Investigation Report

Investigation of a complaint against Hillsborough Medical Practice

NIPSO Reference: 202000111

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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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Listed Authority: Hillsborough Medical Practice

SUMMARY

This complaint is about care and treatment Hillsborough Medical Practice (the Practice) provided to the complainant between July and December 2020. The complainant raised concerns about delays and difficulties in the prescribing and issuing of four types of medication: ondansetron[1], loperamide[2], zomig[3], and diazepam[4].

The investigation examined the details of the complaint, the Practice's response, and relevant guidelines. I sought independent professional advice from a practising General Practitioner, (GP). In relation to the Practice's prescription of ondansetron, the investigation found that upon receipt of the patient's request on 16 September 2020, it did not assign it to an available GP. This caused an unnecessary delay leading to the patient being without her medication for a period. I considered this a failure in care and treatment. The investigation also identified that the Practice did not act in accordance with its own policies and procedures when it prescribed and issued loperamide and zomig to the patient. I considered this maladministration. The investigation did not identify any failings regarding the Practice's prescription and provision of diazepam. The investigation also identified maladministration regarding communication with the complainant about the status of her medication requests.

I recommended the Practice apologise to the complainant for the failures identified. I have made further recommendations to prevent these failures from reoccurring.

1 Ondansetron is a medicine which prevents patients feeling sick (nausea) and being sick (vomiting). This type of drug is called an anti-emetic.

2 Loperamide is used to treat diarrhoea. It can help with short-term diarrhoea or irritable bowel syndrome (IBS).

3 Zomig is used to treat the symptoms of migraine.

4 Diazepam is used to treat anxiety, muscle spasms and fits (seizures).

THE COMPLAINT

1. This complaint is about the actions of Hillsborough Medical Practice (the Practice). The complainant raised concerns regarding treatment she received between July 2020 and December 2020.

Background

2. The complainant was a patient of the Practice since birth. The complainant said she experienced difficulties with the Practice issuing medication she requested between July and December 2020.

3. The complainant said she left the Practice as a patient in December 2020 because of its actions.

Issue of complaint

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

   Whether the care and treatment provided by the Practice to the patient between July 2020 and December 2020 was appropriate, reasonable and in accordance with relevant standards, guidance, and policies?

   In particular, this investigation will consider the prescribing and issuing of the following medication:

   - Loperamide[5];
   - Ondansetron[6];
   - Zomig[7]; and
   - Diazepam[8].

INVESTIGATION METHODOLOGY

5. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation and its comments on the issues the complainant raised. This documentation included information relating to the Practice's complaints process.

5 Loperamide is used to treat diarrhoea. It can help with short-term diarrhoea or irritable bowel syndrome (IBS).

6 Ondansetron is a medicine which prevents patients feeling sick (nausea) and being sick (vomiting). This type of drug is called an anti-emetic.

7 Zomig is used to treat the symptoms of migraine.

8 Diazepam is used to treat anxiety, muscle spasms and fits (seizures).

Independent Professional Advice Sought

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

    - A practising General Practitioner (GP) since 1985 who has held a number of other educational and quality roles (GP IPA).

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

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

Relevant Standards and Guidance

8. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional, and statutory guidance.

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

    - 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 of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's (GMC) Good Medical Practice, updated April 2014, (GMC Good Medical Practice);

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

- The General Medical Council's (GMC) Good Practice in Prescribing and Managing Medicines and Devices, April 2013, (GMC Prescribing Medication);
- Joint Formulary Committee's British National Formulary, April 2020, (BNF);
- The Health and Social Care Board's Developing a Prescribing Protocol, 2016, (HSCB Prescription Protocol);
- Hillsborough Medical Practice's Prescriptions – Issuing a Repeat Prescription, May 2020, (Issuing a Repeat Prescription, RX02v02);
- Hillsborough Medical Practice's Issuing an Acute Prescription, May 2020, (Issuing an Acute Prescription RX03v02).

