Northern Ireland
Public Services
Ombudsman

Investigation Report

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

NIPSO Reference: 19583

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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

I received a complaint about the actions of the Northern Health & Social Care Trust (the Trust) relating to the care and treatment it provided to the complainant's daughter (the patient). He complained that his daughter was assessed in Antrim Area Hospital's Emergency Department, and discharged with painkillers. However, he believed that the Trust failed to perform proper tests for Cauda Equina Syndrome despite being informed that it may have been a possible diagnosis.

My investigation established that, on the basis of the presenting symptoms and the Trust's opinion of mechanical back pain as the most likely diagnosis, the care and treatment provided was reasonable. In addition, I considered that an x-ray was an appropriate method of investigation for this diagnosis, and that it was appropriate to discharge the patient from hospital with analgesia. However, I was concerned about the lack of records relating to the investigation conducted and the advice provided on discharge.

The investigation also established a failure in the patient's care and treatment in relation to a failure to record her pain score on initial assessment or to reassess it at regular intervals.

I recommended that the Trust apologise to the patient for the injustice caused by the failing in her care and treatment. In addition, I also recommended that the Doctor involved should reflect on the advice and my comments, and discuss with her appraiser with the view of improving practice.

I am pleased that the Trust accepted my findings.

THE COMPLAINT

1. The patient was taken to the Antrim Area Hospital's (AAH) Emergency Department (ED) by ambulance on 17 July 2017, following a fall at her home. The complainant said that his daughter was assessed in AAH's ED, and discharged with painkillers. However, he believed that the Trust failed to perform proper tests for Cauda Equina Syndrome (CES) (see paragraph 26) on his daughter, despite being informed that it may have been a possible diagnosis.

Issue of complaint

2. The issue of complaint which I accepted for investigation was:

Issue 1: Whether the care and treatment provided to the patient by the Northern Health and Social Care Trust on 17 July 2017 was reasonable?

INVESTIGATION METHODOLOGY

3. In order to investigate the complaint, the Investigating Officer obtained from the Trust all relevant documentation together with the Trust's comments on the issues raised. This documentation included information relating to the Trust's handling of the complaint. A draft version of this report was shared with the Trust and the complainant for comment and a check on factual accuracy.

Independent Professional Advice

4. After consideration of the issues, I obtained independent professional advice from the following independent professional advisor:

- **Consultant in Emergency Medicine**, FRCEM FRCSEd (A&E) MBBS LLM Medical Law (EM IPA), A Consultant in Emergency Medicine for ten years

5. The information and advice which have informed my findings and conclusions are included within the body of my report. The EM IPA has provided me with

'advice'; however how I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

6. 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.

7. The general standards are the Ombudsman's Principles[1]:
   - The Principles of Good Administration
   - The Principles of Good Complaints Handling
   - The Public Services Ombudsman's Principles for Remedy

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

9. The specific standards relevant to this complaint are:
   - General Medical Council's (GMC) Good Medical Practice, April 2013 (GMC Guidelines);
   - National Institute for Health and Care Excellence (NICE) Guidelines on Spinal injury: assessment and initial management, February 2016 (NICE Guideline on Spinal Injury); and
   - Royal College of Physicians, National Early Warning Score (NEWS), Standardising the assessment of acute-illness severity in the NHS, July 2012 (NEWS Guidance).

10. I have not included all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important has been taken into account in reaching my findings.

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

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the patient by the Northern Health and Social Care Trust on 17 July 2017 was reasonable?

Detail of Complaint

11. The complainant said that on this date his daughter fell on the stairs at home, and was unable to move due to back pain. As a result, she was taken by ambulance to the AAH's ED.

12. Following initial nursing triage assessment, the complainant stated that his daughter was moved to the minors department of the ED, where she was assessed by a doctor and plain film x-rays of her lower back were performed. He complained that the doctor failed to perform the proper tests for CES at this time, despite being informed that the patient had a history of back pain. He complained his daughter informed the doctor that a doctor at the Ballymena MSK [Musculoskeletal] Pain Clinic on 5 May 2017 had advised her to *'go straight to A&E [Accident & Emergency]'*, *'if she had any numbness or pins and needles', 'as it could be Cauda Equina [Syndrome]'.*

13. In addition, the complainant said that his daughter had made the doctor aware that her GP had also advised her on 13 July 2017 to go to the ED *'if she felt numb in the saddle area… as it could be Cauda Equina [Syndrome]'.* He complained that the doctor subsequently discharged his daughter from hospital with analgesia and failed to provide her with advice in relation to managing her symptoms on discharge from hospital. He also complained that his daughter explained to the doctor that she had numbness, but this was ignored, and an examination was not performed. In addition, the complainant said that his daughter needed help to leave the ED as her left leg and hip were giving way.

14. On 19 July 2017, the patient was admitted to the Royal Victoria Hospital [RVH], and underwent an operation on 20 July 2017. The complainant said that his daughter now requires help to make meals, clean, go up and down

the stairs and for general day to day activities.

Evidence Considered

15. I considered Standards 15 and 21 of the GMC Guidelines, which state:

'15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients you must:

- *Adequately assess the patient's conditions, taking account of their history… their views and values; where necessary, examine the patient*
- *Promptly provide or arrange suitable advice, investigations or treatment where necessary*
- *Refer a patient to another practitioner when this serves the patient's needs…*

21 Clinical records should include:

a. *Relevant clinical findings*
b. *The decisions made and actions agreed, and who is making the decisions and agreeing the actions*
c. *The information given to patients*
d. *Any drugs prescribed or other investigation or treatment*
e. *Who is making the record and when'.*

16. I also considered the NICE Guideline on Spinal Injury, which states:

*'**1.5 Diagnostic imaging…***
Suspected thoracic or lumbosacral column injury only (children and adults)
1.5.9 Perform an X-ray as the first-line investigation for people with suspected spinal column injury without abnormal neurological signs or symptoms in the thoracic or lumbosacral regions (T1–L3).
1.5.10 Perform CT if the X-ray is abnormal or there are clinical signs or symptoms of a spinal column injury.'

