Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Western Health & Social Care Trust

NIPSO Reference: 20200376

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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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Appendix 1 – The Principles of Good Administration

Appendix 2 – The Principles of Good Complaints Handling

Case Reference: 202000376
Listed Authority: Western Health & Social Care Trust

SUMMARY

I received a complaint about the actions of the Western Health & Social Care Trust (the Trust). The complainant raised concerns about the care and treatment the Trust provided to her husband (the patient) who attended the emergency department (ED) of the South Western Acute Hospital on three occasions in August 2020 due to chronic pain. In particular, the complainant said that the hospital discharged the patient without pain relief when he was suffering significant pain and was feeling suicidal. She was also concerned that the hospital did not check the patient's blood glucose despite the fact that he is diabetic.

The investigation examined the details of the complaint, the Trust's response and relevant guidance. I also obtained independent professional advice from a Consultant in emergency medicine.

The investigation established that the Trust's decision to prescribe co-codamol to the complainant on 23 August was reasonable. In addition, it found that the Trust's refusal to provide the patient with pain relief on the morning 30 August was reasonable, given that he had already taken a significant amount of strong pain relief before attending the ED. However, it found that the Trust failed to document why it did not follow up with the patient, who told staff he was experiencing suicidal thoughts and left the ED on the evening of 30 August without a doctor's assessment. I concluded that this failure did not cause the patient detriment. The investigation also established that the Trust failed to measure the patient's blood glucose levels on 30 August 2020. I concluded that these failings amounted to a loss of opportunity for the patient.

The investigation also established failings in the Trust's handling of the complaint.

I am satisfied that the maladministration I identified caused the complainant and the patient to experience frustration and uncertainty and the time and trouble of bringing a complaint to this office

I recommended that the Trust provide the complainant with a written apology for the injustice caused as a result of the failures in care and treatment I identified. I also made recommendations for service improvements in relation to record keeping.

THE COMPLAINT

1. The complainant raised concerns about the actions of the Western Health and Social Care Trust (the Trust) in relation to the care and treatment provided to her husband (the patient) at the South Western Acute Hospital (SWAH) between 23 August and 30 August 2020.

Background

2. The patient suffered from chronic pain since childhood. He had been taking Tramadol[1] to manage the pain for approximately 10 years. His medication was withdrawn over a three-week period from 20 July 2020, which led to the patient experiencing withdrawal symptoms and suicidal thoughts. He presented to the SWAH emergency department (ED) on 23 August 2020 at 03.50. The patient said that he was unable to sleep because of increased pain in his arms and legs following the withdrawal of his medication. The Trust examined the patient and discharged him after providing him with co-codamol and ibuprofen and advising him to follow up with his GP.

3. The patient attended the ED at SWAH again on 30 August at 03.33 with leg, arm and back pain. An ED doctor examined him and refused to give him additional medication. The complainant, who had accompanied the patient to the ED asked for a second opinion. She said that the ED doctor returned with another doctor who said that chronic pain and suicidal tendencies did not constitute an emergency. The hospital discharged the patient with no additional medication. The complainant also said that the Trust did not check the patient's blood sugar, despite the fact that he is diabetic.

4. The patient returned to the ED at SWAH at 21.12 on 30 August. He advised the triage nurse that he was experiencing suicidal thoughts and low mood. He said that he sat outside the triage room for hours before speaking to a mental health volunteer for an hour. The patient said that he left SWAH after talking to the volunteer.

[1] A synthetic opioid used to treat moderate to severe pain that is not being relieved by other types of pain medicines.

5. It is evident that the complainant and patient's exact recall of the timeline of events is unclear and it has been necessary on occasion to draw an inference from the medical records to match the issues raised in the complaint with the patient's visits to the ED. A chronology of events is attached at Appendix five to this report.

