SPSO decision report

Case: **201706122, Tayside NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mr C complained about a Do Not Attempt Cardiopulmonary Resuscitation decision (DNACPR - a decision taken that means a healthcare professional is not required to resuscitate the patient if their heart or breathing stops) taken when his mother (Mrs A) was a patient in Ninewells Hospital where she was being treated for heart failure. Mr C held Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters) in relation to his mother. He had been told of the decision in a public place, without being consulted. The doctor who spoke to him said he had spoken to Mrs A, who agreed with the decision. Mr C said his mother was very confused and unable to consent to this. Mr C complained that he had not had his views taken into account in relation to the DNACPR decision despite having POA and that the board unreasonably spoke to Mrs A and gained her consent despite her lacking capacity to give consent at the time.

We took independent advice from a doctor with specialism in acute and general medicine. We found that it was inappropriate to have a discussion with Mr C about the decision in such a public setting, however, we found that the board had acknowledged and apologised for this. We noted that where a patient has granted a POA, the attorney should be involved in the decision wherever possible, with the patient as well if appropriate. However, if cardiopulmonary resuscitation (CPR - where the heart and/or breathing is re-started if it stops) is unlikely to be successful, healthcare staff are under no obligation to attempt CPR. The adviser considered that Mr C should have been involved in the discussions earlier, but ultimately it was the clinical team's decision to make. We did not uphold this aspect of Mr C's complaint.

In relation to gaining Mrs A's consent, we found that the board acknowledged that a discussion had taken place and, given it was recorded that she was confused at this time, they noted it would have been appropriate for a mental capacity assessment to have taken place. We acknowledged that assessing Mrs A's mental capacity was not the priority at the time the decision was taken as she was acutely unwell. However, the fact she was confused should have prompted an assessment of her capacity. We were also concerned that the board did not obtain a copy of the POA document. Therefore, we upheld this aspect of Mr C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mr C and Mrs A for failing to assess Mrs A's capacity and for failing to obtain a copy of the POA document. The apology should meet the standards set out in the SPSO's Guidance on Apology at: https://www.spso.org.uk/leaflets-and-guidance.

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

- Staff should have a working knowledge of Adults with Incapacity legislation insofar as it applies to consent issues. Staff should be clear about the importance of Adults with Incapacity documentation.