17. In addition, I considered the NEWS Guidance, which states:

*'**The NEWS and frequency of clinical monitoring***

26. The NEWS should be used to inform the frequency of clinical monitoring, which should be recorded on the NEWS chart.

27. We recommend that for those scoring 0, the minimum frequency of monitoring should be 12 hourly, increasing to 4–6 hourly with scores of 1–4, unless more or less frequent monitoring is considered appropriate by a competent clinical decision-maker.'

The Trust's response to investigation enquiries

18. The Trust confirmed that the patient attended AAH's ED on 17 July 2017. It stated that *'she was seen by [the doctor] – Locum Middle Grade in Emergency Medicine who documented that she had slipped and fallen down stairs and was complaining of back pain.'* The Trust stated that *'[the doctor] carried out a clinical examination noting power; tone and sensation were all intact and requested a lumbar spine x-ray.'* In addition, the Trust confirmed that *'there is no evidence of a rectal examination being carried.'* The Trust stated that at a meeting with the patient on 1 March 2018, she stated that *'she had advised staff of her history, however this is not documented in her ED notes.'*

19. In relation to the rectal examination, the Trust stated that *'the doctor had documented that the patient was not having any bladder or bowel disturbances; [The Trust's Consultant in Emergency Medicine] presumes this is why she did not perform a rectal examination.'* The Trust stated that *'the consultant has advised that in his opinion, ideally a rectal examination should have been performed although an examination showing normal anal tone and no saddle anaesthesia does not completely rule out CES, similarly an abnormal examination does not completely rule in CES as a cause.'*

20. In addition, the Trust was asked to confirm if the doctor consulted with any other doctors at this consultation. The Trust stated that *'there is no written record of discussion with any other doctors including consultants.'* The Trust stated that it *'would not expect a middle grade doctor to routinely ask advice about musculoskeletal back pain following a mechanical fall.'* However, it

stated that if CES was '*suspected clinically',* then it should have been discussed with a consultant.

21. The Trust was also asked to confirm if the doctor was aware that CES may have been a possible diagnosis. The Trust stated that *'if cauda equina syndrome is mentioned to the patient it would be recorded in the notes by the Doctor whether as a diagnosis or in the form of 'red-flag' symptoms to observe for.'*

22. In relation to learning, the Trust advised that *'all complaints are discussed at a divisional governance meeting and [the consultant] agreed to raise awareness of CES at junior doctor induction and teaching sessions.'* In addition, the Trust stated that *'there has been no further review with the doctor as she was employed on a locum basis.'* The Trust also confirmed that CES is included in AAH's ED Handbook, and advised that *'Locum Doctors would have received a physical copy of the ED Handbook in the past, but more recently been directed to the electronic copy thereof.'*

23. The Trust advised that *'[the consultant] stated that it can be difficult to get it right each time and on reflection we probably did not get it right, on different presentation an MRI would be indicated but without these CES symptoms it is difficult to determine. the consultant confirmed that cost was not a key factor; the doctor had to make a decision based on presenting symptoms; the patient's presenting symptoms did not indicate the need for a red flag referral for MRI.'*

24. The Trust also advised that '[*the consultant] has advised that in his opinion the Trust have investigated and managed the complainant's complaint regarding the patient's treatment appropriately. [The consultant] has been open, transparent and candid during face to face meetings with the complainant and his daughter. [The consultant] apologised for the patient's experience and further emphasis on CES is included for ED Doctors. It is possible that perhaps if [the patient] had been seen by a consultant, she may have had a different style of treatment but this is difficult to substantiate.'*

Relevant Independent Professional Advice

25. As part of investigation enquiries, I received independent professional advice from an EM IPA. The EM IPA considered the care and treatment provided to the patient by the Trust on 17 July 2017.

Cauda Equina Syndrome

26. The EM IPA advised that CES *'is a condition that occurs when the bundle of nerves below the end of the spinal cord… becomes damaged.'* The EM IPA advised that common signs associated with CES include *'low back pain, unilateral or bilateral sciatica (nerve pain), saddle and perineal hypoesthesia or anesthesia (altered sensation or numbness), bowel and bladder disturbance, lower extremity motor weakness and sensory deficit and reduced or absent lower extremity reflexes.'*

27. If left untreated, the EM IPA advised that the risks associated with CES include *'permanent nerve damage leading to irreversible bladder problems, sexual dysfunction, or numbness, however all of these may still occur despite surgical treatment. Estimates of poor outcome vary but may be around 20% of cases despite treatment.'* In addition, the EM IPA advised that *'there is very little specific guidance'* about CES, and *'I consider the information contained in the Trust Emergency Department handbook to be valid and relevant advice on the assessment and investigation of the condition, which can be difficult to diagnose.'*

Arrival at AAH

28. On 17 July 2017, the EM IPA advised that the patient was transferred to AAH by ambulance at 17.05hrs, and registered in the ED at 17.13hrs. The EM IPA advised that the patient was subsequently attended by a Triage Nurse at 17.29hrs. On review of the triage notes, the EM IPA advised that the patient '*had fallen down [four] stairs and was unable to get up. She had a bulging disk and complained of low back pain.'* The EM IPA advised that the triage note clearly recorded the *'mechanism of injury and time of onset… associated problems… pertinent past history… and pre hospital care administered (Morphine 5mg).'*

29. On review, the EM IPA advised that *'there is no other information recorded giving details of the patient's symptoms when she arrived at the emergency department.'* The EM IPA advised that *'I do not consider the staff relied on the paramedic records. They will have used them to supplement their own management.'* The EM IPA also advised that the emergency department record *'was completed correctly'* and *'the brevity of the note suggests a word limit in the electronic triage complaint section of the medical notes.'*

30. The EM IPA also advised that the patient's '*baseline observations (pulse, blood pressure, oxygen saturation levels)'* were recorded as *'normal'.* The EM IPA advised that based on *'observation findings and clinical judgement',* the *'initial nursing assessment… deemed [the patient's] condition to be appropriate to be managed in the minor injury area'* of ED.