Issues of complaint

6. The issues of complaint accepted for investigation were:

Issue 1: Whether the care and treatment provided to the complainant by South Western Acute Hospital on 23 August and 30 August 2020 was reasonable and in accordance with relevant standards?

In particular, this will include consideration of

- Provision of pain relief
- Treatment of suicidal ideation
- Checking of blood glucose levels

Issue 2: Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

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

- Consultant in Emergency Medicine from 2005 MBChB, MD, MPH, FRCEM. An active clinician in Emergency Medicine with 21 years' experience working in this field. Over 50 peer reviewed articles published on various aspects of emergency medicine, prehospital care and aeromedical critical care transport. A contributor to several UK national and international groups concerned with delivery of emergency and prehospital care.

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

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

Relevant Standards and Guidance

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

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

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

11. 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:

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

- The Department of Health's (DoH) Guidance in relation to the Health and Social Care Complaints Procedure, April 2009 (the DoH's Complaints Procedure);
- The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance);
- National Institute for Health and Care Excellence (NICE) Guidelines: ESUOM27 Chronic pain: oral ketamine February 2014 (NICE ESUOM27) ;
- National Institute for Health and Care Excellence (NICE) Guidelines: NG28 Type 2 diabetes in adults: management December 2015 (NICE NG28);
- Nursing & Midwifery Council (NMC) The Code – Standards of Conduct, performance and ethics for nurses and midwives, March 2015 (NMC Code);
- Royal College of Emergency Medicine (RCEM): Pain Management in Adults January 2018 (RCEM Pain Management in Adults); and
- Western Health and Social Care Trust (WHSCT) Policy and Procedures for Management of Complaints and Compliments/Service User Feedback June 2011 (Trust Complaints Policy)

Relevant sections of the guidance considered are enclosed at Appendix four to this report.

12. I did not include 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 was taken into account in reaching my findings.

13. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. The complainant said that she was happy with the report's findings and recommendations. The Trust stated that it accepted the recommendations and had no other comments to make.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the complainant by South Western Acute Hospital on 23 August and 30 August 2020 was reasonable and in accordance with relevant standards?

Provision of pain relief

Detail of complaint

14. The complainant said that on one of patient's attendances at SWAH, despite the extreme pain he was experiencing, the doctor gave him six co-codamol tablets and sent him home. She said that on another occasion, she accompanied the complainant to the ED and the attending doctor refused to provide the patient with any additional pain relief. She said that she requested a second opinion and that the attending doctor returned with another doctor who told her that chronic pain and suicidal thoughts did not constitute an emergency. The doctor discharged the patient with no further pain relief.

Evidence Considered

Legislation/Policies/Guidance

15. I considered the following guidance:
    - GMC guidance;
    - RCEM Pain Management in Adults

The Trust's response

16. The Trust stated that the patient presented to the ED on 23 August with pains in his arms and legs. The Trust stated that a doctor examined the patient who showed no signs of acute illness or injury. It stated that the doctor gave the patient co-codamol in the ED and additional co-codamol and ibuprofen to take home and discharged him with advice to follow up with his GP.

17. The Trust stated that the patient presented to the ED on 30 August at 03.33. It stated that a doctor examined him and found no '*overt, objective signs of acute or severe illness, or injury*.' The doctor discussed the patient's presentation with a Staff Grade doctor in the ED. The Trust stated that it did not offer the patient any additional medication because the patient advised clinical staff that he had already taken strong pain relief earlier in the evening. The Trust stated that '*in an ED setting, the prescribing of analgesics to any patients, who are already on opioids and benzodiazepines and have had management plans from the pain clinic and mental health, must be carefully vetted, given the extremely high risk of causing harm by administering more analgesics'.* The Trust stated that the ED doctor discharged the patient and advised him to follow up with his GP and pain clinic.

18. The Trust stated that the patient attended the ED again on 30 August at 21.12 hours. It said that the patient left the ED at 00.33 without waiting for a doctor's assessment.

