SCOTTISH PUBLIC SERVICES OMBUDSMAN

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The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

SPSO
Bridgeside House
99 McDonald Road
Edinburgh
EH7 4NS

Tel **0800 377 7330**
Web **www.spso.org.uk**

Scottish Parliament Region: Glasgow

Case ref: 201905973, Greater Glasgow and Clyde NHS Board - Acute Services Division

Sector: Health

Subject: Hospitals / nursing care / clinical treatment

Summary

C complained about the care and treatment provided to their adult son (A) when they were admitted to Queen Elizabeth University Hospital for a total thyroidectomy (complete removal of the thyroid gland) and right neck dissection (surgical removal of lymph nodes) due to cancer. On the day of the surgery, the consent form was completed and it mentioned a number of risks, including risk of bleeding.

The surgery went well and two surgical drains were inserted into the right side of A's neck. Three days after surgery, the first drain was removed by a nurse, following instruction by an Ear, Nose and Throat (ENT) Registrar. The second drain was removed the following day. Shortly after, A's neck was numb and swelling and they became distressed with a shortness of breath. A had developed a haematoma (localised bleeding outside of blood vessels) and a subsequent cardiorespiratory arrest. An emergency procedure was performed to relieve the pressure in A's airway. A recovered but was left with mobility and speech difficulties and seizures.

C complained about the nursing care provided to A. They said that A was not appropriately monitored and the removal of the tube was not performed correctly given the haematoma developed. They also complained about the medical care provided, that they were not told of the risk of hypoxic brain injury or of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order that was put in place.

We sought independent clinical advice from a registered nurse (Adviser 1) and a Consultant ENT Surgeon (Adviser 2). Adviser 1 noted that A's drains were removed in accordance with the postoperative and ENT Registrar's instructions and that they were monitored frequently. We concluded that A was appropriately monitored and we did not find any evidence that the removal of the tubes was performed incorrectly. As such, we concluded that the nursing care provided was reasonable and we did not uphold the complaint.

In respect of the medical care provided, Adviser 2 explained that a secondary haemorrhage is a known complication of this kind of surgery and the SCOOP protocol should be followed to help relieve the pressure on the airway. SCOOP

protocol advises to open the wound and remove the haematoma. Our investigation found that while Greater Glasgow and Clyde NHS Board (the Board) said they followed the SCOOP protocol, it was not followed correctly. There was a limited opening of the wound and the haematoma remained present for over 90 minutes, whereas it should have been removed as quickly as possible. If this had been done, it would have most likely prevented A's cardiorespiratory arrest that led to a hypoxic (reduced supply of oxygen) brain injury. Following this event, the Board discussed the case at a morbidity and mortality meeting, however they failed to identify the SCOOP protocol was not followed correctly.

Our investigation found that the risk of a blood clot in the neck causing breathing difficulty was not mentioned and this should have been listed on the consent form and discussed. We also concluded that while there was evidence of regular discussion with the family about A's condition and prognosis, it was not recorded that DNACPR was specifically mentioned or that the family fully understood this.

Overall, we concluded that the Board failed to ensure A was provided with a reasonable standard of medical care and treatment during their admission, specifically in the way the emergency situation was handled and we upheld the complaint on that basis.

We made a number of recommendations to address the issues identified and we will follow up on these recommendations. The Board are asked to ensure guidance on the SCOOP protocol is fully implemented and that staff are aware of the relevant guidelines for DNACPR orders by the date specified. We will expect evidence that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Redress and Recommendations

What we are asking the Board to do for C:

Complaint number	What we found	What the organisation should do	What we need to see
(b)	We found that the Board failed to follow the SCOOP protocol correctly, by ensuring that the family understood fully the DNACPR process, and by explaining that a bleed in the neck causing breathing difficulty was a risk.	Apologise to C and A for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.	A copy or record of the apology. By: 24 January 2022

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(b)	We found that the Board did not follow the SCOOP protocol correctly.	BAETS guidelines should be fully implemented in the relevant department(s).	Evidence that appropriate learning has been implemented in the relevant department(s). By: 22 March 2022
(b)	We found that the Board did not ensure that family members fully understood the DNACPR process.	All staff should be aware of the Resuscitation Council UK guidelines for DNACPR orders.	Evidence that all staff have appropriate understanding of DNACPR procedures. By: 22 March 2022

Feedback

Points to note

Adviser 1 reported that the patient's case record lacked chronology and that some of the notes were difficult to read and it was not always evident who wrote the note or their designation/profession. Whilst appreciating it is not always possible to complete notes at the time of a significant event, someone allocated to noting the timing of events and personnel in attendance should take care to note these details and ensure that records are correct and as full as they can be.