Examination by the doctor

31. At 18.28hrs, the EM IPA advised that medical records state the patient was attended by a *'middle grade'* ED clinician, the doctor*, 'which was appropriate.'* The EM IPA advised that *'middle grade is a loose term for a doctor with several years or more of post graduate experience who is not in a training programme... these doctors would have equivalent experience to a higher specialist trainee which is around 6 years post graduate experience.'* The EM IPA advised that the middle grade rota *'is usually the middle tier (between junior and consultant rotas) and these doctors will assume the doctor in charge role in the absence of a consultant.'*

32. The EM IPA advised that the doctor *'reviewed the history of events leading to [the patient's] injury.'* The EM IPA advised that medical notes record *'the patient had slipped and skidded down the stairs*' and she complained of *'lumbar (lower) back pain, numbness down the left leg (this is noted to have been long standing…) but worse since the fall'.* The EM IPA noted that the doctor *'does not make any reference to the patient's previous back problems other than the pain being long standing.'* In addition, the EM IPA advised that *'there is no comment… about her being known to have a bulging disc in her*

lower back (although this was recorded in the triage notes).' The EM IPA advised that *'the doctor will have been aware of the patient's previous back problem and bulging disk as it had been recorded by the triage nurse… I consider that the notes are reasonable… omission of this information is not unreasonable.'*

33. On examination, the EM IPA advised that *'no swelling or bruising [was] noted. [The patient's] neck and upper back were normal with no midline tenderness, but on examination of the lumbar spine there was diffuse tenderness recorded at s [spine] being at L3-L5 (this is on the lower back).'* The EM IPA advised that examination findings record that *'tone and power (measures of function) were normal and that sensation was intact in both limbs'* and there was *'no acute bone injury.*' However, the EM IPA advised that the doctor should have fully documented *'the detail of the neurological examination of the limbs. General statements of 'tone/ power /sensation intact' give insufficient detail to fully assure anyone reviewing the records that the examination was complete.'* The EM IPA advised that *'I do not consider there to be enough information recorded in the medical notes to be confident that lower limb sensation was effectively tested despite the notes recording that it was considered.'*

34. In addition, the EM IPA advised that *'there is no record that the saddle/ perineal area was checked for altered sensation and reflexes were not tested – abnormalities in these components of the examination would have raised concern about cauda equina syndrome.'* The EM IPA advised that *'in the case of cauda equina syndrome it is important to be quite specific about the presence or absence of numbness in the groin and bottom area.'* The EM IPA also advised that *'if on examination these tests were abnormal it would have increased the possibility that cauda equine [syndrome] was present'.*

35. However, the EM IPA advised that the medical notes record that the patient *'had not experienced any bladder or bowel incontinence',* which '*suggest[s] the doctor had been seeking to rule out cauda equina syndrome as a possible cause during her assessment.'* The EM IPA advised that although *'the medical notes do not document all of the pertinent positives and negatives to confidently assure me that cauda equina syndrome was fully excluded… from*

the examination findings that were recorded there was no reason to suspect cauda equine [syndrome] had developed at that time.'

36. Overall, the EM IPA advised that *'the assessment [and] investigation… were reasonable for the working diagnosis of a mechanical back injury.'* The EM IPA advised that the doctor's notes *'are focused as is often the case in emergency department records. There is a brief history and an outline of the clinical examination findings.'*

Rectal examination

37. As part of investigation enquiries, the EM IPA was asked if the doctor should have performed a rectal examination at this time. The EM IPA advised that *'following a fall which has caused injury to the lower back, a rectal examination is an appropriate examination to undertake if the attending clinician is concerned about the possibility of nerve injury or cauda equina syndrome.'*

38. The EM IPA advised that if clinical examination is *'otherwise normal and there is no demonstrable sensory defect or area of reduced sensation, I would not expect to find abnormal rectal tone on digital examination of the rectum.'* However, the EM IPA advised that *'it would have been a more complete assessment to have done this examination in order to fully document the absence of abnormality just as much as to record the presence of an abnormality.'*

39. As a result, the EM IPA advised that if the doctor considered CES as a possible diagnosis*, 'a rectal examination should have been carried out as part of the full assessment.'* If this examination was declined by the patient, the EM IPA advised that this *'should have been documented'* by the doctor.

Line of Investigation (x-ray vs CT)

40. As a result of the doctor's examination findings, the EM IPA advised that *'[the doctor] requested a Lumbar spine x-ray'.* The EM IPA advised that *'the clinical examination undertaken was based on the mechanism of injury and I would expect that the doctor considered it important to rule out a significant fracture*

in the first instance using plain x-ray imaging.' The EM IPA referred to NICE Guidelines on Spinal Injury, which state that *'lumbar x-ray is an appropriate first line investigation for people with suspected spinal injury without abnormal neurological signs or symptoms.'*

41. In the patient's case, the EM IPA advised that *'she did have some abnormal neurological symptoms, but these were noted to have been long standing so not attributed to the acute injury she had sustained.'* As a result, the EM IPA advised that *'plain x-ray was probably [an] appropriate first choice investigation based on the mechanism of the injury.'*

42. The EM IPA advised that the patient's x-ray results were subsequently deemed *'normal'*, and *'no additional imaging was felt necessary at that time.'* Had there been any concerns raised by the clinical findings or x-ray, the EM IPA advised that a '*CT scan would be the next option.'* However, the EM IPA advised that a *'CT would not identify a bulging disc or nerve compression, it is more useful to identify bony injury e.g. a fracture.'*

43. In addition, the EM IPA advised that a CT scan '*exposes the patient to a significantly larger dose of ionizing radiation that a plain x-ray so should only be done with good clinical indication. From the examination recorded there was no recorded indication for CT on 17 July 2017.'* The EM IPA also advised that *'it may be aspirational to increase the availability of MRI imaging and access for acute assessment it is something that should be considered as an options appraisal or feasibility evaluation.'*

Referral for further investigation

44. As part of investigation enquiries, the EM IPA was asked if the doctor should have consulted with another Doctor at this time. The EM IPA advised that the Trust's Emergency Department Handbook stipulates that cases of possible CES should be discussed with an *'appropriate middle grade or on call consultant."* The EM IPA advised that *'this would imply that [the doctor] is a doctor more junior staff would seek advice from in cases like the patient. As a result, I do not think it unreasonable that she did not seek a second opinion or advice from the consultant if she was happy with her own assessment and*

examination.'