Relevant Independent Professional Advice

19. The IPA advised that the patient was taking a number of '*potent medications*' including a '*long acting opioid*' and another drug for chronic pain. He advised that the Trust's decision to prescribe co-codamol to the patient on 23 August '*in this context, seems appropriate*'. The IPA clarified that there is a relatively small number of medications for discharge in an ED formulary[3] and that '*Co-codamol is usually the most potent analgesia available for discharge*.'

20. The IPA was asked if it was reasonable for the Trust to deny prescribing additional pain relief to the patient on the morning of 30 August, when it had prescribed co-codamol under similar circumstances on 23 August. He advised that while '*it may have been reasonable to trial the addition of Cocodamol on the 23rd August, given that this seems to have no appreciable benefit to the patient, it is then reasonable not to offer this again on the 30th August*'. The IPA acknowledged that this was not the rationale the Trust offered. However, he

[3] an official or authorised publication of an approved list of medicines for use in a **hospital**

advised that the ED doctor's concern that additional medication would have interfered with the patient's current medication regimen was '*understandable*' and '*a reasonable concern…to express*.' The IPA further advised that in his view, the prescription of additional medication was unlikely to harm the patient.

21. The IPA advised that with regard to the patient's presentation to the ED on the evening of 30 August, there was no further interaction with staff noted after triage.

22. The IPA identified that the patient had a complex medical history with diagnoses of depression and Somatic Symptom Disorder[4]. The IPA advised that the role of ED staff was to rule out any life threatening or serious illness and offer as much symptomatic treatment as they could reasonably be expected to. He advised that the patient presented to the ED with symptoms linked to his underlying chronic condition and in light of this, ED staff correctly identified that the patient's GP and the pain clinic could most effectively provide care to him on an outpatient basis.

Analysis and Findings

23. I examined the patient's medical records which document that he had a long history of chronic pain. I consider that in order to present to the ED at SWAH on three occasions in August 2020, the patient must have been in considerable distress.

23 August 2020

24. The patient's emergency attendance record documents that he attended the ED on 23 August 2020 at 03.50. He told the triage nurse that he could not cope with the pain in his arms and legs and had not slept for two weeks. A doctor examined him in the ED at 04.50. The doctor found no indication of injury or illness and no physical abnormalities other than an accelerated heart rate. The doctor noted that the patient suffered from long-term pain and made a diagnosis of '*chronic pain syndrome*' in relation to the patient's symptoms. The doctor prescribed the patient co-codamol and ibuprofen and discharged him.

[4] A significant focus on physical symptoms like pain or fatigue which causes emotional distress and difficulties in activities of daily living.

25. I examined the patient's GP records which document that the patient's GP refused to issue him with co-codamol on 25 August following his attendance at the ED. The GP noted that as the patient had recently weaned off Tramadol, he was reluctant to issue him with another opioid.

26. I note the IPA's advice that the decision to prescribe co-codamol, '*usually the most potent analgesia available for discharge'* in an ED formulary was appropriate given the circumstances. I accept the IPA's advice that it was appropriate for ED staff to discharge the patient with a suggestion to follow up with his GP and neurology.

30 August 2020 a.m.

27. The patient's emergency attendance record shows that he attended the ED at 03.33 on 30 August 2020. He told the triage nurse that he had suffered from chronic pain for 42 years. He said that his pain relief was ineffective and that he could not sleep due to the severity of the pain. A doctor examined the patient at 08.00 and found no indication of injury or illness and no physical abnormalities other than an accelerated heart rate. The notes document that the doctor refused to provide additional pain relief due to the *'medications pt currently on'* and because the patient had taken '*100% medications @ 10pm last night*'. The doctor discharged the patient with a suggestion to follow up with his GP and the pain clinic.

28. I accept the IPA's advice that the ED doctor's reluctance to prescribe additional medication was reasonable, though he also advised that any additional medication was unlikely to cause the patient harm.

