Investigation of a complaint against Templemore Medical Centre

Report Reference: 202003829

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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SUMMARY

This complaint was about care and treatment Templemore Medical Centre (the Practice) provided to the complainant. The complainant attended a face-to-face appointment with a Practice Nurse (the nurse) on 8 November 2022, complaining of a rash and eye styes The complainant was dissatisfied with the nurse's examination and asked a receptionist to speak to a GP after her appointment. A GP considered her request but decided not to see the complainant.

The complainant contacted the Practice on 9 November 2022 and requested a callback with a GP. A receptionist later asked the complainant to email photographs of the styes. A GP reviewed the photographs and prescribed antibiotic drops. The complainant raised concern that a nurse examined her on 8 November 2022 rather than a GP. She raised additional concerns about the outcome of that examination and the Practice's refusal of her request to see a GP.

The investigation found the Practice's decision that a nurse should initially examine the complainant appropriate. However, it found the Practice should have arranged for a GP to see the complainant following her specific request and prior to prescribing antibiotic drops. I considered this a failure in the complainant's care and treatment. I recommended the Practice apologise to the complainant for the injustice she sustained. I also recommended learning for the Practice to implement for service improvement and to prevent the failure recurring.

I am pleased that the Practice accepted my findings and recommendations.

THE COMPLAINT

1. This complaint was about care and treatment Templemore Medical Centre (the Practice) provided to the complainant in November 2022.

Background

2. The complainant said she attended the Practice on 7 November 2022. However, the Practice's records evidence the complainant attended her appointment on 8 November 2022.

3. On this date the complainant visited the Practice regarding a skin rash and styes[1]. A nurse examined her and advised that she could not see a rash or evidence of eye styes. The nurse did not prescribe treatment for either concern. The complainant said she expected a GP to examine her. She was dissatisfied with the nurse's assessment and asked the receptionist to speak to a GP. GP A discussed the complainant's request with the nurse who examined her. GP A decided that as the nurse determined there was no evidence of a rash or styes, a GP examination was not necessary.

4. The complainant telephoned the Practice later that day to request a callback from a GP. The Practice added her to the list for 9 November 2022, the following day.

5. On 9 November 2022, a receptionist from the Practice telephoned the complainant and asked her to send photographs that showed the styes. GP B reviewed the photographs, telephoned the complainant and prescribed antibiotic drops.

6. When the complainant attended the Practice to collect her prescription on 10November 2022, she made a complaint regarding the care and treatment she received. The Practice issued a written response to the complaint on 21 November 2022.

[1] Eye stye – a small painful red lump on the lid of the eye

Issue of complaint

7. I accepted the following issue of complaint for investigation:

> **Whether the care and treatment the Medical Centre provided to the complainant between 8 November 2022 and 16 November 2022 was appropriate and in accordance with guidance and relevant standards. In particular to:**
>
> **i. The diagnosis and treatment of Eye Styes**
>
> **ii. The treatment of Skin Rash**

INVESTIGATION METHODOLOGY

8. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Practice's complaints process.

Independent Professional Advice Sought

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

- **A Registered Nurse** with over 30 years' experience in several areas of nursing including nurse team lead for community treatment rooms. (NIPA); and
- **A GP** MBBS BSc FRCGP ILM5 MSc (med ed)- a senior GP with a special interest in regulatory medicine and complaints. (GPIPA)

I outlined my consideration of the IPA's advice in my analysis and findings below.

10. I included the information and advice which informed the findings and conclusions within the body of this report. The IPAs provided 'advice'. However, how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

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

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

    - The Principles of Good Administration

12. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - The General Medical Council's Good Medical Practice, updated April 2019 (the GMC Guidance);
    - The General Medical Council's Good Medical Practice: Delegation and Referral updated April 2013 (the GMC guidance on delegation);
    - The Nursing and Midwifery Council's The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, updated 10 October 2018 (the Code);
    - The Nursing and Midwifery Council's Future nurse: Standards of proficiency for registered nurses, published May 2018 (FN); and
    - The National Institute for Health and Care Excellence's Clinical Knowledge Summary: Styes (hordeola), October 2019 (NICE CKS).