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. C complained to the Ombudsman about the care and treatment provided to their adult son (A) when they were admitted to hospital for a total thyroidectomy and right neck dissection due to cancer. Shortly after the surgery, A suffered complications, including a haematoma of the neck causing airway obstruction and a subsequent cardiorespiratory arrest. A recovered but has been left with mobility and speech difficulties, takes medication to control seizures and has not been able to return to their previous employment. The complaints from C I have investigated are that:

(a) the Board failed to ensure the patient was provided with a reasonable standard of nursing care and treatment during their admission to hospital in May 2019 (not upheld); and

(b) the Board failed to ensure the patient was provided with a reasonable standard of medical care and treatment during their admission in May 2019 (upheld).

Investigation

2. In order to investigate C's complaint, my complaints reviewer and I obtained a copy of the relevant medical records and sought independent clinical advice from a registered nurse (Adviser 1) in respect of complaint (a) and a Consultant Ear Nose and Throat (ENT) Surgeon (Adviser 2) in respect of complaint (b). In this case, I have decided to issue a public report on C's complaint due to the significant personal injustice suffered by A and the potential for wider learning which could arise from sharing details of this case.

3. This report includes the information that is required for me to explain the reasons for my decision on this case. Please note, I have not included every detail of the information considered. My complaints reviewer and I have reviewed all of the information provided during the course of the investigation. C and the Board were given an opportunity to comment on a draft of this report.

Key events

4. I have set out below the key events that relate to both (a) and (b) above.

5. On 10 May 2019, A underwent a thyroidectomy and neck dissection for metastatic papillary carcinoma (a form of cancer that occurs due to abnormal and uncontrolled cell growth of certain cells (follicular cells) of the thyroid). The consent form completed on the day of surgery mentioned risk of bleeding, although risk of

loss of the airway was not mentioned. A's surgery was noted to have gone without complication. Two surgical drains were inserted into the right hand side of A's neck.

6. On 13 May 2019, A's National Early Warning Score (NEWS, a score allocated to physiological measures: respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness or new confusion, and temperature) was noted as 4 'earlier', but at 05:00 there was an improved score of 2.

7. A was transferred to the High Dependency Unit (HDU) at 06:30 due to symptomatic hypocalcaemia (low calcium levels in the blood) for a calcium infusion.

8. At 14:45, it is noted that A's observations were being performed two hourly. (Note: a NEWS score of 1—4 indicates a low clinical risk and a minimum of 4—6 hourly observations).

9. It is recorded that A's neck was red surrounding the wound and there were no clips or sutures in situ. The ENT registrar was informed and they instructed the nurse to remove the drain with the lowest volume of drainage.

10. At 16:30 it is noted A was pyrexia (high temperature) with a temperature of 38.4 degrees, and also had a tachycardia (fast heart rate) of 106 beats per minute. A's neck and chest were redder and the foundation year 1 (FY1) doctor was asked to review A.

11. At 17:30 it is noted that a number of actions were to be performed following review by the FY1 doctor:

- dip urine (may demonstrate normal/abnormal results including indication of infection)
- mark red areas neck and chest (usually to monitor any spread of the redness)
- bloods and blood cultures (may demonstrate normal/abnormal results including infection)
- administer paracetamol (which could help to address the high temperature).

12. The first neck drain was removed as instructed at 17:30. At 19:15 it is noted that A's observations remained outwith normal limits and a 'one off' dose of intravenous antibiotics were prescribed, to be continued orally thereafter.