30 August 2020 p.m.

29. The patient's emergency attendance record documents that he attended the ED at 21.12 on 30 August 2020. He told the triage nurse that he was experiencing suicidal thoughts and low mood. The triage nurse took his observations and there were no further interactions recorded. The ED notes record that the complainant left the ED at 00.33.

Conclusion

30. I considered the IPA's advice that the role of ED staff was to rule out any life threatening or serious illness and to treat his symptoms as far as they could reasonably be expected to. RCEM Pain Management in Adults states that '*patients with chronic pain can develop new symptoms and should be evaluated accordingly*'. The medical records show that ED staff carried out examinations to ensure that the patient was not presenting with any additional symptoms on both 23 August and the morning of 30 August. The patient left before an ED doctor examined him on the evening of 30 August.

31. I sympathise with the patient who was in such pain and distress that he felt it necessary to go to the ED to try to obtain additional pain relief. His frustration at what he perceived as ED's staff's dismissal of his symptoms is entirely understandable. However, I accept the IPA's advice that the patient received appropriate treatment on both 23 August and 30 August as his symptoms clearly related to his condition, for which he was already receiving strong medication. While the IPA did not share the ED doctor's concern on 30 August that additional pain relief could harm the patient, he said that the doctor's decision was '*understandable'* and '*reasonable'*. The patient's GP was also reluctant to prescribe co-codamol to the patient on 25 August as he had recently weaned off Tramadol. In light of this, I do not uphold this element of the complaint.

Treatment of suicidal ideation

Detail of Complaint

32. The complainant questioned why the Trust sent the patient home after he told ED staff that he was feeling suicidal. The patient said a doctor in the ED told him that being suicidal was not an emergency. The complainant said that the patient spoke to a mental health volunteer for an hour on the evening of 30 August. The complainant said that the person the patient spoke to told him that there were no beds available in Tyrone and Fermanagh Hospital[5] and that he

[5] A hospital providing acute mental health inpatient services for adults and older people

'*could either sit there* (outside triage) *or go home*'. The complainant said that the patient signed what he believed was a discharge form, which the '*mental health volunteer*' gave him and then he left.

Evidence Considered

Legislation/Policies/Guidance

33. I considered the following guidance:
    - GMC Guidance; and
    - NMC Code

The Trust's response

34. The Trust stated that when the patient presented to the ED on 23 August there was '*no mention of suicidal ideation by either the nursing staff, or the medical staff who attended to him*'. The Trust stated that when the patient presented to the ED on 30 August in the morning clinical staff '*did not note suicidal ideation or psychotic elements*'.

35. The Trust stated that when the patient returned to the ED on the evening of 30 August, a nurse noted that he was '*suffering suicidal thoughts and low mood*'. It clarified that there was '*no new suicidal ideation*' from the patient. The Trust stated that the patient left the ED without waiting for medical assessment. It stated that there were no mental health volunteers in the ED and that the Crisis Team did not assess the patient before he left.

Interview with the Crisis Team Manager

36. During the course of the investigation, the investigating officer spoke to the Trust's Crisis Team manager who confirmed that a nurse from the Crisis Team assessed the patient during his presentation to the ED on the evening of 30 August. The manager stated that the nurse who assessed the patient ought to have updated the patient's ED records to reflect this. The manager stated that it was the Crisis Team's fault that this did not happen. The manager stated that the nurse did not have the authority to discharge the patient, nor would he have done so.

Relevant Independent Professional Advice

37. The IPA advised that there were no references to suicidal ideation in the medical records when the patient attended the ED on 23 August and the morning of 30 August. He said that when the patient returned to the ED on 30 August, the triage notes referred to the fact that the patient suffered suicidal thoughts.