13. 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.

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

14. A draft copy of this report was shared with the complainant and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations. I carefully considered the comments I received.

THE INVESTIGATION

Detail of Complaint

15. The complainant raised concern that a nurse, rather than a GP, examined her on 8 November 2022. The nurse looked '*briefly*' at her skin rash and told the complainant there was nothing she (the nurse) could do. The nurse did not recommend any further treatment for the rash. The complainant said when asked about the styes, the nurse advised her to '*wash her eyes'*. She said this caused her upset.

16. The complainant said that following her appointment with the nurse, she asked a receptionist to see a GP. However, the Practice declined her request. The complainant telephoned the Practice on 9 November 2022 and requested a callback. She did not attend an appointment with a GP, but following the Practice's request, she emailed photographs of her styes.

17. The complainant said she continued to struggle with the eye infection. She said this experience affected her mental health, and she lost trust in the Practice. The complainant said she later visited an optician who referred her to an eye specialist in the hospital.

Evidence Considered

Policies/Guidance

18. I considered the following policies and guidance:
    - The GMC Guidance;
    - The Code;
    - FN; and
    - NICE CKS.

The Practice's response to investigation enquiries

19. The Practice stated it did not prescribe treatment for the complainant as the nurse did not see '*any evidence of a skin rash or eye styes.*' The nurse documented in the medical record that the complainant said the rash had resolved.

20. The Practice stated, *'the nurse was familiar with the clinical presentation of eye styes*.' She had over 30 years' experience and it considered her clinically very capable and experienced. The nurse carried out '*the unaided visual examination of both eyes in good lighting*.' The nurse did not recommend any treatment because *'there was nil of note on examination*.' The nurse did not advise the complainant to '*wash her eyes'*.

21. The Practice stated the complainant asked reception to see a GP. GP A discussed the matter with the practice nurse who advised there was nothing to see on examination. Based on her report, there was no indication for a GP appointment as a '*competent health care professional'* examined the complainant. She found nothing abnormal on her assessment. It explained practice nurses follow the Code.

22. The Practice stated it placed the complainant on a GP query list for a telephone call the next day (9 November 2022).

23. The Practice stated it dealt with the complainant promptly and appropriately on each of her contacts. The complainant received prompt and appropriate assessment and management, and there is no evidence of mistreatment or wrongdoing.

Relevant Practice records

24. I considered the relevant medical records.

Relevant Independent Professional Advice

25. I considered the full IPA report.

The Practice's Response to the draft Report

26. The Practice stated that it records discussions between GP / nurse / reception staff and all queries and comments are recorded electronically on a daily query list. Although they do not form part of medical records all communication between reception staff and clinicians is recorded for reference if needed. In order to maintain proper and appropriate records the Practice accepts it may be appropriate to also record comments in the actual patient notes.

27. The Practice stated it had taken note of the recommendations in the draft Report and discussed the findings among practice clinical staff. The Practice reviewed procedures particularly with respect to offering second opinions if requested. Practice GPs will offer face to face second opinions if requested although this may not be immediately possible on same day depending on workload demands and staffing levels.

Analysis and Findings

The decision for a nurse to examine the complainant

28. The complainant was concerned that a nurse examined her rather than a GP. I refer to the GMC guidance, which outlines clinicians' delegation of patient care to their colleagues. Paragraph 3 of the guidance states, '*delegation involves asking a colleague to provide care or treatment on your behalf*'. Paragraph 4, states, '*when delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment'.* In its response to enquiries, the Practice stated it was satisfied the nurse had the necessary skills and experience to examine the complainant.

29. I considered if it was normal practice for a nurse to conduct such an examination. The N IPA advised it was '*wholly reasonable'* for a registered nurse to assess patients if this is within their scope of professional competence. This is in line with the NMC Code.