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

10. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

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

THE INVESTIGATION

Whether the care and treatment provided by the Practice to the patient between July 2020 and December 2020 was appropriate, reasonable and in accordance with relevant standards, guidance, and policies?

In particular, this investigation will consider the prescribing and issuing of the following medication:

- Loperamide;
- Ondansetron;
- Zomig; and

- Diazepam.

Detail of Complaint

12. The complainant outlined instances where she contacted the Practice about prescriptions that were '*declined, delayed, or simply ignored'*. The prescriptions related to the four medications outlined above, which the complainant requested on various dates between July and December 2020. She complained to the Practice on 17 December 2020 after she asked reception staff why her pharmacy did not receive a prescription for diazepam. She left the Practice as a patient in December 2020.

Evidence Considered

Legislation/Policies/Guidance

13. I referred to the following policies and guidance, which were considered as part of investigation enquiries:
    - GMC Good Medical Practice;
    - GMC Guidance for Prescribing Medication;
    - BNF;
    - Developing a Prescribing Protocol HSCB;
    - Issuing a Repeat Prescription, RX02v02; and
    - Issuing an Acute Prescription RX03v02.

The Practice's response to investigation enquiries

14. The complainant raised concerns about the prescribing and issuing of four medications. I consider the Practice's response to investigation enquiries about each of the medications in turn below.

Loperamide

15. The Practice explained the complainant requested loperamide on Saturday 1 August 2020. It said it prescribed the complainant 60 tablets on 23 July 2020, which were to last 28 days. The Practice said the complainant was '*overusing*' the medication. The Practice calculated the amount of medication ordered as a percentage. Its computer system alerts Practice staff when requests for medication are greater than 130%. The Practice said it forwarded the request

for loperamide *'to [the] pharmacist because usage was 147%'.* The Practice said that following the complainant's request for a 'ring back', GP (A) telephoned her on 10 August 2020. During the call, the complainant told GP (A) she requested a further prescription because she '*suffered a flare [up] of diarrhoea'*. The Practice said GP (A) then issued the prescription for the loperamide tablets following the call.

16. The Practice stated that after a telephone medication review on 22 October 2020 with GP (A), the Practice allowed the complainant to order 60 loperamide '*every 14 days on repeats'*.

Ondansetron

17. The Practice explained the complainant used EMIS[10] Access on 7 July 2020 to order seven repeat prescription items and in addition, the complainant added a '*Free Note*[11]' to request, ondansetron, an acute[12] item of medication. It said that patients ordering acute medication need to contact the Practice, as EMIS Access is restricted to ordering repeat prescriptions. The Practice explained the '*Free text note did not transfer to [the] clinical team for Ondansetron. Free text notes do not automatically forward to the clinical team on our clinical system EMIS. Instead they must be manually entered by the office team and in this event, human error has occurred'*. The complainant telephoned the Practice on 10 July 2020 to enquire about her request for ondansetron. Reception staff sent the request to GP (B) at 09.43. GP (B) printed the ondansetron prescription at 16.05 on 10 July 2020.

18. The Practice said the complainant requested ondansetron again on 16 September 2020. It explained that previous to this, it issued a prescription for 10 ondansetron on 8 September 2020. The Practice said the pharmacy reviewed the request and '*added a "sticky note" (virtually) for "GP to review supply". This was passed ownership to [GP] (A) as he was the triage GP on*

10 EMIS Access a 24 hour online service that enables patients to book GP appointments, order repeat prescriptions via mobile or home computer.

11 Only repeat medication can be requested through EMIS Access. Acute medication is displayed for information purposes only. Any medication that is not authorised as a 'repeat' prescription must be requested by contacting the Practice.

12 Acute prescriptions are defined by the Practice- an issue of medication as a '*one-off'* or medication that requires a prescriber to review prior to any further issue.

Thursday morning'. However, GP (A) did not look at the request as he was working in the Covid Centre. The Practice said the complainant called the Practice on 22 September 2020 and spoke to GP (B) who reviewed and issued the medication. It explained '*The prescription was sent as an 'urgent' script via fax to the pharmacy'*.

