Investigation of a complaint against Annagh Family Practice

Report Reference: 201916274

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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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SUMMARY

This complaint was about care and treatment the Annagh Family GP Practice (the Practice) provided to the patient in April 2017. It related to the Practice's prescription of the opioid analgesic drug, oxycodone[1], particularly Shortec[2].

The complainant raised concerns about the Practice's increase in its prescription of Shortec on 25 April 2017, after the patient's attendance at Craigavon Area Hospital's emergency department on 26 April 2017.

This investigation found the Practice's increase in the dosage fell within the prescribing limits for the drug. Therefore, it did not identify any failings in the Practice's care and treatment of the patient. However, it does not detract from what would have been a worrying time for both the patient and complainant.

I was sorry to learn the patient passed away in May 2017. I wish to extend my condolences to the patient's family for this sad loss.

[1] An opioid painkiller used to treat severe pain, for example after an operation or a serious injury, or pain from cancer.
[2] A brand name for fast-acting oxycodone.

THE COMPLAINT

1. This complaint was about care and treatment Annagh Family Practice (the Practice) provided to the patient. The complainant was the patient's son.

Background

1. In April 2017, the patient was terminally ill following a diagnosis of lung cancer. The Practice prescribed the patient both Shortec[3] and Longtec[4] medication.

2. On 24 April 2017, the Practice increased the dosage of Longtec from 20mg to 40 mg twice daily. This was because the patient was *'taking 6 or 8 shortec 5mg tablets in a 24 hr period[5].'*

3. On 25 April 2017, the Practice *'then increased [the dosage] of Shortec from 5 to 20mg 4-6 hrly prn[6]'*.

4. On 26 April 2017, a community nurse found the patient was '*quite unwell'* and contacted the Practice. The Practice sent the patient to Craigavon Area Hospital's (the hospital) Emergency Department (ED), by ambulance, for assessment of opioid toxicity[7]. ED staff monitored the patient for two hours. The hospital discharged the patient, and he returned home.

Issue of complaint

5. I accepted the following issue of complaint for investigation:
   Whether the dosage of oxycodone medication the Practice prescribed for the patient on 24 and 25 April 2017 was appropriate and in line with good clinical practice.

[3] A brand name for fast-acting oxycodone.
[4] A brand name for slow-release oxycodone.
[5] Taken from the GP referral to hospital dated 26 April 2017.
[6] An abbreviation for the Latin term 'pro re nata' meaning 'as required'.
[7] Build up of opioid in a patient's body producing significant functional and cognitive impairment

INVESTIGATION METHODOLOGY

6. In order to investigate this matter, the Investigating Officer obtained from the Practice its comments on the issue of complaint.

Independent Professional Advice Sought

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

    - A senior GP with 13 years' GP experience and a special interest in regulatory medicine.

8. 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 investigation, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to conduct investigations, 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[8]:

    - The Principles of Good Administration

10. 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 Regional Palliative Medicine Group's Guidance for the Management of Symptoms in Adults in the Last Days of Life, 2018 (RPMG guidance);
    - The Faculty of Pain Medicine of the Royal College of Anaesthetists' guidance on Opioids for pain management in palliative care, undated

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

(the FPM guidance); and

- The British National Formulary's guidance on the use of oxycodone hydrochloride, undated (BNF guidance).

The IPA refers to the standards and guidance within their advice.

11. 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.

12. A draft copy of this report was shared with the Practice and the complainant for comment on factual accuracy and the reasonableness of the findings and recommendations. The Practice offered no substantive comment on the draft report, though subsequently advised of actions it had taken having considered learning/improvements suggested by the IPA, which were additional to the issue under investigation. Paragraph 29 refers.

THE INVESTIGATION

Whether the dosage of oxycodone medication the Practice prescribed for the patient on 24 and 25 April 2017 was appropriate and in line with good clinical practice.

Detail of Complaint

13. The complainant was concerned about the Practice's increase in its prescription of Shortec for the patient on 25 April 2017. A question arose as to whether this led to the patient's attendance at the Hospital's ED the following day.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following guidance:
    - RPMG guidance;
    - FPM guidance; and
    - BNF guidance.