38. The IPA was asked if was reasonable not to attempt to contact the patient after he left the ED without notice, given that he told the triage nurse he was experiencing suicidal thoughts. The IPA advised that the escalation of patients with mental health problems who leave before the completion of treatment is a complex decision involving a number of considerations. The IPA advised that it would be good practice to attempt to contact a patient presenting with suicidal ideation if that patient had left the ED without receiving treatment. The IPA advised that ED staff did not document the decision making process as to why there was no attempt to contact the patient after he left the ED. Given this, the IPA said that it was difficult to assess if ED staff's decision not to contact the patient was appropriate. The IPA advised that the documentation in the patient's medical records suggested that he was '*a low, or at most, moderate risk of further harm'.*

Analysis and Findings

23 August and 30 August a.m.

39. I examined the patient's medical records for 23 August and the morning of 30 August and could find no evidence that on either of these occasions he told ED or ambulance staff that he was experiencing suicidal thoughts. The complainant and the patient insist that the patient told medical staff on each occasion he attended that he was feeling suicidal. The complainant said the Trust '*did not take his suicidal thoughts seriously and he was worse leaving than when he went in*'. I examined the patient's GP records which note that on 21 August 2020 he was self-harming to try to ease the pain in his limbs. I have no doubt that the patient was experiencing suicidal thoughts when he attended the ED

on 23 August and the morning of 30 August given the pain that he was suffering.

40. However, there is no reference in the medical records on these dates to any suicidal ideation by the patient. In investigating the complaint, I am reliant upon the contemporaneous records provided by the Trust. Therefore, I cannot conclude that the complainant expressed suicidal thoughts that ED staff ignored or dismissed, however I note the complainant's concern in this regard.

30 August p.m.

41. The Trust stated that when he attended the ED, the patient reported to the triage nurse that he was having suicidal thoughts. The Trust stated that the patient left the ED at 00.33 on 31 August without a doctor assessing him. There is no evidence that ED staff attempted to contact the patient, despite the fact that he had suicidal thoughts. I note the IPA advised that it would be good practice to attempt to contact a patient presenting with suicidal ideation if the patient left the ED without receiving treatment. I also note that while the IPA identified the patient as being at '*low risk'* of further harm, he advised that ED staff did not document their decision making process as to why there was no follow up with the patient, which was not appropriate record keeping.

42. I refer to the GMC Guidance which states '*Clinical records should include: the decisions made and actions agreed, and who is making the decisions and agreeing the actions*'
In my view, the clinical records should accurately record the details of any decisions made by clinicians in order to ensure clarity for those clinicians who will later rely on the information recorded in these records. I am satisfied that these actions in relation to record keeping fall below the required standard and constitute service failures. I therefore partially uphold this element of the complaint. However, I am satisfied that he did not suffer detriment as a result of these record keeping failures.

43. I note in its response to the complainant's claim that the patient spoke to a person involved in mental health during his attendance at the ED on the

evening of 30 August, the Trust stated he was '*not assessed by the Crisis Team*'. I examined the patient's GP records, which showed that a nurse from the Crisis Team examined him on 30 August. The Investigating Officer contacted the Crisis Team manager who confirmed that the assessment took place in the ED at SWAH.

44. I examined the Crisis Team report which recorded that the patient was experiencing '*fleeting suicidal thoughts & lowered mood related to chronic pain*'. It concluded that the patient was not a suicide risk and that he required no further input from the Crisis Team.

45. The patient said that when he finished speaking to the Crisis Team nurse he signed a form and assumed that he had been discharged, which is why he left the ED. The Crisis Team manager told the Investigating Officer that the nurse did not have the authority to discharge the patient, nor would he have done so. She said it was the Crisis Team nurse's responsibility to update the patient's ED records so that ED staff would be aware the Crisis Team had assessed him. It is evident from the patient's records that this did not happen and there was a breakdown in communication between the Crisis Team and ED staff.