19. The Practice said that on 6 October 2020, the complainant added a '*free text'* request to EMIS Access for ondansetron together with a request for three repeat prescription items. The Practice issued three repeat prescription items on 7 October 2020. The '*Free Text'* request was not actioned. The Practice said the complainant contacted reception staff on 13 October 2020 to enquire about the ondansetron. GP (C) subsequently printed the prescription for ondansetron on 13 October 2020.

20. The Practice explained that after a telephone medication review on 22 October 2020 with GP (B), they moved the complainant's ondansetron prescription to '*repeats and doubled the quantity'*.

Zomig

21. The Practice said it changed the complainant's medication after a telephone medication review on 22 October 2020 with GP (A) to allow her to order six zomig tablets every 14 days on repeat prescription. This had previously been every 28 days. The Practice said that on 12 November 2020 the complainant ordered zomig using EMIS Access. The Practice rejected this request on 13 November as this was eight days after it issued her previous prescription on 4 November 2020. The Practice sent the complainant a message asking her to book a call back with a GP. The Practice issued the medication on 17 November 2020 following the complainant's telephone call with a GP.

Diazepam

22. The Practice explained the complainant requested diazepam on 14 December 2020. The office staff forwarded the request to GP (A) who approved the request on 15 December 2020. The Practice provided a printout from their

Docman[13] Document Viewer that showed the pharmacy collected the prescription on 16 December 2020.

Relevant records

23. I enclose a summary of the relevant medical records at Appendix four to this report. These include the complainant's prescription history for the four medications.

Relevant Independent Professional Advice

Loperamide

24. The GP IPA advised that '*loperamide was requested and issued steadily every 13-19 days*. *Prescriptions were normally turned around very quickly (usually the same day) except in early August when a prescription was ordered early after just 9 days and there was a delay between request and issue'*.

25. The GP IPA advised that '*The practice's standard operating procedure RX0[2] states that repeat prescriptions should generally be issued in multiples of 28 days but the complainant was routinely given a 14 day supply of each of her medications'*.

Ondansetron

26. The GP IPA advised '*From July to October 2020 Ondansetron was requested and issued fairly steadily every 8-14 days on an "as required basis" and, as before, prescriptions were normally turned around very quickly*'.

27. The GP IPA advised on 22 October 2020, GP (A) adjusted the prescription to *'accommodate 'current use' of up to 10 tablets a week and increased the number issued on each prescription from 10 to 20. At the same time, he set the prescription interval to 28 days'*. The GP IPA further advised that the prescription '*was adjusted on 17th November'.*

13 Docman is a cloud based software platform that manages clinical correspondence.

Zomig

28. The GP IPA advised that '*requests for Zomig were twice delayed – once on 4th August (this was not an early request) and again on November 12 (just 8 days after the last prescription) when the patient was asked to book a call back with the GP'*.

Diazepam

29. The GP IPA advised '*Three prescriptions for Diazepam were issued*'. He advised he had '*no concerns about them'*.

Overall

30. The GP IPA advised '*I also find no evidence that the complainant was deliberately or systematically denied medication'*.

31. The GP IPA advised that there were inconsistencies in the Practice's response to prescribing medication. The GP IPA referred to 'Issuing a Repeat Prescription RX02' "*Patient ordering early; reviewed by dates and/or compliance (over 130%) is rejected'*. He advised that on a number of occasions the compliance figures were greater than 130% but the Practice issued the prescription regardless.

32. The GP IPA concluded the Practice '*missed opportunities to make things easier for the complainant'*. He also concluded that a combination of factors *'created the illusion that the complainant was over-using her medication: operating a 14 day system for what were effectively regular repeat drugs; the compliance percentages highlighted by the computer software; using "as required" without actually documenting how the patient used these medications; not aligning the different drugs so that they were ordered separately'*.

Complainant's Response to Draft Decision Report

33. I shared a draft copy of this report with the complainant and the Practice for comment on factual accuracy and the reasonableness of the findings. The Practice had no comments. The complainant's comments are noted below.

