SPSO decision report

Case: **202001906, Lanarkshire NHS Board**
Sector: Health
Subject: Clinical treatment / diagnosis
Decision: some upheld, recommendations

Summary

C, an advocate, complained on behalf of their client (B). B's spouse (A) died of advanced lung cancer.

A started experiencing pain between their shoulder blades and was referred by their GP practice to University Hospital Hairmyres for a chest x-ray. A attended A&E at University Hospital Hairmyres on three different occasions and received further x-rays. A was admitted to University Hospital Wishaw and after undergoing further investigations, they were diagnosed with advanced lung cancer.

C complained about the clinical assessment of A's symptoms when they attended A&E. C complained that A had signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form during a hospital admission when they did not have capacity to understand it. B was unhappy that they had not been consulted about the DNACPR.

C also complained that communication about A's diagnosis was very poor. They complained that A was not informed that their cancer was life limiting or terminal. According to B, they were unaware of the prognosis or that A only had a short time to live.

We took independent advice from an emergency medicine adviser. We found that A's symptoms were appropriately assessed and treated during each of their attendances at A&E. We considered that A was appropriately referred for further investigation and we did not uphold this aspect of the complaint.

We also took advice from a consultant physician. In relation to communication regarding the DNACPR, we found that A's capacity was appropriately assessed and that their consent was reasonably obtained. We considered that there was no obligation for staff to discuss the DNACPR with A's family and we noted that A's admission was during the initial weeks of the COVID-19 outbreak when restrictions for visits were in place and hospitals were under considerable pressure. We did not uphold this aspect of the complaint.

We noted that there was a disparity between what clinicians thought that A's family understood regarding A's condition and what their understanding actually was, although it was not possible to say whether this was due to a communication failing on the clinicians' part or whether the family had failed to grasp what they were being told. We took into account that B said that they did not realise how ill A was until they found the DNACPR form on which it was noted that they were not expected to live more than 28 days. In recognition of the impact that this must have had on B and taking into account that A's family did not feel sufficiently informed about A's condition throughout their illness, on balance, we upheld the complaint that the board's communication regarding A's condition was unreasonable.

Recommendations

What we asked the organisation to do in this case:

- Apologise to B for the communication failings our investigation has identified. 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:

- This case should form part of the annual appraisal for staff involved in communicating A's condition, with training undertaken where any gaps are identified.

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.