Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against Belfast Health and Social Care Trust

NIPSO Reference: 22704

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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: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient when she attended the emergency department (ED) of the Royal Victoria Hospital (RVH) in February 2020. The patient explained that the treating Registrar informed her that her blood results were '*all clear'* despite showing a raised white cell count[1]. She said her community GP treated her for an infection the following week. The patient considered that the Registrar's failure to treat the infection caused her to '*suffer unnecessarily'*.

The investigation examined the details of the complaint, the Trust's response, and relevant guidance. I sought independent professional advice from a Consultant of emergency medicine. The investigation established that the Registrar diagnosed the patient with gastritis[2], which was considered reasonable and appropriate based on the information available to him. It also established that the patient was prescribed appropriate medication to treat her symptoms.

The investigation identified that it was reasonable for the Registrar to inform the patient that her blood results were 'normal'. However, it found that he failed to advise the patient about what signs or symptoms to monitor that may prompt her to revisit the ED or to attend her GP. I considered this a failure in the patient's care and treatment causing her to experience uncertainty and the loss of opportunity to receive earlier treatment.

I recommended that the Trust apologise to the patient for the injustice resulting from the failure identified. I also recommended actions for it to undertake to prevent the failure from recurring. The Trust accepted the findings and recommendations.

[1] A high white blood cell count may indicate that the immune system is working to destroy an infection.

[2] A general term for inflammation of the lining of the stomach.

THE COMPLAINT

1. This complaint is about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the patient when she attended the emergency department (ED) of the Royal Victoria Hospital on 18 February 2020.

Background

2. The patient said she underwent a colonoscopy[3] and an oesophago-gastro-duodenoscopy[4] (OGD) in the RVH on 3 February 2020. She said she felt unwell and experienced stomach pain for the following two weeks, causing her to attend the ED on 18 February 2020. The patient explained that the attending ED Registrar said her blood tests were normal and sent her home without any further treatment. She said she continued to feel unwell and attended her general practitioner doctor (GP) the following week. She said her GP diagnosed her with an infection and prescribed antibiotics.

Issues of complaint

3. The issue of complaint accepted for investigation was:
   Issue 1: Whether the care and treatment the patient received at the emergency department of the Royal Victoria Hospital in February 2020 was in accordance with good medical practice.

INVESTIGATION METHODOLOGY

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

Independent Professional Advice Sought

5. Independent professional advice was obtained from an independent professional advisor (IPA).

[3] The examination of the large bowel and the distal part of the small bowel with a camera on a flexible tube.
[4] A procedure where a thin, flexible tube called an endoscope is used to look inside the oesophagus, stomach and first part of the small intestine.

6. The information and advice that informed my findings and conclusions are included within the body of my report and its appendices. The IPA provided me with 'advice'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

7. 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[5]:

   - The Principles of Good Administration
   - The Principles of Good Complaint Handling

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

   The specific standards relevant to this complaint are:

   - The General Medical Council's (GMC) Good Medical Practice, as updated April 2014 (the GMC Guidance); and
   - The Royal College of Emergency Medicine's (RCEM) Best Practice Guideline, February 2017 (the RCEM's Guideline).

9. 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.

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

10. A draft copy of this report was shared with the patient and the Trust for comment on factual accuracy, and the reasonableness of the findings and recommendations.

INVESTIGATION

Issue 1: Whether the care and treatment the patient received at the emergency department of the Royal Victoria Hospital in February 2020 was in accordance with good medical practice.

Detail of Complaint

11. The complaint is about the care and treatment the patient received during her attendance at the ED of the RVH on 18 February 2020. The patient said the ED Registrar informed her that her blood results were '*all clear*'. However, she said that when she attended her GP a week later, he informed her that her ED blood results showed a raised white cell count[6] (WCC), and treated her with antibiotics. Following further enquiries, the patient said the ED Registrar failed to inform her that her WCC was raised and what symptoms to monitor over the coming days that may prompt her to return to the ED. She said she ought to have received treatment with antibiotics a week earlier, and the failure to do so caused her to '*suffer unnecessarily'*.

Evidence Considered

Legislation/Policies/Guidance

12. I referred to the following policies and guidance, which were considered as part of investigation enquiries:

    i. The GMC Guidance; and
    ii. The RCEM's Guideline.

    Relevant extracts of the guidance considered are enclosed at Appendix three to this report.

[6] A high white blood cell count may indicate that the immune system is working to destroy an infection.