Loperamide

34. The complainant referred to the sentence '*During the call, the complainant told GP (A) she requested a further prescription because she 'suffered a flare [up] of diarrhoea'*. She said that she had not said this. She had just been using the maximum dose of loperamide.

Ondansetron

35. The complainant said that all of the repeat items '*had been rejected and then issued'*. She said that she thought that this was strange. She agreed that it did not make any difference to the outcome of the report. She explained she ordered ondansetron, an item of acute medication on EMIS Access as a free text note. When she went to the pharmacy on 10 July 2020, the item was not there. She called the Practice on 10 July and spoke to a receptionist who told her that the item *'had not been put on request but that she would sort it out'*. She called a second time and spoke to another receptionist who told her that the request '*had been put through to the Practice Pharmacist but he had left for the day'*. The complainant said that she needed the medication before the holiday and the Practice transferred the request a GP who faxed the prescription to the pharmacy. The complainant said that although the Practice had issued the medication, she felt that she had to *'jump through hoops to get it'*.

Zomig

36. The complainant queried the sentences 'The Practice sent the complainant a message asking her to book a call back with a GP. The Practice issued the medication on 17 November 2020 following the complainant's telephone call with a GP'. She said that the Practice had not sent her a message. She further explained that in this instance she had not spoken to a doctor but to a member of reception staff.

Diazepam

37. The complainant queried whether there was a time stamp on the document. She explained that this issue had been the '*final straw in her interactions with the Practice'*. When my investigation confirmed that there was no time stamp on the document, the complainant found this suspicious.

She noted '*It just bothers me that there is no time stamp, the day (16th December) that the Practice say this script went to the chemist is the surgery's half day, the doors close at 1pm*'. She further noted '*This prescription wasn't at the chemist for me either the morning or afternoon of the 16th December, and I will always wonder was it scanned on the system on that date and just physically not collected/delivered, or was it scanned on by staff working after the surgery had closed at 1pm? which again would have been useless*.

Free Text Notes

38. The complainant said that she had not known that acute items should not be requested using EMIS Access. It was her understanding that this was a *'well established method of ordering medication that was still in use in the Practice today'*.

Two working days

39. The complainant said the Practice always turned around prescriptions in two working days and she was not aware that the Practice updated their procedures to state that prescriptions would be issued in 72 hours. She said that the Practice had not informed patients of this difference.

Analysis and Findings

Loperamide

40. The complainant said the Practice '*rejected'* her request for a prescription for loperamide, which she ordered on 1 August 2020. I note the GP IPA's advice that the complainant requested the prescription nine days after receiving her previous prescription that the Practice expected to last 28 days. The Practice's guidance, Issuing a Repeat Prescription RX02v02, states that if reception staff are concerned patients are ordering medication too early, they should refer the matter either to the prescriber or to the Practice's pharmacist. The records evidence reception staff referred the request on 4 August 2020. Therefore, I consider their actions appropriate and in accordance with internal guidance. The Practice issued the medication on 10 August 2020 after the patient booked a telephone triage encounter.

41. A further issue arose with loperamide when the complainant ordered it on 18 October 2020. The reception team rejected the request on 20 October 2020 on the grounds of overuse. The Practice had previously issued loperamide on 7 October 2020. I again consider the reception team's actions appropriate and in accordance with internal guidance, Issuing a Repeat Prescription RV02v01. I note the Practice issued the medication following the complainant's telephone triage encounter with GP (A) on 22 October 2020.

42. Issuing a Repeat Prescription RX02v02, states that if a prescriber decides to reject a request, they should contact the patient directly. Therefore, I would have expected the Practice to contact the complainant to inform her it had rejected her request and the reason for it. However, they left the onus on the complainant to contact the Practice.

43. I note the Practice issued the medication immediately after the telephone triage encounters. I note also that GP (A) attempted to address the issues affecting the rejection of the complainant's medication, as on 22 October 2020 he recorded on the complainant's medical notes '*altered scripts to current use, all appropriate'*.

