# SPSO decision report

SPSO Scottish Public Services Ombudsman

**Case:** **201406607, Borders NHS Board**
**Sector:** health
**Subject:** communication / staff attitude / dignity / confidentiality
**Outcome:** some upheld, recommendations


## Summary

Mr C complained about the care and treatment of his late mother (Mrs A) at Borders General Hospital. He raised concerns that staff unreasonably put in place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order without discussing this with him, despite him holding welfare power of attorney. We took independent advice from a consultant physician. They found no evidence of the decision having been discussed initially with Mr C. We were critical of the board for failing to properly involve Mr C in discussions and we upheld this part of the complaint.

Mr C also complained about the actions of staff in relation to his mother's feeding. In particular, he questioned the process surrounding the insertion of a PEG (percutaneous endoscopic gastronomy) feeding tube. The advice we received indicated that Mrs A's nutritional intake was appropriately monitored throughout her stay. We were satisfied that Mr C was appropriately consulted and involved in decisions in this regard, including the decision to insert a PEG tube. We did not uphold this part of Mr C's complaint. In addition, Mr C complained about the general nursing care provided to his mother. We took independent advice from a senior nurse who reviewed the records and advised that the overall nursing care provided to Mrs A was of a good standard. We did not uphold this aspect of Mr C's complaint.

Finally, Mr C complained about the adequacy of the board's response to his complaint. We found their response generally to have been of a reasonable standard. However, in addressing Mr C's concerns surrounding the DNACPR decision, they provided some information that was not supported by the medical records. Furthermore, while the board acknowledged and apologised for a failure to prescribe some of Mrs A's usual medication, they did not identify a subsequent gap in the prescribing chart. We upheld this aspect of Mr C's complaint. We made some recommendations in relation to both the complaints handling and prescribing failures identified.


## Recommendations

We recommended that the board:

- apologise to Mr C for failing to properly involve him in discussions about Mrs A's DNACPR status;
- remind their medical staff of the importance of involving patients and their carers in discussions about end of life care and of documenting such discussions;
- review their process for checking and prescribing relevant medication following admission and inform us of the steps they have taken to avoid a repeat of the failings this investigation has highlighted;
- apologise to Mr C for the inadequate response to his complaint; and
- remind complaints handling staff of the importance of investigating and responding to complaints comprehensively and accurately, ensuring that the information provided is supported by available evidence and that any discrepancies are reflected in their correspondence with complainants.