65. I recommend that a fulsome written apology be provided to the patient by the Trust Chief Executive.

PAUL McFADDEN
Deputy Ombudsman

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.