44. Based on the evidence available, I do not consider the Practice's actions constitute a failure in its care and treatment of the complainant in this instance. However, I consider that the Practice failed to act in accordance with the first and second Principles of Good Administration. The first Principle of Good Administration, '*Getting it Right'*, requires bodies to act in accordance with their internal guidance. The second Principle of Good Administration, '*Being customer focused'*, requires bodies to deal with people '*helpfully, promptly and sensitively, bearing in mind their individual circumstances'*. In this instance, the Practice did not contact the complainant to let her know it had rejected her medication due to over use in accordance with its internal guidance. I consider the failings constitute maladministration. I appreciate that this failure would have caused the complainant frustration and uncertainty.

45. I acknowledge that the Practice recently updated its guidance, Issuing a Repeat Prescription Standard Operating Procedure, RX02 Version 03, to instruct reception staff to inform patients when their requests are rejected. I welcome this learning.

Ondansetron

46. The complainant said that she ordered ondansetron on 7 July 2020 but it was not available to collect from the pharmacy on 10 July 2020. The complainant contacted the Practice, and reception staff referred the issue to GP (A) who faxed the prescription to the pharmacy the same day. The Practice explained that the complainant had ordered the prescription using the free note function on EMIS Access, and it failed to process the request. It said this was due to '*human error*'.

47. The complainant requested ondansetron on 6 October 2020, again using a free text note on EMIS Access. However, reception staff did not action her request. The complainant telephoned the Practice and it faxed the prescription to the pharmacy on 13 October 2020. I note the Practice's comments that '*On Patient Access you can select only your repeat medication and not acute items*'.

48. I note on these occasions, the complainant requested an acute prescription rather than a repeat prescription. In accordance with the Practice's Issuing an Acute Prescription RX03v02 guidance and the HSCB's Developing a Prescribing Protocol, staff should not generate requests for acute medication. Instead, patients should consult with a GP before ordering an acute prescription. Therefore, in this instance, the Practice acted in accordance with relevant guidance. However, having seen the free text note, I would have expected the Practice to take action to advise the complainant it could not issue the prescription and she would need to speak to a GP. I consider the Practice's actions were not in accordance with the first and second Principles of Good Administration. I consider this failing constitutes maladministration.

49. A further issue arose when the complainant requested ondansetron on 16 September 2020 using the repeat prescription telephone line. The reception

team referred this request to GP (A) to review. However, he was not available and did not review the request. I note reception staff did not transfer the request to another GP to process. When the complainant did not hear from the Practice, she telephoned on 21 and 22 September 2020. GP (B) prescribed the requested medication after their telephone call on 22 September 2020.

50. The Practice Acute Prescription RX03v02 guidance states it should issue prescriptions within 72 hours of the request. However, in this instance, the Practice did not refer the request to an available GP, which resulted in an unnecessary delay. I note the complainant explained the delay led to her being without the medication for a period. Therefore, I am satisfied that the Practice's actions resulted in a failure of the complainant's care and treatment. I appreciate this failure would have caused the complainant unnecessary discomfort for the time she was without her medication. I also consider it caused her frustration and uncertainty.

Zomig

51. The complainant raised concerns that the Practice rejected her request for zomig made on 4 August 2020. The prescription history provided by the Practice showed it rejected her request due to '*overusing*'. The complainant said she telephoned the Practice on 10 August 2020 and a GP issued the prescription that day.

52. I note the GP IPA advised that '*this was not an early request'.* However, he also advised that a '*combination of factors created the illusion that the complainant was over-using her medication'*. Therefore, I consider it likely the system incorrectly identified the complainant was overusing her medication and the Practice rejected her request.

53. In accordance with its internal guidance, Issuing a Repeat Prescription RX02v02, I again would have expected the Practice to contact the complainant. However, it did not do so, and instead the Practice placed the onus on the complainant to enquire why it did not issue the prescription.

