SPSO decision report

Case: **202106450, Lothian NHS Board - Acute Division**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C complained about the care and treatment provided to their late partner (A). A had a history of Chronic Obstructive Pulmonary Disease (COPD, a group of lung conditions that cause breathing difficulties). A was suffering from constipation which was treated by the district nursing team at home. When this did not resolve, A was admitted to hospital for review and treatment of their constipation. C said they asked that A be treated and discharged home as quickly as possible. A fell whilst in hospital and fractured their shoulder. A developed a chest infection and subsequently died in hospital.

C believed A's condition could have been treated in the community. C felt A's vulnerability had not been recognised by nursing or clinical staff in hospital. C said that A had been designated as an adult with incapacity (AWI) and do not attempt cardiopulmonary resuscitation (DNACPR) without discussion with them as A's power of attorney (POA). C felt A's fall was avoidable had staff listened to the family's requests for 1-to-1 nursing.

We took advice from a registered nurse and a consultant respiratory physician. We found that A was not provided with a reasonable standard of nursing care in the community, as more could have been done to treat their constipation at home. Therefore, we upheld this part of C's complaint.

In relation to A's care while in hospital, we found both the standard of nursing and medical care to be reasonable. Therefore, we did not uphold these part's of C's complaint.

In relation to communication with C as A's next of kin and POA, we found there was a lack of communication regarding A's care and in particular decisions around designating A as AWI and DNACPR. Therefore, we upheld this part of C's complaint.

Finally, we found that A's death certificate should have included the fall as a secondary factor in their death. Initially it was believed that C would need to request this amendment, but the responsibility in fact lay with the board, who have been asked to ensure that the death certificate is amended. We upheld this part of C's complaint.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for the issues highlighted in this decision. 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:

- That the board develop a bowel management guideline to ensure appropriate prescribing and escalation if no response to treatment. This should include clear escalation pathways for patients with deteriorating

health.

- That the board remind the clinical team of the importance of discussing and recording discussions about DNACPR and AWI decisions with patients and their next of in/powers of attorney, including ensuring that all parties understand how and why the decision has been reached.
- The responsible consultant should contact the Death Certificate Advisory Service and have the full amendment made as soon as possible.

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.