13. On 14 May 2019 at 05:15 it is recorded that A was receiving oxygen therapy via a nasal cannula as their saturation levels remained lower than optimum on room air. Cardiac monitoring showed a sinus rhythm (normal heart rhythm) but with

tachycardia and normal blood pressure. The high temperature was controlled by the paracetamol.

14. At this time, A's wound was dry and intact, however, the redness had spread beyond the marks and was now affecting A's back and shoulders, and resembled a rash. The second wound drain remained in situ and the dressing showed 'old' staining. A was continuing to receive intravenous fluids, was tolerating oral fluids, passing urine and had been mobile to the toilet.

15. At 12:30 A was reviewed by the Intensive Care Unit (ICU) Consultant and it was agreed A could be transferred to the ward. A was also reviewed by ENT who advised the second drain could be removed as it had only yielded 7mls in 24 hours. A's observations were noted with saturation levels, temperature and pulse rate all remaining outwith optimum levels; however, A continued to pass urine and mobilise, and oxygen therapy was reduced to one litre via nasal cannula.

16. The drain was removed and it was noted that a blood clot was removed with the drain and a dressing was applied. It is also noted A's neck wound remained red. At this time, A was waiting on a bed in the ENT ward and it is recorded A 'felt brighter today'.

17. At 13:45 it is recorded A's drain site was oozing and a dressing was applied.

18. At 15:00 a family member asked for A to be reviewed as A was feeling their neck to be numb and swollen. The nurse attended and noted A's neck appeared swollen and saturation level on the one litre oxygen was 96%. The FY1 doctor was asked to review A and when the nurse returned to A, their neck appeared more swollen and they had become distressed with a shortness of breath. It is noted that the FY1 doctor phoned ENT to review A and simultaneously the nurse called the ICU Consultant for an urgent review.

19. The nurse noted that within seconds A was distressed, struggling to breathe and their neck was swollen. A trauma mask was applied to provide a high concentration of oxygen and the emergency buzzer was activated. The ICU Consultant, Registrar and team attended.

20. The notes written by a staff nurse stated that a 'suture cutter was used to decrease neck swelling' and a note written by a doctor stated 'a scalpel to the left edge of the wound revealed haemorrhage/haematoma under pressure'. It then goes on to state 'attempted at forced mechanical ventilation and then indirect laryngoscopy. Tissue grossly oedematous (swelling caused by excess fluid) and

anatomy difficult to discern. Attempted intubation with bougie (a thin flexible surgical instrument)'.

21. Loss of cardiac output occurred immediately prior to front of neck access. CPR was commenced and adrenaline given.

22. Notes further state 'uncertainty of position of endotracheal tube so front of neck opened and size six endotracheal tube inserted by ENT registrar'.

23. Circulation was noted to return after four minutes and A was then taken to theatre.

24. The notes record 14 minutes of pulseless electrical activity (PEA) meaning that the heart was not producing any significant output to circulate to the body, including the brain. The Board explained this period of PEA alludes to the absence of monitoring following interrogation of the machine by a Consultant following the event. This was due to a combination of loss of monitoring as A struggled to sit up and then the re-emergence of blood pressure and saturations as the cardiac output improved.

25. There is a record of a discussion on 15 May 2019 with the family and three medical staff, including the surgeon. It was explained that a period of at least 72 hours was needed for a neurological assessment.

26. A discussion was held with the family on 16 May 2019. It was explained that if the clinical assessment was consistent with poor outlook they would discuss what A would have wanted and discuss transition to comfort/palliative care.

27. On 17 May 2019, with the surgeon present, it was discussed with the family that more time was needed to establish whether A could recover, and that if A deteriorated they would be allowed to die and CPR would not be attempted.

28. There were further discussions on 18, 19, and 20 May 2019. On 22 May 2019, the Consultant Neurologist expressed a view that the DNACPR should be revoked. It was only later that the family discussed with the nurse that they were not made aware or involved in the decision of the DNACPR being originally made.