30. The Code states that to practice effectively, nurses '*should assess need and deliver or advise treatment or give help without too much delay and to the best*

of their abilities.' Paragraph 6.2 of the Code states nurses must *'maintain the knowledge and skills you need for safe and effective practice'.*

31. I also refer to Paragraph 4.5 of FN, which states '*at the point of registration the registered nurse will be able to demonstrate the knowledge and skills required to support people with commonly encountered physical health conditions'*.

32. I note the nurse who examined the complainant was a registered nurse with 30 years' experience and was familiar with the clinical presentation of a stye. I have not reviewed any evidence that would cause me to question the nurse's competency in this regard. Therefore, taking account of the GMC guidance on delegation, the Code, FN, and the N IPA's advice, I am satisfied it was appropriate for the nurse to examine the complainant and I do not uphold this element of the complaint.

The nurse's examination of the styes

33. The complainant raised concern with the nurse's examination of the styes and said she advised her to '*wash her eyes'*. She said this caused her upset.

34. NICE CKS states that assessment of a person with a suspected stye should include:
    - Asking about the timescale of symptoms; previous episodes; associated eye symptoms; any risk factors or triggers for symptoms; and
    - Examination of the eye for typical clinical features, including eversion of the lower and upper eyelids

35. I note the records do not evidence that the nurse documented a detailed history as NICE CKS recommends. However, the N IPA advised the consultation notes evidence that the patient did not present with symptoms of a stye. Therefore, I accept the N IPA's advice that *'It is wholly reasonable a full history was not required given the patient presented with no symptoms then'*.

36. In relation to action taken, the records do not provide evidence that the nurse told the complainant to '*wash her eyes*.' In the absence of independent evidence, I cannot make a finding on this element of the complaint.

37. The N IPA advised a nurse should refer a patient with styes to a GP, but only if they present with symptoms of a severe eye infection that may require onward referral. I have already established that the nurse's assessment of the complainant did not identify symptoms of an eye infection. Therefore, I accept the N IPA's advice that it '*was reasonable that the nurse did not refer the complainant to a GP*.'

38. Having reviewed all relevant documentation and the N IPA's advice, I consider the care and treatment the nurse provided to the complainant in relation to styes was appropriate and in accordance with relevant guidelines. I do not uphold this element of the complaint.

Examination and treatment of the rash

39. The complainant said the nurse did not provide any treatment for the skin rash. The records document that the nurse examined the complainant but did not see evidence of a rash. Furthermore, the records document that the complainant said her rash had '*resolved*'.

40. I refer to Standard 13.2 of the NMC Code, which states that nurses should '*make a timely referral to another practitioner when any action, care or treatment is required'*. Based on this guidance, I accept the N IPA's advice that as the rash had resolved, there was no requirement for the nurse to refer the complainant for treatment. I therefore consider the care and treatment the nurse provided for the skin rash was appropriate and in accordance with the relevant guidelines. I do not uphold this element of the complaint.

The GP's decision not to see the complainant

41. The complainant said that following the nurse's examination she asked a receptionist to speak with a GP. The Practice stated that the receptionist spoke to GP A, who then discussed the outcome of the clinical examination with the nurse who carried it out. Based on this discussion, GP A decided she did not

need to examine the complainant further.

42. I am unable to determine what information the receptionist passed onto GP A as there is no record of this interaction. There is also no record of the discussion between GP A and the nurse, or of GP A's decision. Therefore, I cannot establish if GP A's rationale for not seeing the complainant at that time was appropriate. Standard 21(b) of the GMC Guidance states that clinicians must record '*decisions made and actions agreed, and who is making the decisions and agreeing the actions*.' I consider that by not recording these interactions, the decision made, and the rationale for it, GP A did not act in accordance with this standard. I consider this a service failure.

43. In relation to GP A's decision not to see the complainant on 8 November 2022, I refer to Standard 49 of the GMC guidance, which states that clinicians must work in partnership with patients when making decisions about their care. I also refer to Standard 56, which states that clinicians must give *'priority to patients on the basis of their clinical need if these decisions are within your power'.* I recognise that in considering clinical need, GP A consulted with the nurse who examined the complainant. However, I note the GP IPA's advice that GP A should have also asked the complainant why she wished to see a GP rather than a nurse and considered her reasons. I accept this advice and consider that GP A should have spoken to the complainant directly before making her decision on 8 November 2022. I note the Practice has reviewed my recommendations regarding offering second opinions.