The Practice's response to investigation enquiries

15. The Practice said its GP saw the patient on 24 and 25 April 2017. The GP left his employment with the Practice in June 2017.

16. Referring to the patient's medical records, the Practice stated it prescribed the patient *'Shortec 20mg four-six hourly as required'* on 25 April 2017.

The named GP's response to the investigation enquiries

17. The named GP referred to the RPMG guidance which sets out the dosage calculation for breakthrough[9] pain medication. It was *'generally 1/6th of the total daily dosage of any long action opiate given every 2 to 4-hourly.'* For a Longtec dosage of 80mg, *'this would equate to 13.3mg dosage of breakthrough analgesia to be taken every 2 to 4 hours as required'*.

18. The named GP said this would equate to a maximum dosage of Shortec of 120mg per day. That is, one 20mg tablet taken every four hours (20 x 6).

Relevant Practice records

19. The Practice's records for the patient included an entry for a prescription of 56 Shortec 20mg tablets to be taken *'1 every 4 – 6 hours as required'.*

20. The record also included an entry for a prescription of 56 Longtec 40mg tablets, one to be taken '*every 12 hours'*.

[9] Breakthrough pain is defined as "a transitory flare of pain that occurs on a background of relatively well-controlled baseline pain" and in general is moderate to severe in intensity, comes on quickly, and is of short duration.

Relevant Independent Professional Advice

21. The IPA advised that Longtec and Shortec both contain the drug Oxycodone Hydrochloride. *'According to BNF a patient can be prescribed up to 400mg Oxycodone Hydrochloride for moderate to severe pain'.*

22. The IPA advised *'the patient can [therefore] be prescribed a dose of Shortec of 20mg to be taken 4 to 6 hourly for break through pain, in addition to regular Longtec of a total dose of 80mg a day'.*

23. The IPA advised *'the total amount of oxycodone prescribed by [the named GP] did not exceed the total amount recommended by the BNF'*.

24. The IPA commented on the frequency of communication with the patient and their family, *'suggested by the BNF [guidance]'*, in relation to the patient *'being initiated on opioid medication for the first time, and following up the patient whilst having regular dosage increases of medication'.*

Analysis and Findings

25. The Practice records document that it prescribed the patient 56 Shortec tablets, each of 20mg in strength, on 25 April 2017. The records also document the patient was to take one tablet every four to six hours, as required. I calculate this as a maximum Shortec dosage per day of 120mg (six 20mg tablets).

26. The Practice also prescribed the patient Longtec medication at a dosage of 56 tablets, each of 40mg in strength, one to be taken twice daily. I calculate this as a maximum Longtec dosage per day of 80mg. Taken together, I calculate the maximum prescribed daily dosage of Longtec and Shortec as 200mg (120mg plus 80mg).

27. The IPA advised the dosage prescribed was within the limitations stipulated in the guidance. I note the BNF guidance stipulated a maximum oxycodone dosage of 400mg per day. I therefore accept this advice. That being so, I consider the dosage of Shortec the Practice prescribed to the patient on 25 April 2017 appropriate. I have not identified a failure in care and treatment and do not uphold the complaint.

28. Finally, whilst it did not form part of my investigation, I note the IPA commented on the Practice's communication with the patient and their family in relation to follow-up after it prescribed opioid medication. I would ask the Practice to consider the IPA's advice in this regard.

CONCLUSION

29. This complaint was about the Practice's prescription of pain relief medication for the patient on 24 and 25 April 2017. My investigation found the dosage prescribed fell within the limitations of the guidance. Therefore, I have not identified a failing in care and treatment. This does not diminish the effect this worrying time had on both the patient and complainant.

30. I am conscious the patient, a dearly loved father, passed away a month afterwards and this report will serve as a reminder of very sad and difficult events. Nonetheless, I hope this small but important follow-up enquiry has been of assistance in providing reassurance to the patient's family.

31. I wish to extend my sympathy to the family for their loss.

MARGARET KELLY **16 February 2024**
Public Services 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.

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.