Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against a Medical Practice in County Antrim

NIPSO Reference: 202000500

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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.

COMPLAINT

1. The complainant raised concerns that her GP failed to provide her with appropriate treatment and medication to help control her chronic pain.

2. The complainant developed a disc prolapse in her back in 2007, and received surgery but never regained normal function. The complainant said she lives with constant pain and restricted movement.

3. Prior to joining the Practice in June 2017, the complainant was prescribed: 75cmg Fentanyl transdermal patches[1], Maxitram[2] 100mg capsules, Duloxetine[3] capsules 30mg and Pregabalin[4] capsules to manage her pain. Since the complainant's registration with the Practice, she was no longer prescribed Maxitram, but received the following additional medications: Methocarbamol[5] 750mg and Naproxen[6] 500mg.

4. The complainant contacted the Practice in August 2020 as her pain had increased. The Practice increased the complainant's prescribed dosage of Pregablin to help her manage this. The complainant said that due to the pain increase she also began changing her Fentanyl patches every two days instead of the prescribed three, as the Practice refused to increase her dosage of this medication.

5. The complainant contacted the Practice on 4 February 2021 to order her repeat prescription of the Fentanyl patches, but was advised it was not due. The complainant then spoke to the GP on 15 February 2021. She told the GP that she had been changing her patches every two days instead of three, for the past five months. The GP said that the Practice had assumed the complainant had been ordering the medication early for ease of collection. The GP reminded the complainant that she should not be using the patches more frequently than prescribed, and stipulated that this should not be done due to the risk of

[1] Transdermal patch is a patch that attaches to a patient's skin and contains medication. The medication from the patch is absorbed into the patient's body over a period of time.
[2] Slow release form of Tramadol which is another opiod based pain killer.
[3] Treatment used for neuropathic pain.
[4] Treatment used for neuropathic pain.
[5] Medication used to treat muscle spasm and pain relief in back-related pains.
[6] Anti-inflammatory painkiller.

accidental overdose. The GP said that it could not increase the strength of her patches as she was at the recommended maximum dosage of opiate for a non-cancer patient.

6. The complainant said that she does not feel she has received sufficient help, support or understanding from the Practice in relation to her treatment for chronic pain, and that the Practice's decisions are not made in her best interest.

7. A full chronology of the complaint is attached to Appendix three to this report.

8. The issue of complaint accepted for investigation was:

   Whether the care and treatment provided by the Practice to the patient in relation to pain management was appropriate and in accordance with relevant procedures and guidance.

9. The complainant's medical records document the medication she received for her pain management.

10. The Practice provided the complainant's medical records as well as an explanation of the care and treatment the complainant received.

11. I obtained Independent Professional Advice from a registered General Practitioner (IPA) who has over 37 years' experience since qualifying as a GP in 1984.

12. The complainant provided a response to the draft report, the content of which I have considered.

Analysis

13. The IPA advised that all *"drugs that [the complainant] was taking were appropriate to try and help her pain"* from registration with the Practice in June 2017.

Fentanyl Patches

14. The IPA advised that Fentanyl is a controlled drug that can cause dependence and therefore requires close monitoring. The Health and Social Care Board (HSCB) Guidance for Managing Controlled Drugs for Prescribers in Primary Care states *"controlled drugs prescribed should not exceed 30 days supply"*. The Practice medical records document that the complainant received 28 days of most of her medication, together with ten Fentanyl patches. The IPA advised that the prescription of ten Fentanyl patches per month was the appropriate amount to prescribe to the complainant.

15. The complainant's medical records document that the complainant is prescribed Fentanyl 75mcg patches. The Practice's instructions were to change the patches every 72 hours. The British National Formulary (BNF) and the manufacturer (Matrifen) advised *"the Matrifen patch should be replaced every 72 hours"*.

16. The HSCB Northern Ireland guidelines on converting doses of opioid analgesics for adult use 2018 states: *"On removal of an opioid patch a reservoir of the drug remains under the skin with levels falling by 50% (half-life) approximately every 18 to 24 hours"*. The IPA advised if the patches were changed more frequently than every 72 hours *"this would result in the patient having a higher total dose of Fentanyl in their blood stream than had been prescribed."*

17. I accept the IPA's advice that it was not appropriate for the patches to be changed every two days instead of three, and that *"the GPs did follow correct procedure on 6 August 2020 in recommending [the complainant] changed her patches every 72 hours and not more frequently"*.