45. From review of the information in the medical records, the EM IPA advised that *'the most likely diagnosis when the patient presented to the emergency department was a musculo-skeletal injury (mechanical back pain), which would normally resolve spontaneously. As a result, there was no indication for onward referral for further investigation at this time.'*

Administration of pain medication

46. In relation to the administration of pain relief, the EM IPA advised *'I cannot find any record of medication being administered to the patient whilst she was in the Emergency Department.'* However, the EM IPA advised that the patient *'received Paracetamol orally, Entonox gas and intravenous Morphine – 5mg, prior to her arrival.'* The EM IPA advised that analgesia treatment would generally be an *'incremental process to provide adequate analgesia. In most cases this would be an initial treatment with simple oral analgesia e.g. paracetamol or ibuprofen, moving to a weak opioid e.g. codeine and if necessary escalating treatment to intravenous medications e.g. Morphine for cases of severe pain.'*

47. The EM IPA advised that *'[the patient's] pain score on arrival to the emergency department was 2/10 (low pain).'* The EM IPA advised that *'it is difficult to comment on whether any other pain relief should have been provided as there is no recorded pain score in the emergency department records. It is not clear whether the patient was asked if she needed further pain relief at triage (though the nurse has commented on the Morphine administered by the Ambulance Service).'* The EM IPA advised that *'in a patient whose primary complaint is pain it is important for the initial triage assessment to document a pain score.'*

48. The EM IPA also advised that the doctor *'has not recorded anything about the level of pain experienced by the patient whilst attending her.'* The EM IPA advised that the patient *'was discharged from hospital about 4 hours following the morphine and about 3 hours after arrival in the department so [she was]*

not reassessed as per NEWS guidance.'

49. On review, the EM IPA advised that there are several potential reasons why the patient did not receive pain medication in the ED. The EM IPA advised that she may not have been '*asked about her pain level so no-one realised she was in pain or it may have been because staff did not perceive her to be in pain following the strong pain relief she had received from the paramedics.'* The EM IPA also advised that the patient's *'triage observations showed a normal pulse and blood pressure, these parameters often increase in association with pain so normal levels could be considered to correlate with minimal or no pain.'*

50. In addition, the EM IPA advised that the patient may not have asked for pain relief, *'in general patients with significant pain will ask for some pain relief if it is not offered.'* However, the EM IPA advised that *'this is somewhat speculative and there is no documentation of the rationale of why no pain relief was offered or administered to the patient.*' The EM IPA advised that had pain relief been offered and declined, *'I would expect the nurse or doctor to have recorded this fact.'* The EM IPA also advised that *'there should be reassessment of the pain score following administration of any medication or at regular intervals to ensure the patients are not left in significant pain.'*

Discharge from AAH

51. The EM IPA was also asked if the patient should have been admitted to hospital during this time. The EM IPA advised that *'admission to hospital is always a consideration when attending a patient in the emergency department however, when making this assessment the doctor must evaluate why admission is needed and how will this benefit the patient.'* The EM IPA advised that while symptom relief such as pain control *'is sometimes an indication if the symptoms are severe, admission may not be required if the symptoms can be controlled with treatment readily administered at home. It is generally preferable for patients to manage their condition at home rather than be admitted to hospital.'*

52. In addition, the EM IPA advised that *'unless there was a specific reason to justify admission on that day it would be very hard for an emergency doctor to get inpatient specialists to agree to admit the patient and in normal circumstances a patient with presumed mechanical back pain would be encouraged to mobilise with analgesia and be discharged.'* Therefore, as a result of the doctor's assessment and examination findings, the EM IPA advised that the patient was *'advised to mobilise and discharged home with oral analgesia.'* The EM IPA advised that the patient was given Co-codamol 30/50 tablets, which is *'a standard moderate strength painkiller containing codeine and paracetamol.'*

53. The EM IPA also advised that *'no formal diagnosis'* was recorded on the patient's medical notes. In general, the EM IPA advised that *'I would expect that once completing a clinical assessment a doctor will develop a differential diagnosis of the likely cause for the symptoms and signs identified from the history and physical examination.'* However, the EM IPA advised that *'it is not essential to record a diagnosis at the end of an assessment.'* On review, the EM IPA advised that due to the doctor's 'c*omment reporting a normal lumbar x-ray – this presumably ruled out the possibility of a fracture leaving the most likely cause for pain being soft tissue or muscular injury.'*

54. Regarding advice given to the patient on discharge, the EM IPA advised that *'I could find no documentation of the information the patient was given by the doctor… the medical records simply note 'Mobilise, Home with analgesia''.* The EM IPA advised that it is unclear what advice the patient was given about *'management of her symptoms or what symptoms to look for that could suggest worsening of her condition and the need to seek further medical attention.'*

55. The EM IPA advised that the Trust's Emergency Department handbook *'provides doctors with advice regarding the information they should tell patients about when advising about the symptoms of Cauda Equina Syndrome. The advice in the handbook is relevant and consistent with the standard advice given to patients on discharge.'* However, the EM IPA advised that *'if the doctor did not consider that the patient was at risk of*

Cauda Equina Syndrome (CES) and that her injury was simply mechanical back pain, there was no reason to give extensive details.' The EM IPA advised that *'In the case of the patient who already had a pre-existing back problem with a bulging disc, I would have expected her to already be aware of the symptoms of CES from the time when her condition was diagnosed.'*

56. Based on the available evidence, the EM IPA advised that it was *'reasonable to have discharged the patient on 17 July with oral analgesia.'* The EM IPA advised that if the patient's *'symptoms were not controlled by this medication, she should have been advised to seek further advice either from her GP or from the hospital.'* The EM IPA also advised that *'there is always a concern when a patient re-attends hospital with a deterioration of symptoms… however, the nature of many conditions is that there is a natural progression of symptoms, and what is not present one day may be observable the next. Cauda Equina Syndrome can have either a rapid or gradual onset.'* The EM IPA also advised that the outcome of the patient's attendance to ED *'is documented (i.e. Mobilise and home with analgesia).'*

Impact of delay in admission to hospital

57. As part of investigation enquiries, the EM IPA was asked what impact the delay in the patient's admission to hospital, from 17 to 19 July 2017, had on her health. The EM IPA advised that had the patient been admitted on 17 July 2017, she would have been *'assessed by an orthopaedic specialist on duty… [and] depending on the findings… she may have been discharged by the specialist or admitted for further investigations/ imaging.'*

