SPSO decision report

Case: **201802753, Ayrshire and Arran NHS Board**
Sector: health
Subject: clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

Mrs C's mother (Mrs A) was transferred to hospital by ambulance with low oxygen levels. Mrs C had a power of attorney (POA) in place, enabling her to make decisions on Mrs A's behalf. Mrs A was admitted to hospital and the following day medical professionals spoke with her regarding a 'do not attempt cardiopulmonary resuscitation' (DNACPR) agreement, without first consulting Mrs C. Mrs C complained to the board that it was inappropriate for medical professionals to speak with Mrs A regarding the DNACPR as she had dementia and did not understand what was being said. Mrs C also complained about the lack of knowledge of the POA that was in place. In their response, the board explained that it was a priority to complete a DNACPR given Mrs A's deteriorating condition, and it was appropriate in the circumstances to discuss this with her. The board said that they were aware of the POA and this was appropriately recorded in Mrs A's medical records.

Mrs C complained that the board's actions in implementing a DNACPR were unreasonable, that they unreasonably failed to clearly record in Mrs A's records that a POA was in place and that the handling of the complaint was unreasonable.

We took advice from an independent medical adviser. With respect to the actions in implementing the DNACPR, we found that given Mrs A's state of health on admission to hospital, it was appropriate for medical professionals to consider a DNACPR and discuss this with Mrs A. Whilst there were concerns about Mrs A's capacity, the records indicated that this was considered by medical professionals. It was reasonable for medical staff to decide DNACPR was required and that Mrs A had capacity at the time to be involved in the discussions. We did not uphold this complaint.

With respect to the complaint that the POA was not clearly recorded in the file, we found that at the time of Mrs C's complaint, the board were unable to locate a copy of the POA on file. Whilst the medical notes showed the medical professionals were aware of the POA in place, there was not a record kept on file at all times. On this basis, we concluded that the board failed to clearly record in the file that an active POA was in place. We upheld this complaint.

In relation to Mrs C's complaint, we found that the board failed to respond to the complaint within the 20 working day time-frame and failed to provide any explanation for the delay. Therefore, we upheld the complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to Mrs C for the failure to keep her updated on the progress of her complaint, the delay in completing the investigation or to provide a revised timescale for response. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/leaflets-and-guidance.

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

- Where the board have been provided with a physical copy of a POA document, a copy should be kept in the relevant patient's medical records, in a prominent position, at all times.

In relation to complaints handling, we recommended:

- Complaints handling staff should be aware of the requirements of the Complaints Handling Procedure with respect to timescales for response and keeping complainants informed about their complaint.