The Trust's response to investigation enquiries

13. The Trust explained that the Registrar's '*evaluation including [the patient's] history, examination and blood tests were consistent with a diagnosis of gastritis. He prescribed a change to [the patient's] medication for this condition. It was his opinion that the raised white blood cell count described by [the patient's] GP was in keeping with the inflammation of gastritis as opposed to infection'*.

14. The Trust explained that a Consultant undertook an investigation into the complaint. It said that the Consultant '*examined the relevant clinical documentation and discussed [the patient's] assessment and decisions made in relation to her ongoing care with [the Registrar]. [The Consultant] has advised that he is satisfied that [the Registrar] acted responsibly in terms of his clinical assessment'*.

15. The Trust explained that the Registrar '*offered a sincere apology to [the patient] regarding his interpretation of her blood results being normal and where he did not communicate this effectively or ensured she understood her diagnosis and treatment plan before discharge. He does recall offering to facilitate a discussion with the consultant in charge however, [the patient] did not wish to avail of this'*.

Relevant medical records

16. The ED records document that the patient reported '*epigastric pain*[7] *– 2 weeks'*. It also documents the diagnosis as '*gastritis*'. The patient's blood results document the WBC [white blood cells] as 13.0; NEUT [neutrophils[8]] as 10.8; APL [alkaline phosphatase level[9]] as 337; GGT [gamma-glutamyl transpeptidase[10]] as 102; and, CRP [C-reactive protein[11]] as 0.9. The records document that the patient was prescribed lansoprazole[12] for a period of two weeks.

[7] Pain or discomfort directly below the ribs in the area of the upper abdomen.
[8] A type of white blood cell that helps heal damaged tissues and resolve infections. Higher levels may indicate infection or injury.
[9] High ALP levels relate to a person's liver, gallbladder, or bones.
[10] High levels of GGT in the blood relate to a person's liver or damage to the bile ducts.
[11] CRP increases when there's inflammation in your body, which is a common indicator of infection.
[12] A medication which reduces stomach acid.

Other information considered

17. I obtained records of the patient's interactions with her GP between 24 and 28 February 2020. The patient reported to her GP on 24 February 2020 that she continued to experience pain in her abdomen. The records for this date refer to the patient's WCC result from her ED attendance on 18 February 2020, and document that the GP prescribed ciprofloxacin[13]. The records further document that the patient continued to experience pain and dizziness up until 28 February 2020. The patient underwent a further blood test on 28 February 2020. The results, returned on 29 February and 3 March 2020, were reported as normal.

18. The GP Practice also provided correspondence it received from the RVH regarding the patient's attendance on 18 February 2020. The letter documents the patient's symptoms, and the diagnosis and prescription the patient received. It also documents that the patient was '*not happy'* about the Registrar's management of her attendance.

Relevant independent professional advice

19. I sought independent professional advice from a Consultant of emergency medicine (E IPA). The E IPA advised that the tests undertaken for the patient while she was in the ED were '*appropriate*' and all of the results were '*normal*'.

20. In relation to whether the patient's blood results showed signs of infection, the E IPA advised that '*the white cell count was around the upper margin of normal/high, at 13.0…At RVH, 13 is cited as just above the normal range. The distribution of white cells showed a slightly high neutrophil count, suggestive of bacterial infection, but again very much at the borderline value. The CRP, which is the third way that infection is routinely measured for emergency patients, was normal'*. The E IPA advised that '*in the situation of a borderline result, a high proportion of doctors would not mention the result, so as not to worry the patient. A significant proportion would mention the white cell count as being uncertain, and give advice about what to look out for over coming days, to suggest infection'*.

[13] An antibiotic used to treat a number of bacterial infections.

21. In relation to the diagnosis of gastritis, the E IPA advised that '*…gastritis was indeed the most likely diagnosis. Other options included biliary tract disease or diverticular disease but these were much less likely'*. The E IPA was asked if the Registrar ought to have diagnosed the patient with an infection. She advised that '*I do not think she should have been diagnosed with an infection at that point in time…The only omission that I can see is written documentation of the advice the doctor gave her about going home and what to expect over coming days….As they stand, the notes fall short of the documentation that the Royal College [RCEM Guideline] would expect to see'*. In relation to the treatment offered, the E IPA advised that the Registrar prescribed '*an acid-blocking drug to counteract gastritis'*. She advised that '*this was a very reasonable prescription to try for a week or two'*.