46. In view of this I must record my concern that the patient's ED notes do not evidence that the Crisis Team assessed him on the evening of 30 August. Although the Trust's record keeping is not a matter the complainant raised in bringing her complaint to me, it is important that I highlight it in this report, particularly as the patient's recollection of events differs markedly from the information contained in his ED records. I note the NMC Code requires nurses to '*maintain effective communication with colleagues*' and to '*keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff*'

47. It is my expectation that the Trust will give careful consideration to this matter and to the need to remind relevant staff of the specific requirement of keeping their colleagues appraised of any treatment provided to patients.

48. I will address the Trust's claim that the Crisis Team did not assess the patient in

the section on complaint handling.

Checking of blood glucose levels

Detail of Complaint

49. The complainant was concerned that ED staff did not check the patient's blood glucose levels during his attendances at the ED.

The Trust's response to the complainant.

50. The Trust apologised for not checking the patient's blood glucose levels on each of his visits to the ED. It stated that it had informed staff that patients who have diabetes and present to the ED should have their blood glucose levels tested as soon as possible.

Relevant Independent Professional Advice

51. The IPA advised that ED staff checked the patient's blood glucose levels on 23 August. He advised that staff did not test the patient on 30 August. The IPA advised that it was good practice to test a diabetic patient with non-specific symptoms. The IPA advised that abnormally low blood glucose could cause a patient to become agitated or confused which could be misinterpreted as pain or distress. He advised further that high blood glucose may be due to an infection which could exacerbate the patient's pain. However, the IPA advised that he could see no evidence of detriment from the Trust's failure to check the patient's blood glucose.

Analysis and Findings

52. The Trust admitted that it failed to test the patient's blood glucose levels and apologised to the complainant. The IPA outlined the potential consequences of failing to test a diabetic's blood glucose levels, which include the possibility of increased levels of pain, or a misinterpretation of a patient's symptoms. I accept the IPA's advice.

53. I refer to the GMC Guidance 15 (a) which states that those clinicians assessing, diagnosing, or treating patients must '*adequately assess the patient's*

conditions, taking account of their history'. I consider that the Trust's failure to check the patient's blood glucose during his attendances at the ED on 30 August constitutes a failure in his care and treatment. I am satisfied that the patient suffered the injustice of the loss of opportunity to have his blood glucose tested. However, I also accept the IPA's advice that the patient did not suffer detriment as a result of this failure. I am pleased to note that the Trust advised that it sent out notification to all staff that patients with diabetes who present to the ED should have a blood glucose level recorded as soon as possible.

Issue 2: **Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?**

Detail of complaint

54. The complainant said that most of the Trust's response to her complaint was '*wrong, mistaken or lies'.* In particular, the complainant said that the Trust's claim that the patient did not speak to a mental health volunteer was hurtful as there was '*little or no truth in it*'.

Evidence Considered

Legislation/Policies/Guidance

55. I considered the following guidance:
    - Trust Complaints Policy; and
    - The DoH's Complaints Procedure

The Trust's response

56. The Trust stated that '*sometimes the Crisis Team will have an informed discussion with a patient they have assessed in the ED about further management and treatment options.'* It stated in its response to the complainant and its original response to this office that it could confirm that the patient was '*not assessed by the Crisis Team'.* The Trust subsequently acknowledged that the Crisis Team assessed the patient during his presentation to the ED on the evening of 30 August.

GP Records

57. The records document that the '*patient was seen and assessed by the Crisis Response/Home Treatment Team on 31/08/20.* They document that the primary diagnosis was '*fleeting suicidal thoughts and lowered mood related to chronic pain*'. The records also document that the patient '*has guaranteed his safety at home*' and that there was to be '*no further input*' from the Crisis Team.

Analysis and Findings

58. The patient's records contain a letter from the Crisis Team to his GP confirming that the Crisis Team assessed the patient on 31 August 2020. The Crisis Team subsequently confirmed that it assessed the patient during his presentation to the ED at SWAH on the evening of 30 August 2020. I am satisfied therefore that the Trust's statement to the complainant and this Office that the Crisis Team did not assess the patient is incorrect and the patient's claim that he spent time '*with someone discussing [his] mental health'* is accurate. I note that the Trust has now acknowledged that the Crisis Team assessed the patient in the ED.

