SPSO decision report

Case: **201906403, Grampian NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late parent (A) during an admission to Aberdeen Royal Infirmary. C complained that during the admission, they did not see A being provided with nebulisers (a device which helps to moisten the airways; or allow medicine to be administered as a vapour) or oxygen therapy. C also felt that A was not given appropriate pain relief, particularly towards the end of their life, and that A's condition and potential outcome were not explained to C and their family.

We took independent advice from a consultant in acute medicine. We found that the management of A's need for oxygen was reasonable. The evidence that had been provided suggested that A was receiving regular nebulisers, however there was no medication record to confirm this and this was unreasonable.

There was no evidence that A was in unrelieved pain towards the end of their life and the prescription of medication and documentation regarding this matter was reasonable.

We considered the timing of the conversation with A's family regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was likely reasonable, but some of the documentation around this conversation was not reasonable.

On the basis of the lack of evidence regarding the prescription of nebulisers, and poor documentation of the initial DNACPR conversation, we upheld C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the failure to provide a record of the nebulisers prescribed for A; and for the lack of documentation around the initial Do Not Attempt Cardiopulmonary Resuscitation conversation.nThe apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.

What we said should change to put things right in future:

- DNACPR conversations should be documented with an appropriate level of detail.
- There should always be complete records of prescribed medication.

We have asked the organisation to provide us with evidence that they have implemented the recommendations we have made on this case by the deadline we set.