54. While I do not consider the Practice's actions constitute a failure in its care and treatment, I consider it again failed to act in accordance with the first and second Principles of Good Administration. I appreciate that this would have caused the complainant frustration and uncertainty.

55. The complainant also ordered zomig on 18 October 2020. The Practice initially rejected this request due to overuse, as it had issued it 11 days previously. After a review of her medication on 22 October 2020, the Practice issued the prescription and altered her future prescriptions to reflect current usage. I note on 13 November 2020 the complainant ordered zomig, eight days after her previous prescription. At this time, she should have been ordering every 14 days. As she had ordered early, the Practice sent her a message asking her to book a call back with the GP. The complainant disputes that the Practice sent her a message. She explained that she spoke to a member of reception staff and after this, the Practice printed the prescription on 17 November 2020. I note that as the complainant ordered the medication on a Friday, the Practice issued the prescription within 72 working hours, in accordance with its internal guidance.

56. The GP IPA highlighted inconsistencies in the Practice's response to the complainant's ordering of zomig. He advised that it did not follow its procedures outlined in RX02 "*Patient ordering early; reviewed by dates and/or compliance (over 130%) is rejected- ''Reject and Reply''; they should give a reason and/or clear guidance to the reception team that is required*." The Practice prescribed medication despite their systems indicating that the complainant was '*overusing'.* This did not adversely impact upon the issuing and prescribing of medication to the complainant. Therefore, I do not consider it a failing in relation to this complaint. However, I would ask the Practice to remind staff to adhere to its guidelines in future.

Diazepam

57. The complainant said she requested diazepam on 14 December 2020 via EMIS Access. However, when she went to the pharmacy the prescription was not

available to collect. She said she called the Practice to ask about the prescription and reception staff told her the pharmacy had collected the prescription on 16 December 2020. I note the Practice records support this.

58. I accept the GP IPA's advice that '*Three prescriptions for Diazepam were issued – two directly by the GP and one requested. All three were for just three tablets of 5mg and I have no concerns about them'*. Based on the evidence available, I consider the Practice acted in accordance with its internal guidance, as it issued the medication within 72 hours of the complainant requesting it. Therefore, I do not uphold this element of the complaint.

CONCLUSION

59. This complaint is about care and treatment the Practice provided to the complainant between July and December 2020. I identified a failure in care and treatment in relation to the Practice's issuing of a prescription for ondansetron in September 2020. I appreciate this would have led the patient to experience unnecessary discomfort for the period she was without her medication. I also identified maladministration in relation to the Practice's issuing of prescriptions for loperamide and zomig. I recognise the uncertainty and frustration this likely caused the complainant. I hope this report goes some way to address the complainant's concerns. I did not identify a failure in the Practice's issuing of prescriptions for diazepam.

60. I acknowledge the pressure GP practices were under at the time of this complaint due to the Covid 19 pandemic. I recognise the impact this had on its provision of services to its patients. However, the uncertainty and frustration the complainant experienced could have been alleviated had the Practice followed its own procedures and contacted the complainant to update her on the status of her medication requests.

Recommendations

61. I recommend that within **one month** of the date of this report the Practice:

i. Provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused to her as a result of the failures identified; and

ii. Discusses the findings of this report with relevant staff and asks them to reflect on the failures identified.

62. If it has not already done so, I further recommend that the Practice provides training to relevant staff on its revised prescription procedures, particularly in relation to:

i. Contacting patients when their prescription request is rejected to inform them of this and the appropriate reasons;

ii. Remind staff to check notes on a medication request as patients may not be aware of the requirement to speak to a GP before ordering an acute prescription; and

iii. The requirement to issue prescriptions within 72 hours of its receipt of the request.

The Practice should provide evidence it has delivered this training within **three months** of the date of this report.

63. While not a formal recommendation, I would ask the Practice to reflect on the GP IPA's advice regarding the potential advantages of aligning out of step drugs and its use of 14-day prescriptions.

MARGARET KELLY
Ombudsman **August 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 Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, 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 learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on 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.

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

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.

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 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.

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.

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 the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.