22. In summary, the E IPA advised that '*the medical care given to the patient was proportionate, rational and thorough'*. In relation to learnings, the E IPA recommended '*…a discussion with his line manager about improving the section of the notes relating to safety-netting symptoms over the coming days, in line with Royal College of Emergency Medicine guidelines which recommend clear recording of discharge advice; and, a further more detailed written explanation to the patient that her white cell count was just above the upper limit of normal, which is inconclusive of infection, and that there was no hard and fast evidence of infection found either on the day of consultation or subsequently, through further tests organised by the GP practice'*.

The patient's response to the draft report

23. The patient explained that the ED Registrar prescribed her lansoprazole. However, she said she was already taking esomeprazole[14] following a previous procedure. She explained that these medications belong to the same family. The patient also said that a nurse in the ED administered 30mg of codeine for her pain, which is a medication she already takes at home.

24. In relation to her blood test results, the patient explained that the ED Registrar said they were normal. However, he failed to tell her that her WCC was 14

[14] A medication which reduces stomach acid.

when it is normally 4 or 5. She said she should have been informed about this. The patient also said she does not know how her bloods could have been classified as normal when she has an auto-immune disease and her bloods are '*never normal*'.

Analysis and Findings

25. The patient said that when she attended the ED on 18 February 2020, the Registrar wrongly informed her that her blood results were '*all clear*'. She also said the Registrar failed to inform her that her WCC was raised.

26. I reviewed the patient's blood results from her attendance at the ED. I note the E IPA's advice that the test results were '*normal*'. This included the CRP, which is a common indicator of infection. I also note her advice that based on these results, the Registrar's diagnosis of gastritis was '*the most likely diagnosis'*, and it was appropriate not to diagnose an infection at that time. I consider the Registrar's diagnosis of gastritis was reasonable and appropriate based on the information available to him.

27. I note the Registrar prescribed the patient a two week course of lansoprazole. While I note the patient's view that it was similar medication to that she was already prescribed, I accept the E IPA's advice that this was '*a very reasonable prescription'*. I consider that given the diagnosis, the decision to prescribe this medication was reasonable and appropriate.

28. The E IPA advised that the patient's WCC and neutrophil count was on the higher side of normal. I note that while the E IPA advised in this situation, '*a high proportion of doctors would not mention the result, so as not to worry the patient'*, she also advised it was appropriate for the Registrar to '*give advice about what to look out for over coming days, to suggest infection'*. This is also in accordance with the RCEM Guidelines, which state that doctors ought to provide patients with *'advice about symptoms or signs that should prompt further assessment'.*

29. I note the patient said the Registrar did not provide her with any advice regarding the monitoring of her symptoms. I also note the ED clinical record

does not document that the Registrar provided any advice to the patient before her discharge. It was also not documented in the hospital's correspondence with the patient's GP. Based on the evidence available to me, I consider the Registrar did not advise the patient what symptoms to monitor that might prompt her return to the ED, or to attend her GP earlier than she did. I am satisfied that by not doing so, the Registrar failed to act in accordance with the RCEM Guidelines. I consider this a failure in the patient's care and treatment.

30. I note from the patient's GP records that she continued to experience abdominal pain, was prescribed antibiotics, and underwent further tests up until 28 February 2020. However, it was a further six days before the patient approached her GP (24 February 2020). I consider that had the Registrar advised the patient about what symptoms to monitor, she would likely have attended her GP, or the ED, earlier for treatment. I am satisfied the failure identified caused the patient to experience uncertainty and the loss of opportunity to receive earlier treatment.

CONCLUSION

31. The patient raised concern with the care and treatment provided to her when she attended the RVH's ED in February 2020. The investigation established it was reasonable for the Registrar to inform the patient that her blood results were 'normal'. It also found that the Registrar diagnosis of gastritis was reasonable and appropriate based on the information available to him at that time. It also established that the patient was prescribed appropriate medication for her symptoms.

32. The investigation identified that the Registrar failed to act in accordance with the RCEM Guidelines as he did not advise the patient about what signs or symptoms to monitor that may prompt her to attend her GP or the ED. I consider this a failure in the patient's care and treatment. I am satisfied the failure identified caused the patient to experience uncertainty and the loss of opportunity to receive earlier treatment.

Recommendations

33. I recommend within **one** month of the date of this report:

i. The Trust provides the patient 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 failure identified; and

ii. The Trust discusses the findings of this report with the Registrar involved in the patient's care at their next staff appraisal. This discussion ought to include the importance of advising patients of what signs or symptoms they should monitor that might prompt their return to the ED, or to attend their GP, in accordance with the RCEM Guidelines.

34. The Trust accepted my findings and recommendations.

MARGARET KELLY
Ombudsman **June 2021**

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:

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.