59. The First Principle of Good Complaint Handling 'Getting it right' requires public bodies to '*act in accordance with the law and relevant guidance and with regard for the rights of those concerned*'. The Third Principle of Good Complaint Handling 'Being open and accountable' requires public bodies to provide '*honest evidence-based explanations and giving reasons for decisions'.* In addition the Fourth Principle of Good Complaint Handling 'Acting fairly and proportionately' requires public bodies to ensure '*that complaints are investigated thoroughly and fairly to establish the facts of the case*'. In its response to the complainant regarding the patient's assessment by the Crisis Team, I do not consider that the Trust meets these standards for the reasons outlined above. I consider that this failure to conduct a thorough and accurate investigation constitutes maladministration.

60. Consequently, I am satisfied that the maladministration identified caused the complainant to experience the injustice of frustration, uncertainty and the time

and trouble of bringing a complaint to this office. Therefore, I uphold this element of the complaint

CONCLUSION

61. I received a complaint about the actions of the Trust. The complainant raised concerns about the care and treatment the Trust provided to patient in the ED at SWAH on 23 August and 30 August 2020. The complaint also concerned the Trust's handling of the complaint.

Issue One

62. The investigation established failures in the care and treatment in relation to the following matters:

    - The failure to document the decision not to follow up with the patient when he left the ED without treatment following his suicidal ideation at triage;
    - The failure to measure the patient's blood glucose on 30 August.

63. I am satisfied that the failure in care and treatment identified caused the patient to experience the injustice of the loss of opportunity to have his blood glucose measured.

64. The investigation established maladministration in relation to the following matters:
    - The failure to act in accordance with relevant guidance;
    - The failure to provide the complainant with an honest evidence based explanation; and
    - The failure to conduct a thorough and accurate investigation

65. I am satisfied that the maladministration identified caused the complainant and the patient the injustice of frustration, uncertainty and the time and trouble of bringing a complaint to this office.

Recommendations

66. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report

67. I further recommend for service improvement and to prevent future recurrence, the Trust

    - Carry out a random sampling audit of patients' records within the ED from 1 April 2022 to the date of issue of the final report. This is to ensure that staff have documented their decision making around the escalation of patients with acute mental health presentation who have self-discharged prior to assessment. The Trust take action to address any shortcomings identified; and
    - The Trust provide evidence that it has reviewed why its own investigation of the complainant's concerns did not identify or acknowledge all the failings highlighted here

68. I recommend that the Trust implement an action plan to incorporate these recommendations and should provide me with an update within **three** months of the date of my final report. That action plan should be supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

69. I am pleased to note the Trust accepted my recommendations.

Margaret Kelly
Ombudsman **September 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. Getting it right

- Acting in accordance with the law and 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 learned from complaints.
- Including complaint management as an integral part of service design.
- Ensuring staff are equipped and empowered to act decisively to resolve complaints.
- Focusing the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. Being customer focused

- Having clear and simple procedures.
- Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.
- Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.
- Listening to complainants to understand the complaint and the outcome they are seeking.
- Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. Being open and accountable

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

- Publishing service standards for handling complaints.
- Providing honest evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

4. **Acting fairly and proportionately**

- Treating the complainant impartially, and without unlawful discrimination or prejudice.
- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.
- Ensuring that decisions and actions are proportionate, appropriate and fair.
- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.
- Acting fairly towards staff complained about as well as towards complainants

5. **Putting things right**

- Acknowledging mistakes and apologising where appropriate.
- Providing prompt, appropriate and proportionate remedies.
- Considering all the relevant factors of the case when offering remedies.
- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. **Seeking continuous improvement**

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.
- Having systems in place to record, analyse and report on learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.