Dosage of Fentanyl patches prescribed.

18. The HSCB – Northern Ireland guidelines on converting doses of opioid analgesics for adult use 2018 states: *"When considering prescribing opioids for persistent non-malignant pain, medication will achieve a 30-50% pain reduction at best. The risk of harm increases substantially above daily doses of oral*

morphine sulfate 120mg (or equivalent), without significant benefit." The IPA advised that Fentanyl are strong opioids that should not be used for patients with chronic, non-cancer pain. The IPA also advised that the complainant was taking a high strength opioid *"the amount she absorbed in 24 hours being equivalent to about 270mg of morphine"*. The IPA advised: *"there are recommendations that GPs should not increase a patient's dose of opioid above the equivalent of 120mg per 24 hours"*, and there was a risk of the complainant accidentally overdosing because of the potency of the Fentanyl patch being used.

19. The IPA advised, *"an increase in the dose of an opiate that is already being taken at a high dose significantly increases the risks of harm, including an increased risk of dependency and confusion"*.

20. I accept the IPA's advice that *"not only was it appropriate that the GPs did not increase [the complainant's] dose of fentanyl, but if they had increased her dose and she had come to harm in any way, then [the Practice] would have a degree of moral and legal culpability."*

Monitoring of the complainant's prescription.

21. The IPA referred to the COMPASS Therapeutic Notes on the Use of Strong Opioids in Chronic Non-Cancer Pain. This recommends that if a patient is stable and taking Fentanyl long-term, the Fentanyl should be reviewed and monitored at least every six months. I note that this guidance also states that this review should include an assessment of the patient's pain, whether the Fentanyl is being taken as prescribed, and whether the patient is experiencing any side-effects from the medication. I accept the IPA's advice that the Practice's reviewing and monitoring of the complainant's medications was in line with acceptable Practice.

Pain management.

22. The Practice records document that the complainant asked the GP to refer her for counselling, which the GP did. The records also document that the GP

received a reply from the Northern Health and Social Care Trust Community Mental Health Team on 22 February 2021, stating that the referral had been discussed and it was not considered appropriate for the complainant to have counselling via their service, but instead for the complainant to be referred to the Condition Management Programme (CMP). I note from the Practice records the GP made this referral on 25 February 2021, and the complainant was assessed by a physiotherapist at the CMP on 9 April 2021.

23. The Practice records indicate that during the assessment on 9 April 2021 it was determined that CMP was not right for the complainant at that time but she should attend the Arthritis Care Plan Management Programme (the Programme) and the Pain Clinic. The Practice records document that the complainant was already on the waiting list for these services.

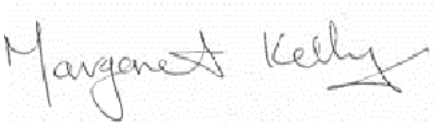
24. Updated information was obtained from the complainant who said that she has now completed a course through the Programme. The complainant also said that the Pain Clinic had reviewed her, and that she has received a letter from the Pain Clinic as well as a questionnaire. She also said that she is currently completing a six week training course through the Pain Retrained Programme.

25. I accept the IPA's advice that the Practice worked within the range of appropriate clinical practice and offered the complainant appropriate pain management medication and also other measures to try and help her with her pain.

CONCLUSION

26. I conclude that after consideration of all evidence available to me, the complainant received appropriate care and treatment from the Practice in relation to her pain management. Therefore, I do not uphold the complainant's issue of complaint. However, I acknowledge how difficult living with ongoing pain must be for the complainant. I hope that the advice I received from the IPA and the findings in this report offers some reassurance to the complainant that the Practice acted appropriately in relation to her pain management.

27. I encourage the Practice and the complainant work together to find a pain management strategy that works for the complainant, and is in line with the guidance to help control her pain.



Margaret Kelly
Ombudsman **March 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, and with regard for the rights of those concerned.
- Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.
- Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on the outcomes for the complainant and the public body.
- Signposting to the next stage of the complaints procedure, in the right way and at the right time.

Being customer focused

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

Being open and accountable

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

- Providing honest, evidence-based explanations and giving reasons for decisions.
- Keeping full and accurate records.

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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