44. The complainant received a telephone call from the Practice on 9 November 2022 during which a receptionist asked her to email photographs of her eyes. The records evidence that GP B reviewed the photographs, and that the complainant was '*keen for treatment*.' GP B then prescribed the complainant antibiotic drops. The complainant did not attend a face-to-face consultation with GP B.

45. I refer to Standard 16(a) of the GMC Guidance. It states that clinicians must prescribe treatment '*…only when you have adequate knowledge of the patient's*

health and are satisfied that the drugs or treatment serve the patient's needs.' The GP IPA advised that in establishing if the treatment provided was appropriate, GP B should have held a face-to-face consultation with the complainant. She further advised that this would have provided GP B an opportunity to examine the complainant's eye and explore her reasons why she was '*keen for treatment'*. I accept this advice.

46. In relation to antibiotic treatment for styes, NICE CKS states, '*Do not routinely prescribe a topical antibiotic. Consider prescribing a topical antibiotic only if there are clinical features of spreading infection causing conjunctivitis, such as copious muco-purulent discharge*.' GP B's record of the decision to prescribe the antibiotic documents that there was '*little in way of infection seen, some mild injection of conjunctiva, small ?scale?lump left upper upper lid on one pic, not present in others*.'

47. This record evidences that GP B did not consider the complainant had a '*spreading infection*.' Therefore, I cannot be satisfied that the decision to prescribe the antibiotic was in accordance with NICE CKS. I recognise the pressure GP Practices were under at that time. However, I consider that had GP B held a face-to-face consultation with the complainant, it would have provided an opportunity for them to obtain '*adequate knowledge'* of the complainant's health before deciding how to treat the stye. I consider this a failure in the complainant's care and treatment and uphold this element of the complaint. I consider the failures identified caused the complainant to sustain the injustice of uncertainty, and a loss of opportunity to have a face-to-face consultation with a GP.

CONCLUSION

48. I received a complaint about care and treatment the complainant received from Templemore Medical Practice on 8 and 9 November 2022. The investigation found the Practice's decision that a nurse should initially examine the complainant appropriate. It also found the nurse's treatment of the complainant appropriate and in accordance with relevant standards.

49. However, the investigation found the Practice should have arranged for a GP to see the complainant following her request and prior to prescribing the antibiotic drops. I consider this a failure in the complainant's care and treatment. I am satisfied this caused the complainant to sustain the injustice of uncertainty, and the loss of opportunity to have a face to face GP consultation. The investigation also established that the Practice did not retain adequate records of its interactions between the receptionist, GP A, and the nurse. I consider this a service failure.

Recommendations

50. I recommend that the Practice provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (August 2019), for the injustice caused as a result of the failures identified within **one month** of the date of this report.

51. For service improvement and to prevent future recurrence, I further recommend that the Practice:

    i. Discusses the findings of this report with all staff involved in the complainant's care to allow them to reflect on the findings;
    ii. Reminds relevant staff of the importance of exploring with patients their reasons for requesting face-to-face consultations and taking appropriate action; and
    iii. Reminds all staff of the importance of maintaining proper and appropriate records in accordance with Standard 19 of the GMC Guidance.

52. I am pleased to note that the Practice accepted my recommendations regarding record keeping and will keep records of such interactions in patient notes. I note the Practice has reviewed its procedures and I am pleased that GPs will offer a face to face second opinion if requested. I accept that this may not be possible on the same day due to workload demands or staffing pressures.

MARGARET KELLY

OMBUDSMAN **20 February 2024**

Appendix One

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

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

2. Being customer focused

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

3. Being open and accountable

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

4. Acting fairly and proportionately

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

5. Putting things right

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

6. Seeking continuous improvement

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

Appendix Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

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

Being customer focused

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

Being open and accountable

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

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

Acting fairly and proportionately

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

Putting things right

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

Seeking continuous improvement

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