(a) The Board failed to ensure the patient was provided with a reasonable standard of nursing care and treatment during their admission to hospital in May 2019

Concerns raised by C

29. A was not appropriately monitored and it was the family that alerted nursing staff to the haematoma.

30. A's vitals were not appropriately monitored.

31. Given the haematoma developed, it cannot be reasonably said the removal of the tube was performed correctly.

32. There was a trickle of blood after the tube was removed but the nurse said this was okay.

33. There was a delay in responding to the haematoma.

The Board's response

34. I have set out below the main points of the Board's response.

The Board's response to C's complaint

35. The Board explained that secondary haemorrhage is a known complication postoperatively and can be caused by an erosion of a vessel. The removal of the drain may have caused some internal disruption and a small artery to bleed which unfortunately led to this.

36. The Board assured C that removal of the neck drain is a routine procedure which would have taken place in the ward setting if A had not been in the HDU receiving treatment for low calcium levels.

37. Staff in the unit are more than competent in this procedure and there was no indication that the removal of the tubes was performed incorrectly.

38. Acute deterioration in A's condition was recognised and treated in a timely fashion.

39. The Board noted that it was a very difficult clinical scenario for staff to deal with due to the physical area where the bleed had occurred however, thankfully staff managed to gain an airway and A was resuscitated in a prompt fashion.

The Board's response to SPSO

40. In response to my enquiries, the Board confirmed they did not have any additional comments to make.

Nursing advice

41. Adviser 1 was asked to comment on the reasonableness of the care provided when the tubes were removed from A's neck. Their comments are summarised as follows:

- A's records indicate the drains were removed in accordance with the postoperative and ENT registrar's instructions.

- A blood clot was noticed during the removal of the second drain, however this would not be unusual as this was a suction drain which only drains liquid so, if any clots were present, it would not be unusual for a clot to be on the end of the drain.

- Nurses providing care to surgical patients should be knowledgeable about the different types of drains and be competent in the correct technique for drain removal as well as having knowledge of potential complications to maintain high quality and safe patient care.

- The procedure to remove a drain should be carried out using an aseptic technique in a suitable environment which may include the patient's bed in the surgical ward. It is not necessary for this to take place in a HDU, although in A's case it happened to be the case.

42. Adviser 1 was also asked to comment on whether A was monitored appropriately prior to and after the tubes were removed, and whether there was an unreasonable delay in nursing staff reacting to the haematoma. Their advice is summarised as follows:

- The case record indicates that A's vital signs were being monitored 2—4 hourly which was in keeping with A's NEWS score at the time. A NEWS score of 0—4 indicates a low clinical risk and ward-based response with the frequency of monitoring 4—6 hourly. The patient should be reviewed by a registered nurse who can use clinical judgement to change the frequency of monitoring and this appears to have been the case for A, as monitoring is recorded as more frequent.

- The detail of the event was, as would be expected when a clinical event has taken place, written in retrospect. This makes it challenging to fully understand the sequence and times of the event. There is a lack of chronological detail of the event of 14 May 2019 which means there is a lack of assurance that emergency care was instigated in a timely fashion, and that all personnel knew their role in this type of event, including accurate recording.

- It can be deduced from A's records that the FY1 doctor called for assistance and the wound was opened by a Consultant in Anaesthesia and Intensive Care Medicine (ICM).

(a) Decision

43. C complained that A was not monitored properly, there was a delay in staff responding to A's developing haematoma and, given the haematoma developed, it cannot be reasonably said the removal of the tube was performed correctly.

44. It is Adviser 1's view, which I accept, that A was appropriately monitored. I note in particular, that monitoring was performed 2—4 hourly even though the NEWS score only required monitoring 4—6 hourly. From the evidence available, there is no indication that the removal of the tubes was performed incorrectly. It is noted they were removed as per the postoperative instructions.

45. In light of the above, it is my view that the nursing care provided to A was reasonable and as such, I do not uphold the complaint.