58. The EM IPA advised that *'it is unlikely that imaging would have been before the 18 July due to the unavailability of MRI scanning out of hours at Antrim [Area] Hospital and the absence of new acute symptoms (as per the medical notes).'* The EM IPA also noted that the patient was assessed by another doctor at the RVH on 18 July 2017 and was also discharged from hospital then, *'this would suggest that nothing was missed at Antrim [Area] Hospital.'*

59. In addition, the EM IPA advised that if the patient had been admitted on 17 July 2017, *'I do not consider… she would have undergone an operation any*

sooner.' The EM IPA also referred to a pre-assessment functional questionnaire completed by the patient prior to an L5 nerve root injection on 11 May 2017, and advised that *'many of the symptoms the patient attributes to inadequate care at Antrim [Area] Hospital were present'* then. These symptoms included *'severe pain with walking, moderate problems with washing and dressing, moderate problems doing usual activities and severe pain or discomfort.'*

60. As a result, the EM IPA advised that *'I feel it is impossible to conclude that the symptoms currently experienced by the patient can be attributed to a failure of care and treatment on the 17 July.'* The EM IPA advised that although it is *'unfortunate that the surgical intervention did not alleviate the symptoms… I do not think this is a consequence of the doctor not referring her for admission on 17 July 2017.'*

Record keeping

61. In relation to record keeping, the EM IPA advised that the ED notes *'are focused and to the point',* but *'not particularly well recorded.'* As detailed above, the EM IPA advised that there *'there are several omissions from the notes that I would consider important to have recorded to evidence a full and thorough assessment of the patient.'* The EM IPA advised that *'it is important to document the details relevant to demonstrate the parts of the clinical assessment which have been used to exclude potentially serious conditions.'*

62. Due to the high pressures of the ED, the EM IPA advised that '*doctors will generally record very specific information relating to the patient's reason for attending and the clinical findings of their assessment without going into wider detail of more general health questions.'* The EM IPA advised that *'there is a tendency to consider that 'not recorded means not done''*. While this is not always the case, the EM IPA advised that the lack of contemporaneous notes make it *'difficult for medical and nursing staff to prove their actions when caring for patients and demonstrate the adequacy of their treatment.'*

63. Overall, the EM IPA advised that *'the written notes were reasonable, though in*

retrospect greater detail would have given more evidence of the quality of the assessment delivered at the time.'

The Trust's response to IPA

64. As part of investigation enquiries, the Trust was given an opportunity to respond to the EM IPA's comments. The consultant commented *'that overall [the IPA] is reasonable and balanced and broadly reflects [the Trust's] correspondence to date.'*

65. In response to the EM IPA's comment that if the patient had of been admitted to hospital, she would have been assessed by an orthopaedic surgeon who may or may not have been a spinal specialist, the Trust stated that AAH *'does not have onsite orthopaedics/spinal specialists.'* It stated that *'there is no provision for acute admission/ assessment of orthopaedic/fracture/spinal patients. If a patient has a condition of this nature requiring admission the process is firstly discussion with the on-call fractures junior doctor in the Royal Victoria Hospital [RVH]. Following this the options advised with back pain are generally (but not exclusively)*
    - *No acute RVH input required, manage locally*
    - *No acute RVH input required, discharge locally, GP to refer to ICATs*
    - *No acute RVH input required, discharge locally, refer to spinal service RVH by email*
    - *Workup locally (e.g. MRI) and discuss again*
    - *Transfer for assessment*
    - *Transfer for admission.'*

66. The Trust stated that *'based on the patient's clinical findings on presentation, the consultant has advised that he would not have initially discussed her case with RVH fractures on call; furthermore the consultant is of the opinion that the patient would not have been accepted for emergency transfer for assessment/ emergency MRI by the RVH fracture service.'*

Responses to draft report

67. In response to the draft report, I note the complainant stated that *'the medical*

notes… [are not an accurate reflection on what took place' on 17 July 2017. The complainant stated that his *'wife and daughter both say [that] no examinations'* or tests were performed by the doctor at this time. In addition, the complainant stated that no advice was given by the doctor on discharge. He stated that the nurses advised the patient*, 'if we can get you up you can go home'.*

68. In relation to the EM IPA's comment that the patient had been assessed and discharged by another doctor on 18 July 2017, suggesting *'that nothing was missed'* on 17 July 2017, the complainant stated that he considered this *'cherry picking and half story'.* On 18 July 2017*,* the complainant stated that his daughter *'was examined properly. Lower limbs, rectal and power and tone etc. were all tested which is how we know that the doctor did not examine her properly. Indeed the doctor went to the surgery ward for a second opinion… the next day she was admitted following an MRI which was nearly misdiagnosed and had emergency surgery which would not have happened unless it was needed. Therefore she had CES.'*

69. The complainant stated that if the review on 18 July 2017 *'is being used as a standard then the doctor did not do any of the examinations which were done there'.* Therefore, the complainant said that his daughter *'was not examined properly for suspected CES.'* The complainant stated that '*the only way to diagnose CES is an MRI which even the EM IPA says'.* He said that even the Trust's *'consultant told us that with hindsight [the patient] would have been treated differently and he has asked for changes to be made'*. As a result, the complainant stated that he rejected the findings of the report, and the accuracy of the evidence.

70. I have reflected on the complainant's response, and have considered the issues he raised within my analysis below.

71. I note the Trust stated it considered the EM IPA advice *'reasonable and balanced'.*

Analysis and Findings

72. As part of investigation enquiries, I have examined the Trust's care and treatment of the patient on 17 July 2017. I have addressed the complaint under the following headings:

    i. **Arrival at AAH**
    ii. **Examination by the doctor**
    iii. **Line of Investigation**
    iv. **Administration of pain medication**
    v. **Discharge from AAH**
    vi. **Record keeping**

i. Arrival at AAH

73. On 17 July 2017, I note that the patient was transferred to AAH ED by ambulance, as a result of a fall at her home. I note the EM IPA advised that the patient was first assessed by a Triage Nurse at 17.29hrs, who recorded that she *'had a bulging disk and complained of back pain.'* On review, I note the EM IPA advised that the triage note clearly records *'mechanism of injury and time of onset… associated problems… pertinent past history… and pre hospital care administered (Morphine 5mg).'*

74. I note the EM IPA also advised that the patient's baseline observations were recorded as *'normal',* and based on '*observation findings and clinical judgment'*, the '*initial nursing assessment… deemed [the patient's] condition to be appropriate to be managed in the minor injury area'* of ED. I note the EM IPA advised that the patient's ED record *'was completed correctly'.* On review, I accept the EM IPA's advice that the patient was appropriately triaged on arrival at AAH's ED.

ii. Examination by the doctor

75. I note the patient was attended by the doctor at 18.28hrs. I note the EM IPA advised that the doctor was a *'middle grade'* doctor, with *'around 6 years post graduate experience.'* I note the EM IPA advised that it *'was appropriate'* for the doctor to review the patient, as middle grade doctors, '*will assume the doctor in charge role in the absence of a consultant.'* On review, I accept the

EM IPA's advice on this matter and I am satisfied that the doctor was appropriately experienced to examine the patient.

