SPSO decision report

Case: **202005553, Tayside NHS Board**
Sector: Health
Subject: record keeping
Decision: upheld, recommendations

Summary

C complained on behalf of their late spouse (A) who was admitted to Ninewells Hospital. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR, a decision taken that means a healthcare professional is not required to resuscitate the patient if their heart or breathing stops) was put in place some time after their admission and they died a week later.

C complained that clinicians failed to discuss the DNACPR with family prior to this being put in place and, when they were consulted, the family were clear that they were not in agreement with it. The family also complained that the DNACPR form was only signed by one clinician, rather than the two required for the form. C considered this was further evidence that the DNACPR decision was taken incorrectly.

In response, the board said that the decision to put a DNACPR in place was made following discussion at the multi-disciplinary team meeting, the records did not show any disagreement by the family at the time and the form was completed by one of the junior medical staff, on the lead consultant's instruction.

We took independent advice from an appropriately qualified adviser. We found that the board failed to follow appropriate processes and procedures in relation to the implementation of the DNACPR, in as far as they failed to both adequately document conversations with family members, and to complete the required paperwork correctly. We upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to follow appropriate processes and procedures in relation to the implementation of the DNACPR, more specifically for failing to adequately document conversations with family members, and also in failing to complete the required paperwork correctly. The 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:

- Clinicians involved should reflect on the complaint and identified failures with respect to the implementation of the DNACPR, specifically documenting communications with family and completing the relevant paperwork and forms.
- Medical professionals and clinicians are aware of, and adhere to, relevant professional standards and guidance with respect to maintaining clinical records and recording decision-making.

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.