

SPSO decision report



Case: 202110569, Grampian NHS Board
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: upheld, recommendations

Summary

C complained about the care and treatment provided to their late spouse (A) who had chronic obstructive pulmonary disease (COPD, a group of lung conditions that cause breathing difficulties). A was admitted to hospital as an emergency with kidney failure, and high blood acid and potassium levels. A died the following day. The cause of death appeared to be a cardiac arrest resulting from high potassium, in the context of coronary artery disease.

C complained that A should not have been stepped down from the critical care unit to a medical ward resulting in a lack of monitoring and timely treatment for A and that A had inappropriately been deemed DNACPR (do not attempt cardiopulmonary resuscitation). C also said that the board's review into A's death failed to identify or acknowledge clinically significant evidence and that communication and provision for bereaved families was poor.

We took independent advice from a consultant in acute and general medicine. We found that while it was reasonable for the board to have considered moving A to a general medical ward, an arterial blood gas test conducted prior to the transfer had indicated that A's condition was deteriorating. This test was not acted upon. We were also critical that the board had missed the significance of these test results during their complaints investigation. Furthermore, while the process for declaring a DNACPR was reasonable, we found that the way in which this had been explained to C had been lacking. We also noted that while the board had confirmed that facilities for bereaved families were available, they were not utilised for A's relatives on this occasion. Therefore, we upheld all of C's complaints.

Recommendations

What we asked the organisation to do in this case:

- Apologise to C for failing to provide A with reasonable care and treatment. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.
- Apologise to C that the board's critical care governance review into A's death unreasonably failed to identify or acknowledge clinically significant evidence. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.
- Apologise to C for failing to provide reasonable facilities for bereaved families and for failing to provide a reasonable level of communication to the family during A's admission. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spsso.org.uk/information-leaflets.

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

- Adequate procedures should be in place to ensure that all arterial blood gas results are reviewed and acted upon by clinical staff. Appropriate clinical assessment and patient observation should be carried out when a patient is admitted to a ward and the patient should be monitored thereafter. Patient admission documentation should be completed in a timely manner.

- Communication and terminology used when talking to a patient's family should be clear and easily understood. In relation to a DNACPR decision, the resuscitation process should be clearly explained to patients and, where appropriate, their families with the use of easily understood lay terms and in accordance with NHS Scotland's Cardiopulmonary resuscitation decisions guidance. Notification of a patient's death should be delivered in person where possible in an appropriate environment e.g. a relative's room.
- Critical Care Clinical Governance reviews should be comprehensive, accurate and productive. Where adverse event(s) occur, an adverse event review should be held in line with relevant national guidance to ensure there is appropriate learning and service improvements that enhance patient safety.

In relation to complaints handling, we recommended:

- Complaints should be investigated and responded to in accordance with the Model Complaints Handling Procedures. They should fully investigate and address the issues raised and appropriately identify and action learning.

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.