(b) The Board failed to ensure the patient was provided with a reasonable standard of medical care and treatment during their admission to hospital in May 2019

Concerns raised by C

46. They were not told of the risk of hypoxic brain injury during the consenting process.

47. The Board did not explain why the haematoma occurred in the first place.

48. The family had been told a bleed could be an issue within the first 24 hours post-surgery, but not on day four.

49. It was only by chance that A was still in HDU for treatment of their calcium levels.

50. The DNACPR was put in place without their consent/prior notification. The discussion that took place was a hypothetical conversation and not a declaration that a DNACPR was in place.

51. The ENT surgeon was shocked that the DNACPR was in place, whereas the Board's complaint response stated the surgeon was in the room when it was discussed.

<u>The Board's response to C's complaint</u>

52. Neck haematoma and airway compromise is a recognised complication of all neck surgery and should have been explained as part of the consent process.

53. The management of acute neck haematoma and airway obstruction is very challenging. Even with early recognition and appropriate management, regrettable hypoxic brain injury (due to a lack of oxygen) and death are recognisable outcomes.

54. A's case was reviewed by the ENT department and the HDU team. A joint morbidity and mortality meeting was undertaken with ENT and HDU staff where A's case was discussed at length.

55. A best practice post was circulated through the unit to raise staff's awareness. This was that all staff should be trained in SCOOP protocol (skin, cut sutures, open skin, open muscles, pack wound). The SCOOP protocol is in relation to the management of postoperative parathyroidectomy and thyroidectomy patients who develop a haematoma.

56. Staff were also reminded that for a time critical intervention, ENT should not be awaited to gain front of neck access.

57. It is understood that the DNACPR was discussed with C, the extended family and Critical Care Consultant, in the presence of the ENT Consultant and staff nurse on 17 May 2019.

58. During these discussions it was stated that if A's heart was to stop it would not be in their best interests for CPR to be performed. It was reinforced that this did not affect other aspects of A's overall care plan.

59. This discussion took place amongst a number of other aspects of A's care and prognosis at what was a very difficult and stressful period of care.

60. The DNACPR was revoked on 22 May 2019 following input from the Neurology Consultant.

The Board's response to SPSO

61. In response to my enquiries, the Board advised that the consent process was appropriately followed by ENT and A's surgery had gone well. They noted the DNACPR is a clinical order that does not require patient consent and the family cannot prevent a DNACPR from being signed[1].

62. The ENT Consultant advised that the teaching of SCOOP protocol had been made available to anaesthetics and taught prior to these events.

[1] Cardiopulmonary resuscitation decisions - integrated adult policy: guidance - gov.scot (www.gov.scot)

Medical advice

63. Adviser 2 was asked if they agreed a secondary haemorrhage is a known complication of this kind of surgery. Adviser 2 agreed that secondary haemorrhage is a known complication in any wound and explained it can certainly occur in the neck after any surgery, particularly for thyroid surgery as the gland has a rich blood supply. They also said that bleeding is more likely earlier on, although until all drains are removed, a risk remains. The removal of drains would also normally happen on the main ward.

64. Adviser 2 explained that the presence of drains in the wound does not always prevent blood collecting if bleeding occurs rapidly in the neck. Sometimes, removing a drain can disturb a blood vessel and cause bleeding. If blood accumulates rapidly in a neck wound and the wound is not opened, the pressure of the increasing blood volume/clot (called a haematoma) presses on the veins that drain the windpipe.

65. The result of this is that the lining of the windpipe swells because the blood cannot drain and this results in the centre (lumen) of the windpipe getting smaller and smaller leading to a reduced airflow to the lungs and poor oxygen levels getting into the blood.

66. If prolonged, this then leads to the brain getting less oxygen in the circulation and can lead to complications including seizures and brain death.

67. Adviser 2 was asked if there was any evidence to suggest that it was unreasonable care that caused this complication to happen. Adviser 2 told me that there is no evidence of unreasonable care up to the point of the haematoma occurring in the neck. However, they considered there was failure in the management of this emergency.

68. They explained the number one priority in this situation is to open the wound and evacuate the haematoma. This is neatly described in the British Association of Endocrine and Thyroid Surgeons (BAETS) guidelines[2].

69. Adviser 2 noted that although it appears there was a limited opening of the wound, the haematoma remained present in the neck for over 90 minutes and a tracheostomy was performed.