76. At this time, I note the EM IPA advised that the doctor *'reviewed the history of events leading to [the patient's] injury.'* I note the Trust stated that at a meeting with the patient on 1 March 2018, she stated that '*she had advised staff of her history'.* However, I note the EM IPA advised that the doctor made no *'reference to the patient's previous back problems other than the pain being long standing.'* I note the EM IPA also advised that the doctor made no reference to the patient's bulging disc in her lower back, but advised that she *'will have been aware [of this]… as it had been recorded by the triage nurse.'* Despite these omissions, I note the EM IPA advised that the doctor's notes *'are reasonable.'* On review, I accept the EM IPA's advice.

77. I note the complainant stated that his *'wife and daughter both say [that] no examinations'* or tests were performed by the doctor. I note the complainant stated that the patient *'was not examined properly for suspected CES'.* However, I note the EM IPA advised that, on examination, no swelling bruising or midline tenderness was noted by the doctor. I note the EM IPA advised that *'on examination of the lumbar spine there was diffuse tenderness recorded… on the lower back'.* In addition, I note the EM IPA advised that the patient's tone and power '*were [recorded as being] normal… sensation was intact in both limbs… [and there was] no acute bone injury.'* I note the EM IPA advised that *'the most likely diagnosis when the patient presented to the emergency department was a musculo-skeletal injury (mechanical back pain).'*

78. However, I note the EM IPA advised that the doctor failed to detail '*the neurological examination of the limbs. General statements of 'tone/ power /sensation intact' give insufficient detail to fully assure anyone reviewing the records that the examination was complete.'* I note the EM IPA advised that '*I do not consider there to be enough information recorded in the medical notes to be confident that lower limb sensation was effectively tested despite the notes recording that it was considered.'*

79. In addition, I note the EM IPA advised that *'there is no record that the saddle/ perineal area was checked for altered sensation and reflexes were not tested – abnormalities in these components of the examination would have raised concern about cauda equina syndrome.'* I refer to the GMC Guidance, Standards 15 (a) and (b), which state that good clinical care must *'adequately assess the patient's conditions… where necessary, examine the patient' and 'promptly provide or arrange suitable advice'.* I have carefully considered the EM IPA's advice and the available evidence, however due to the lack of records, I cannot conclude whether an adequate neurological examination of the patient's limbs was conducted.

80. I note the complainant has indicated that both his wife and daughter consider an inadequate examination for CES was performed. I am critical that the records do not provide sufficient evidence as to the tests performed. As outlined above, this is a requirement of the professional standards for doctors. I would expect that such an examination if performed would be recorded. I am concerned what tests were performed given the lack of records, and the accounts of the patient and her mother, as relayed by the complainant.

81. Having considered the available evidence, I cannot conclude whether an adequate examination of the patient's saddle/ perineal area was performed. However, I note the EM IPA advised that the doctor noted that the patient *'had not experienced any bladder or bowel incontinence',* which suggests she *'had been seeking to rule out cauda equina syndrome as a possible cause during her assessment.'* I note the EM IPA advised that although *'the medical notes do not document all of the pertinent positives and negatives to confidently ensure me that cauda equina syndrome was fully excluded… from the examination findings that were recorded there was no reason to suspect cauda equine [syndrome] had developed at that time.'* I note the EM IPA also advised that '*Cauda Equina Syndrome can have either a rapid or gradual onset.'* As CES was not suspected, I note the EM IPA advised that '*the assessment [and] investigation… were reasonable for the working diagnosis of a mechanical back injury.'*

82. I accept the EM IPA's advice that CES was considered and ruled out as a possible diagnosis at this time, as the doctor had no reason to suspect it had developed from her consideration of the patient's presenting symptoms. Therefore, I consider that the doctor's assessment and investigation for mechanical back injury was appropriate. However, I am critical of the lack of records detailing the neurological examination and exclusion of CES, and remain concerned given the accounts of the patient and her mother. I have addressed the Trust's record keeping in paragraph 105.

83. I note the Trust also confirmed that *'there is no evidence of a rectal examination being'* performed by the doctor at this time. I note the EM IPA advised that following a fall, if the *'clinician is concerned about the possibility of nerve injury or cauda equina syndrome'*, then a rectal examination should be performed.

84. However, I note the EM IPA advised that '*it would have been a more complete assessment to have done this examination in order to fully document the absence of abnormality just as much as to record the presence of an abnormality.'* In response to investigation enquiries, I also note the Trust stated that *'the consultant has advised that in his opinion, ideally a rectal examination should have been performed*'. However, I note that this opinion has been formed with the benefit of hindsight. The judgements I have made are based on the evidence available to the doctor at that time. I note the EM IPA advised that as a result of her examination, the doctor did not appear to have considered CES as a possible diagnosis at this time. The records indicate that the doctor considered that the patient was suffering a *'musculo-skeletal injury'* as a result of her fall.

85. Given the presenting symptoms recorded it is not possible to conclude that a rectal examination was required. However, going forward, I am of the opinion that the Trust should consider ensuring that medical staff conduct this examination as part of assessment where clinically necessary, to rule out the possibility of CES and ensure a more complete assessment.

iii. Further referral for investigation

86. Following the doctor's examination, I note the EM IPA advised that a lumbar spine x-ray was requested. I note the complainant said that an x-ray would not identify CES, *'the only way to diagnose CES is an MRI'.* However, as detailed above the doctor did not consider CES as a possible diagnosis at this time. I note that the doctor was treating the patient for mechanical back injury.