70. Adviser 2 explained what should have happened was that the surgical wound was opened fully to relieve the pressure of the windpipe's blood drainage. This may

[2] https://www.baets.org.uk/management-of-post-operative-haemorrhage-in-thyroid-and-parathyroid-surgery/

well have avoided the need for any further airway intervention such as placing a tube into the windpipe via the mouth and there should have been no need for the tracheostomy.

71. This should have been done on the ward; the effect would have been instantaneous and would have most likely prevented A's cardiorespiratory arrest that led to the hypoxic brain injury and seizures. Adviser 2 observed that the procedure in theatre commenced after 16:45 and so the large haematoma was present for over 90 minutes.

72. Adviser 2 considered that staff were perhaps worried the wound would bleed, but in an emergency, airway situation should be prioritised first (ABC - airway, breathing, circulation).

73. Adviser 2 was asked whether they considered reasonable process was followed in discussing the relative risks and obtaining A's consent prior to surgery. Adviser 2 explained the risk of hypoxic brain injury should be an avoidable situation. However, the risk of a blood clot in the neck causing breathing difficulty was not mentioned and this should have been listed on the consent form and discussed.

74. Adviser 2 was asked whether there was evidence to show an appropriate discussion took place regarding the DNACPR, and whether it was appropriately reviewed. They said it appears the DNACPR was first put in place on 17 May 2019, however there is documentation that the family felt they were not aware of, or involved in the decision-making and it was discussed further with them on 22 May 2019.

75. Adviser 2 went on to explain that a DNACPR would normally be discussed with any family prior to signing the order. Where possible, this should be consultant led.

76. The Resuscitation Council UK guidelines[3] state:

> 'where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and explained to the patient and those close to the patient at the earliest practicable and appropriate opportunity'.

77. Adviser 2 was asked whether they considered the Board identified appropriate learning from this incident. They advised that they did not think they did. Although the Board stated that they need to train staff in the SCOOP protocol, as referred to

[3] https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf

the BAETS guidelines, they still refer to 'front of neck access'. The key learning point must be to always ensure the haematoma is evacuated from the neck as quickly as possible; this doesn't need the expertise of an ENT surgeon, but simply a need to open the wound and manually scoop out the blood clot.

78. Adviser 2 commented that having faced this scenario themselves on more than one occasion, they can attest that this simple removal of clot can prevent the patient arresting and have the immediate impact of improving their breathing. There is then the opportunity to take the patient back to the operating theatre and locate the source of the bleeding in a controlled manner.

(b) Decision

79. I have carefully considered the advice I received, which I confirm I accept. Adviser 2 told me that the failings that occurred were not in the lead up to the haematoma developing, but rather in how clinical staff reacted to it.

80. While the Board referred to the correct protocol following an incident such as this, it would appear it was not followed correctly. It is noted the haematoma remained present for at least 90 minutes after it was first identified. As Adviser 2 confirmed, the haematoma should have been evacuated from A's neck as quickly as possible. If this had been done, it would have most likely prevented A's cardiorespiratory arrest that led to the hypoxic brain injury and seizures.

81. It is also of concern that despite discussing this case at a morbidity and mortality meeting, the Board did not identify for themselves that the SCOOP protocol was not followed correctly. Or indeed, if they did, this was not clearly stated in their complaint response.

82. I also note the Board said in their complaint response that going forward, they would ensure all staff were trained in SCOOP protocol but they also said in their response to my enquiries that training was provided prior to the events that occurred. It is not clear which account is accurate. In any case, I will recommend that further training is provided, in light of the findings of this investigation.

83. With regards to the DNACPR process, the Board referred to NHS Scotland's guidance on DNACPR orders. I accept that the overall responsibility for making an advanced decision about CPR rests with the senior clinician who has responsibility for the patient and that the process does not require consent from the patient or their family. However, I also note it is a requirement to consult with those close to the patient.