87. I refer to the NICE Guideline on Spinal Injury, which states that *'lumbar x-ray is an appropriate first line investigation for people with suspected spinal injury without abnormal neurological signs or symptoms.'* I note the EM IPA advised that the patient '*did have some abnormal neurological symptoms, but these were noted to have been long standing so not attributed to the acute injury she had sustained.'*

88. As a result, I note the EM IPA advised that *'plain x-ray was probably [an] appropriate first choice investigation based on the mechanism of the injury.'* I note the EM IPA advised that the patient's x-ray was deemed *'normal'*, and *'no additional imaging was felt necessary at that time.'* On the basis of the assessment performed and that the doctor suspected a musculoskeletal injury, I accept the EM IPA's advice that the appropriate line of investigation was followed.

89. In relation to whether the doctor should have referred the patient's case to a more senior doctor, I note the EM IPA advised that the Trust's Emergency Department Handbook states that cases of possible CES should be discussed with an *'appropriate middle grade or on call consultant.'* I note the EM IPA advised that *'this would imply that the doctor is a doctor more junior staff would seek advice from in cases like the patient. As a result, I do not think it unreasonable that she did not seek a second opinion or advice from the consultant if she was happy with her own assessment and examination.'*

90. In addition, I note the EM IPA advised that *'the most likely diagnosis when the patient presented to the emergency department was a musculo-skeletal injury (mechanical back pain), which would normally resolve spontaneously. As a*

result, there was no indication for onward referral for further investigation at this time.' I accept the EM IPA's advice that it was reasonable for the doctor not to seek a second opinion on the patient's treatment or consider further referral at this time.

iv. Administration of pain medication

91. On review, I note the EM IPA advised *'I cannot find any record of medication being administered to the patient whilst she was in the Emergency Department.'* However, I note the EM IPA advised that prior to the patient's arrival at hospital, she *'received Paracetamol orally, Entonox gas and intravenous Morphine – 5mg.'*

92. On arrival at hospital, I note the EM IPA advised that the nurse recorded the patient's pain score as two. I note the EM IPA advised that a pain score was not subsequently recorded by the nursing team or the doctor in the patient's ED records, and the doctor did not record whether she was experiencing pain. I also note the EM IPA advised that as the patient was discharged from hospital '*about 4 hours following the morphine and about 3 hours after arrival in the department [she was] not reassessed as per NEWS guidance.'* I refer to the NEWS Guidance, which states that individuals with a score of one to four, should be assessed four to six hourly.

93. However, I note the EM IPA advised that '*in a patient whose primary complaint is pain it is important for the initial triage assessment to document a pain score.'* I note the EM IPA advised that there were several reasons that the patient may not have received further pain medication at this time and these should also have been documented. For example, I note the EM IPA advised that if pain relief had been offered and declined by the patient, *'I would expect the nurse or doctor to have recorded this fact… there should be reassessment of the pain score following administration of any medication or at regular intervals to ensure the patients are not left in significant pain.'*

94. I consider that the Trust's failure to record the patient's pain score on initial assessment or to reassess it at regular intervals resulted in a failure in her

care and treatment. I consider that this failure resulted in the patient suffering the injustice of loss of opportunity, as the medical team could not assess and manage her pain appropriately. I will address remedy in the conclusion of the report. In addition, I will address the Trust's record keeping in relation to its decision not to provide pain relief in paragraph 105.

v. Discharge from AAH

95. In relation to whether the patient should have been admitted to hospital at this time, I note the EM IPA advised that '*unless there was a specific reason to justify admission on that day it would be very hard for an emergency doctor to get inpatient specialists to agree to admit the patient and in normal circumstances a patient with presumed mechanical back pain would be encourage to mobilise with analgesia and be discharged.'*

96. I note the EM IPA advised that *'no formal diagnosis'* was recorded on the patient's medical notes, however the EM IPA stated that *'it is not essential'* to record this information. I note the EM IPA advised that given the doctor's '*comment reporting a normal lumbar x-ray – this presumably ruled out the possibility of a fracture leaving the most likely cause for pain being soft tissue or muscular injury.'* I note the EM IPA advised that as *'musculo-skeletal injury'* was a possible diagnosis at the time, the patient was *'advised to mobilise and discharged home.'* I note the EM IPA advised that it was *'reasonable to have discharged the patient on 17 July with oral analgesia.'*

97. On discharge, I note the complainant said that the doctor did not provide advice to the patient. I note he complained that the nurses said that if the patient could mobilise then she could go home. I note the EM IPA advised that *'I could find no documentation of the information the patient was given by the doctor.'* I note the EM IPA advised that it is unclear what advice the patient was given about *'management of her symptoms or what symptoms to look for that could suggest worsening of her condition and the need to seek further medical attention.'* However, I note the EM IPA advised that *'if the doctor did not consider that the patient was at risk of Cauda Equina Syndrome (CES) and that her injury was simply mechanical back pain, there was no reason to*

give extensive details.' On the basis of the complainant's account and the lack of records, I am unable to conclude that the patient was given appropriate advice on discharge.

98. While I am concerned about the lack of detail in the records, I accept the EM IPA's advice that it was reasonable to discharge the patient from hospital on 17 July 2017, with oral analgesia. Therefore, I do not uphold this element of the complaint.

99. In relation to the patient's subsequent admission to hospital on 19 July 2017, I note the EM IPA advised that *'there is always a concern when a patient re-attends hospital with a deterioration of symptoms… however…Cauda Equina Syndrome can have either a rapid or gradual onset.'* I note the EM IPA advised
that had the patient been admitted on 17 July 2017, it is unlikely that she would have received an MRI before 18 July 2017. In addition, I note the EM IPA advised that *'I do not consider… she would have undergone an operation any sooner.'*

100. I also note the EM IPA referred to a pre-assessment functional questionnaire completed by the patient prior to an L5 nerve root injection on 11 May 2017, and advised that *'many of the symptoms the patient attributes to inadequate care at Antrim [Area] Hospital were present'* at that time. These symptoms included *'severe pain with walking, moderate problems with washing and dressing, moderate problems doing usual activities and severe pain or discomfort.'*

101. I note the EM IPA also advised that the patient was assessed in the RVH on 18 July 2017 and discharged, suggesting that '*nothing was missed at Antrim [Area] Hospital'* on 17 July 2017. In response, I note the complainant stated that the patient was *'examined properly*' on 18 July 2017, '*which is how we know that the doctor did not examine her properly.'* In addition, he stated that the RVH doctor '*went to the surgery ward for a second opinion'*. However, I note that the patient was subsequently discharged on the same day. On 19

July 2017, I note the patient attended RVH ED again. On this occasion, I note the complainant stated that the patient *'was admitted following an MRI which was nearly misdiagnosed and had emergency surgery… Therefore she had CES."*

102. It is not in dispute that the patient had CES as confirmed by the MRI, which the EM IPA has indicated is the method used to confirm such a diagnosis. The issue I considered was whether the examination and tests conducted on 17 July 2017 were reasonable on the basis of the presenting symptoms. As noted in paragraph 99, the EM IPA has indicated that CES can have either a rapid or gradual onset. I note the complainant's strongly held view that the examination on 17 July 2017 was not reasonable. On the basis of all the available evidence I do not consider this to be the case, although I remain concerned about the lack of detail in the medical records.

103. Given the subsequent diagnosis of CES I considered whether the symptoms currently experienced by the patient could be attributed to her care and treatment in AAH ED. I note the EM IPA advised that *'I feel it is impossible to conclude that the symptoms currently experienced by the patient can be attributed to a failure of care and treatment on the 17 July.'* The EM IPA advised that although it is *'unfortunate that the [subsequent] surgical intervention did not alleviate the symptoms… I do not think this is a consequence of the doctor not referring [the patient] for admission on 17 July 2017.'* I conclude that, on the balance of probabilities, the doctor's decision not to admit the patient on 17 July 2017 did not impact on the long-term outcome the patient experienced after her surgery on 20 July 2017.

104. It is also not clear that even if CES was suspected on 17 July 2017, that the patient would have received her surgery earlier that 20 July. If CES had been suspected in AAH ED the most likely course of treatment would have been an MRI on 18 July, with subsequent assessment, discussion with a specialist, and referral to RVH.

vi. Record keeping

105. During the investigation, I identified a number of instances in which the doctor's record keeping on 17 July 2017 was not adequate:
    - Failure to record details of the neurological examination of the patient's limbs
    - Failure to record all the pertinent positives and negatives confirming that CES was excluded
    - Failure to record why the patient was not given further pain medication
    - Failure to record what advice was provided to the patient on discharge

106. I note the EM IPA advised that *'it is important to document the details relevant to demonstrate the parts of the clinical assessment which have been used to exclude potentially serious conditions.'* However, I note the EM IPA advised that *'there is a tendency to consider that 'not recorded means not done''*. This is not always the case, however I note the EM IPA advised that the lack of contemporaneous notes makes it *'difficult for medical and nursing staff to prove their actions when caring for patients and demonstrate the adequacy of their treatment.'*

107. I refer to Standard 21 of the GMC Guidance, which states that clinical records should include *'relevant clinical findings'*, '*the decisions made and actions agreed'*, and '*the information given to patients'*. Although, I consider that overall the doctor conducted appropriate examinations and the decision to discharge the patient was reasonable, I am critical of the doctor's lack of record keeping at this consultation. I consider that the doctor's failure to record this information is a failure to meet the professional standards required by the GMC Code. The lack of clear records has hampered the consideration of this complaint. However, I do not consider the patient suffered an injustice as a result.

108. Aside from the omissions above, I note the EM IPA advised that the doctor's notes *'are focused as is often the case in emergency department records. There is a brief history and an outline of the clinical examination findings.'* I note the EM IPA advised that *'the written notes were reasonable, though in*

retrospect greater detail would have given more evidence of the quality of the assessment delivered at the time.' I note the quality of the assessment is at the core of the complaint.

CONCLUSION

109. The complainant submitted a complaint about the care and treatment provided to his daughter by the Trust on 17 July 2017. I have investigated the complaint and while I am concerned about the lack of records, overall I consider that the doctor's assessment was reasonable. On the basis of the examination there were no suggestions of CES. As a diagnosis of mechanical back pain was considered, I am of the opinion that an x-ray was an appropriate method of investigation, and I note this was normal. I also consider that the patient's discharge from hospital with analgesia was appropriate. I therefore did not uphold this element of the complaint.

110. However, I have found a failure in the patient's care and treatment in relation to the doctor's failure to record the patient's pain score on initial assessment or to reassess it as regular intervals.

111. I am satisfied that this failure in care and treatment caused the patient to experience the injustice of loss of opportunity to receive appropriate pain relief if required.

112. I also consider that the doctor failed to keep adequate records of the consultation. However, I consider that the patient did not suffer injustice as a result of these failures.

113. I also note that there are no records to indicate that the patient was given appropriate advice on discharge. I do not consider the patient suffered an injustice as given her past medical history, the patient knew what symptoms to be aware of and I note she attended the RVH ED the next day when she remained concerned about her symptoms.

114. While overall I have concluded that it was appropriate for the patient to be discharged from AAH ED on 17 July 2017, I remain concerned about the different experience the complainant describes in terms of the assessment at AAH on 17 July 2017 and the RVH on 18 July 2017. It is noteworthy that the complainant did not complain about the assessment made on 18 July 2017, despite the same clinical outcome i.e. discharge. I consider this gives the complainant's concerns a considerable degree of credibility. While it is clear that the complainant considers the difference in the standard of this assessment points towards a failing in the assessment of 17 July 2017, this is not necessarily the case. My role is to objectively assess the actions against good medical practice standards, not best practice or gold standard.

115. I hope that by reading my final report the complainant can appreciate the reasons for my decisions.

Recommendations

116. I recommend that the Trust issues the patient with an apology in accordance with the NIPSO guidance on apology. This is for the failings identified, and should be issued **within one month** of the date of my final report.

117. I consider that the doctor should reflect on the ED IPA's advice and my comments, and discuss these with her appraiser with the view of improving practice.

118. I am pleased to note the Trust accepted my findings and recommendations.

PAUL MCFADDEN
Acting Ombudsman **March 2020**

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.