84. While there is evidence of frequent discussions with the family about A's condition and prognosis, it is the adviser's view, which I accept, that it is not recorded the family fully understood the meaning of the DNACPR. The notes prior to 22 May 2019 do not specifically mention DNACPR. I consider it important to document that the order was specifically mentioned and the family understood the meaning of it. The Board said the discussion took place with the surgeon present, but C said that the surgeon had expressed shock that the DNACPR was in place. The records indicate the surgeon was present during the discussion on 17 May 2019 and the DNACPR order was removed following recommendation by the Consultant Neurologist.

85. I accept Adviser 2's view that the risk of a blood clot in the neck causing breathing difficulty should have been listed on the consent form.

86. In light of the above, having accepted the advice I received, it is my view the Board failed to ensure A was provided with a reasonable standard of medical care and treatment during their admission, specifically in the way the emergency situation was handled. I uphold this complaint. We made a number of recommendations to address the issues identified and these are set out at the end of this report. We will follow up on these recommendations and we will expect evidence that appropriate action has been taken before we can confirm that the recommendations have been implemented

Recommendations

Learning from complaints

The Ombudsman expects all organisations to learn from complaints and the findings from this report should be shared throughout the organisation. The learning should be shared with those responsible for the operational delivery of the service as well as the relevant internal and external decision-makers who make up the governance arrangements for the organisation, for example elected members, audit or quality assurance committee or clinical governance team.

What we are asking the Board to do for C:

Complaint number	What we found	What the organisation should do	What we need to see
(b)	We found that the Board failed to follow the SCOOP protocol correctly, by ensuring that the family understood fully the DNACPR process, and by explaining that a bleed in the neck causing breathing difficulty was a risk.	Apologise to C and A for the failings identified. The apology should meet the standards set out in the SPSO guidelines on apology available at www.spso.org.uk/information-leaflets.	A copy or record of the apology. By: 24 January 2022

We are asking the Board to improve the way they do things:

Complaint number	What we found	Outcome needed	What we need to see
(b)	We found that the Board did not follow the SCOOP protocol correctly.	BAETS guidelines should be fully implemented in the relevant department(s).	Evidence that appropriate learning has been implemented in the relevant department(s). By: 22 March 2022
(b)	We found that the Board did not ensure that family members fully understood the DNACPR process.	All staff should be aware of the Resuscitation Council UK guidelines for DNACPR orders.	Evidence that all staff have appropriate understanding of DNACPR procedures. By: 22 March 2022

Feedback

Points to note

Adviser 1 reported that the patient's case record lacked chronology and that some of the notes were difficult to read and it was not always evident who wrote the note or their designation/profession. Whilst appreciating it is not always possible to complete notes at the time of a significant event, someone allocated to noting the timing of events and personnel in attendance should take care to note these details and ensure that records are correct and as full as they can be.

Terms used in the report **Annex 1**

'A'	the aggrieved/patient
Adviser 1	a registered nurse, nursing adviser to the SPSO
Adviser 2	an ENT Consultant, medical adviser to the SPSO
BAETS	British Association of Endocrine and Thyroid Surgeons
Board	Greater Glasgow and Clyde NHS Board
'C'	the complainant and the parent of the aggrieved
DNACPR	do not attempt cardiopulmonary resuscitation
ENT	ears, nose and throat
FY1	foundation year 1 doctor
haematoma	localised bleeding outside of blood vessels
NEWS	National Early Warning Score
right neck dissection	surgical removal of lymph nodes
SCOOP	skin, cut sutures, open skin, open muscles, pack wound
total thyroidectomy	complete removal of the thyroid gland
tracheostomy	a surgical procedure which consists of making an incision on the front of the neck and opening a direct airway through an incision in the trachea (windpipe)

List of legislation and policies considered **Annex 2**

NHS Scotland Cardiopulmonary Resuscitation Decisions – Integrated Adult Policy: Guidance

Cardiopulmonary resuscitation decisions - integrated adult policy: guidance - gov.scot (www.gov.scot)

British Association of Endocrine and Thyroid Surgeons (BAETS) guidelines

https://www.baets.org.uk/management-of-post-operative-haemorrhage-in-thyroid-and-parathyroid-surgery/

The Resuscitation Council UK Guidelines

https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf