Investigation Report

Investigation of a complaint against the Western Health and Social Care Trust

NIPSO Reference: 16990

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

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EXECUTIVE SUMMARY

I received a complaint about the care and treatment provided to the complainant's late mother (the patient) by the Western Health and Social Care Trust (the Trust). The patient was treated at the South West Acute Hospital in Enniskillen, Co. Fermanagh, during the period 6 to 12 July 2014.

Issues of Complaint

I accepted the following issues of complaint for investigation:

- Whether the decision to discharge the patient from the hospital back to her residential care home on 10 July 2014 was reasonable;
- Whether the administration of doxycycline to the patient in the hospital was appropriate, given that the complainant claims that his mother was allergic to that antibiotic; and
- Whether it was appropriate to place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on the patient's medical file in July 2014, and whether the Trust's policy for the putting that DNACPR order in place was followed.

Findings and Conclusion

The investigation of the complaint identified maladministration by the Trust in respect of the following matters:

(i) A failure to ensure participation by the patient's family in relation to the DNACPR decision, in accordance with the Trust's obligations under article 8 of the European Convention on Human Rights (ECHR); and

(ii) A failure in record keeping in relation to the completing of the DNACPR Communication Sheet placed on the patient's medical file on 11 July 2017.

I am satisfied that it was reasonable to discharge the patient from hospital on 10 July 2014 as there is evidence of improvement in her medical condition by that date.

I am satisfied that she was not allergic to doxycycline, and that she was rightly prescribed and administered that antibiotic. Rather, there was an inaccurate

reference with her medical notes to her being allergic to doxycycline, an error that has been acknowledged by the Trust.

I am satisfied that in the circumstances prevailing at the time, it was appropriate to put a DNACPR order in place for the patient on her readmission to hospital on 11 July 2014. However, I have found that there was no discussion of the DNACPR order with her family, which denied them the opportunity to participate in this decision and impacted on their human rights. I am unable to conclude, however, that a different decision would have been reached in this case, given the patient's co-morbidities. I am also satisfied that putting the DNACPR order in place did not impact adversely in the overall care and treatment that was provided to her.

I have concluded that the patient and her family have suffered the injustice of distress and uncertainty as a result of the lack of information provided to them at the time about the DNACPR decision. I am satisfied that they also suffered the injustice of a loss of opportunity to participate in the DNACPR decision, and that the complainant sustained the further injustice of having to take the time and trouble to bring his complaint to my Office.

Recommendations

I have recommended that the Trust apologise for the failings identified in this report and that it provide the complainant with a payment of £500 within **one month** of the date of the report, by way of solatium for the injustices he has sustained.

I have also recommended the following service improvements:

(i) The Trust adopt the 2016 Guidance from British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing on 'Decisions Relating to Cardiopulmonary Resuscitation' in relation to participation of the patient or next of kin in DNACPR decisions; and

(ii) The Trust remind all relevant clinicians of the importance of good communication and record keeping, particularly in relation to a matter as critical as the putting in place of a DNACPR order.

The Trust should implement an action plan to incorporate these service improvements and provide me with an update within **four months** of the date of this report, supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

THE COMPLAINT

1. The patient's son complained about the care and treatment the Western Health and Social Care Trust (the Trust) provided to his late mother during the period 6 to 12 July 2014.

2. On 6 July 2014, she was admitted to the Trust's South West Acute Hospital from her place of residence, The Three Rivers Nursing Home, Omagh (The Three Rivers). She was suffering from an exacerbation of Chronic Obstructive Pulmonary Disease (COPD)[1]. She was discharged back to The Three Rivers on 10 July 2014.

3. Staff from The Three Rivers were concerned about her condition and called a doctor on 11 July 2014. She was readmitted to hospital later that day. However, sadly, she passed away in hospital on 12 July 2014.

4. Her son complained to me that the standard of care and treatment his late mother received in hospital, '*fell well below the standard that she was entitled to.'* He also complained, '*the doctors responsible for her care failed in their duty to provide suitable treatment which would it have been administered sooner, would have prevented her untimely death, bearing in mind that she had been in hospital for almost a week before being discharged in the week leading up to her death and then readmitted the day before her death.'*

Issues of complaint

5. The issues of complaint that I accepted for investigation are:

   Issue 1: Whether the decision to discharge the patient from hospital back to her residential care home on 10 July 2014 was reasonable.

   Issue 2: Whether the administration of doxycycline to in hospital was appropriate, given that her son claims that his mother was allergic to that antibiotic.

[1] Chronic Obstructive Pulmonary Disease (COPD) is a lung disease characterised by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.

Issue 3: Whether it was appropriate to place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Order on the patient's medical file in July 2014, and whether the Trust's policy for the putting that DNACPR order in place was followed.

INVESTIGATION METHODOLOGY

6. As part of the investigation of the complaint, the Investigating Officer obtained all relevant documentation from the Trust, including the patient's medical records, together with the Trust's comments on the issues raised. The Investigating Officer also made enquiries of The Three Rivers.

7. An initial draft of this report was shared with the complainant, with the Trust and with the individuals named within it for comment on its factual accuracy and the reasonableness of my proposed findings and recommendations. The complainant and the Trust submitted comments to me in response, and I gave careful consideration to each of the matters they raised.

8. I have not included in this report all of the information obtained during the course of the investigation of the complaint. However, I am satisfied that everything that I consider to be important and relevant to the period 6 to 12 July 2014 has been taken into account in reaching my findings.

9. After further consideration of the issues raised, I obtained independent clinical advice from an independent professional adviser (IPA), a Consultant Physician and Nephrologist.

11. The IPA has provided me with 'advice'. How I have weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards

12. In order to investigate complaints, I must establish a clear understanding of the relevant standards, both of general application and those which are specific to the circumstances of the case.

13. The general standards are the Ombudsman's Principles[2]:

- The Principles of Good Administration
- The Principles for Remedy

14. The specific standards are those which applied at the time the events in question occurred, and which governed the exercise of the administrative and professional functions of the Trust and individuals whose actions are the subject of this complaint.

15. The clinical and operational standards relevant to this complaint are:

- Western Health and Social Care Trust – Secondary Care Antimicrobial Therapy Guidelines (December 2012)
- Western Health and Social Care Trust – First-line Empirical Antibiotic Therapy in Hospitalised Adults (December 2012)
- Western Health and Social Care Trust –Do Not Attempt Cardiopulmonary Resuscitation Adult Policy (DNACPR) (December 2012)
- National Institute for Health and Clinical Excellence – Drugs allergy: diagnosis and management of drug allergy in adults, children and young people (September 2014)
- General Medical Council - Good Medical Practice Guidelines (March 2013) (Standard 15 (a) and (b))
- Infectious Diseases Society of America - Guidelines for the Diagnosis and Treatment of Asymptomatic Bacteriuria in Adults (March 2005).

I refer to relevant extracts of these documents in the body of this report.

2 These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

INVESTIGATION

Issue 1: Whether the decision to discharge the patient from hospital back to her residential care home on 10 July 2014 was reasonable

16. The complainant stated that his late mother had been admitted to the hospital on numerous occasions during 2014, in the lead up to her sudden death. On each occasion, her admission was due mainly to breathing difficulties. She had urine and blood samples taken during each inpatient stay. The complainant said that although samples taken on the occasions of her admissions to hospital between 6 and 12 July 2014 showed that his mother had a urine infection, she died from urosepsis. He questioned why doctors in the hospital did not treat his mother at an earlier stage, and also why they left it so late to try to clear this infection as it was the day before she died that she was given intravenous antibiotics. He believes that the antibiotics should have been administered sooner, and that the failure to do so resulted in his mother's death.

17. He also stated that his mother was admitted to hospital on 6 July 2014, discharged on 10 July 2014, readmitted on the 11 July 2014 and passed away on 12 July 2014. He has questioned why, if his mother was so ill, the doctor in charge of her care discharged her from hospital on 10 July 2014, only for her to be readmitted on 11 July 2014. He also complained that his mother should not have been discharged from hospital on 10 July 2014, as she was in need of medical treatment for a urinary tract infection. He believes that as this was not the main reason for her admission to hospital, the infection was ignored until it was too late to treat effectively.

Evidence Considered

(i) The Trust's response to investigation enquiries

18. In response to investigation enquiries about the patient's discharge on 10 July 2014, the Trust stated that she was admitted on 6 July 2014 with exacerbation of COPD, in which her main complaint was shortness of breath and cough; she had no urinary symptoms at this time. The Trust also stated that there was an improvement in her condition with antibiotics (doxycycline), steroids and

nebulisers. Further, the Trust stated that as the patient had made a good recovery, she had been discharged on 10 July 2014. At the time of her discharge, she had been clinically well.

20. The Trust acknowledged that the patient was readmitted on the 11 July 2014 with worsening shortness of breath and a cough, and that there were no urinary symptoms at that time. It also said that the consultant in charge had advised that he had reviewed the patient later that day and that she had complained of generalised abdominal pain. The Trust further stated that the consultant had confirmed that she had been seen by a surgeon in relation to the pain around the epigastric area (upper central region of the abdomen), which was not related to the urinary area. The consultant had also advised that on 11 July 2014, the patient's CRP[3] was 0.5, which did not evidence any sepsis condition. The Trust stated the patient's condition had deteriorated on 12 July 2014, as evidenced by an abnormal Liver Function Test.

21. The Trust provided the following test results for 11 and 12 July 2014: *'…11 July 2014, it was noted a slight increase to AST of 49 and ALT 29; 12 July 2014, there was a marked increase in AST of 3642 and ALT of 3236 which indicated an acute ischemic liver injury with high Troponin[4] of 584'.* The consultant had advised that *"the level of Troponin may indicate Myocardial Infarction and [the patient's] inflammation marker increased to 20[5]...'.*

22. The consultant advised that on the basis of these results, he believed the most likely cause of death was ischemic gut and myocardial infarction, rather than sepsis.

23. The Consultant Gastroenterologist who examined the patient on 6 July 2014, shortly after her admission to hospital, also provided comments in response to the investigation enquiries that were made of the Trust. He advised that the patient had been admitted from her nursing home because of increased

[3] C-reactive protein (**CRP**) is a substance produced by the liver in response to inflammation. A high level of CRP in the blood is a marker of inflammation.
[4] A **Troponin** test measures the levels of Troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. The more damage to the heart, the greater the amount of Troponin there will be in the blood.
[5] CRP: Normal CRP levels are below 3.0 mg per litre of blood (mg/1).

shortness of breath. He advised that when she was examined on admission, she was found to have '*an elevated respiratory rate … and her chest x-ray showed clear lung fields with over inflated lungs consistent with COPD'.* He further advised that when she was reviewed at 06:30 on the morning of her admission, the reviewing doctor agreed that she was suffering from an exacerbation of COPD.

24. The Consultant Gastroenterologist also stated that the patients' *'urine dipstick revealed + protein, ++ nitrate and leucocytes were present'.* He explained, *'Urine dipsticks are chemical tests that look for leucocytes, blood, protein and nitrates. In the context of dysuria or suprapubic tenderness, then these results could be suggestive of a urinary tract infection. In the absence of symptoms, they are neither diagnostic nor definitive of a urinary tract infection. In the absence of symptoms, they could be consistent with Asymptomatic Bacteriuria.'* In relation to the patient, he advised, *'A mid-stream specimen of urine was sent off to ensure we identified any organisms, as well as cultures for antibiotic sensitivity. Urine samples were also sent to look for legionella and pneumococcal antigen as sources of chest infection'.*

25. He further advised that when he saw the patient at 9:00am on 6 July 2014, he was satisfied, on the basis of his examination of her, that she was suffering from an exacerbation of COPD. He went on to refer to having prescribed the antibiotic, doxycycline, being satisfied that she was not allergic to that antibiotic. He also commented that doxycycline was an appropriate choice for infective exacerbation of COPD. In addition, he stated that the patient '*did not have any of the* markers *of severe sepsis syndrome, she did not require broad spectrum intravenous antibiotics'*. He added that having reviewed her notes, he disagreed with the diagnosis of urosepsis[6]. He stated, '*I believe she died from a combination of ischaemic gut and myocardial infarction, and not urosepsis'*

26. Enquiries were also made of the Trust in relation to the content of the discharge letter that was prepared for the patient on her discharge from hospital to The Three Rivers on 10 July 2014. It had been noted that the discharge letter

[6] Urosepsis is the cause of death recorded on the death certificate

referred to her having a 'positive urinalysis' and to a secondary diagnosis of *'UTI'*.

27. The Specialist Trainee who wrote the response advised that did not see or assess the patient during her admission to hospital from 6 to 10 July 2014. He also advised that her clinical notes showed that his only involvement in her care had been the documenting of blood results on 9 July 2014 and the writing of her discharge letter on 10 July 2014. In relation to a reference on the discharge letter to *'Urinalysis positive'*, he stated, *'I have no specific recollection of writing [the] discharge letter dated 10th July 2014 but my normal practice would be to write the initial urinalysis results into a discharge letter – in this case this would be the positive* urinalysis *(2+ nitrates, 500 leucocytes and 1+ protein) documented in [the] clerk in notes on 6th July 2014'*.

28. In relation to the reference in the discharge letter to a secondary diagnosis of *'UTI'*, he advised, *''I have no specific recollection of writing [the] discharge letter dated 10th July 2014 and as I was not directly involved in her care, my normal practice would be to write the diagnosis recorded by the medical team involved in her care. I note that in the "Staff Grade/SHO/ Registrar Review [Post Results] section of the […] notes, she was diagnosed with a urinary tract infection and exacerbation of chronic obstructive pulmonary disease by [a Core Trainee Year 1 in Medicine doctor] and I most likely transcribed this into the discharge letter.*

(ii) Clinical Records

29. The Investigating Officer reviewed the patient's clinical records for her admission to hospital during 6 to 10 July 2014, and relevant extracts are set out below:

Medical Clerking Sheet 6 July 2014:

'Source of Referral: GP

Reason for request for Assessment: Worsening SOB

…

History of Presenting Complaint: GP referred this lady who was complaining of increased SOB with an associated cough.

…
Problem/Diagnosis: Infective exacerbation of COPD.
…
Investigation Results: Urine dipstix: Leucocytes: 5000 Protein: + Nitrates: 2+
…
Staff Grade/SHO/Registrar Review: … ΔUTI and exac COPD'

Nursing notes:

6 July 2014: '03.00 *Pt admitted via GP OOH* [Patient admitted via General Practitioner Out of Hours]…' '04.30 S/B [seen by] *JHO imp* [impression*] infective exacerbation of COPD…'* '10.40 *Patient well this am…Seen by consultant this am impression is exacerbation of COPD. Plan: 1) Nebs / Prednisolone. 2) Oral Doxycycline...*'

7 July 2014: '03.50 *C/O [*complaining of] *chest tightness - wheeze noted...*' *17.10… Patient's daughter came to ward – she told her "that she had been complaining of chest pain for 1 hour and that staff had not acted on this." Spoke […] with her family present – she then changed her story and told us she had told the nurse during the night...' '18.45 admitted to Ward 3' – sat out in chair. Pt comfortable…'*

8 July 2014: '*07.00 settled + slept well overnight. Bloods obtained Nebs given overnight as pt c/o* [increased] *SOB* [shortness of breath]*….' '15.50 S/B* [seen by] *(SHO) P* [plan] – *c/w* [continue with] *doxycycline, discharge tomorrow, repeat bloods tomorrow…'*

9 July 2014: *'11.05 Clinical obs stable…' '15.35 seen by Dr [ ]…Home tomorrow if bloods ok + clinically improved…' 'Pt does not appear to be unduly SOB @ present. Neb therapy continued. Reassurance given.'*

10 July 2014: '*00.30 Observations stable. Oral medications given…' 'Settled and slept well …' '10.00 Up to sit at bedside…S/B I…' '11.00 Contacted 3 Rivers Care Home re: dsc* [discharge]. *Aware patient for dsc home 2day. Contacted NoK* [next of kin] – *no answer. No messaging service available….' '12.30 NoK aware of dsc'. Ambulance control contacted – aware patient mrsa+ive. Changed time for nursing home aware patient mrsa+ive dsc to 3pm…' '12.40 SHO […]*

aware ↑INR 4.2 2day. Still dsc.patient home 2 day.' '17.00 Patient dsced (discharged) home.'

(iii) Independent Clinical Advice

30. Advice from the IPA was obtained in relation to the patient's discharge on 10 July 2014. The IPA advised, '*From the available records it seems not unreasonable that [she] was discharged on 10/7/14. Her vital sign observations were stable. Oxygen saturation was acceptable at 95% and there was no respiratory distress. She was clinically assessed and deemed fit for discharge. On this basis I would conclude that the discharge was reasonable.'*

31. In addition, the IPA was asked to consider her blood test results as the complainant said that these had showed high inflammatory markers and she should not, therefore, have been discharged from hospital. The IPA was specifically referred to the blood test results for a sample taken between 9 and 10 July 2014. The IPA was asked if those results indicated a high inflammatory marker and potentially required further consideration by medical professionals about discharging the patient. The IPA advised, *'the blood test taken on 10/7/14 shows a CRP (marker of inflammation) of 1mg/l, which is entirely normal. No evidence to support the allegation*.'

32. The IPA was also asked about blood test results for samples taken between 8 July and 11 July 2014, which the complainant claimed showed fluctuations in the INR [International Normalized Ratio][7] The IPA's advice was sought as to whether the test results gave cause for concern and would have been a factor in the decision whether or not to discharge her from hospital. The IPA advised, '*The fluctuations in INR seen on those dates are fairly unremarkable, and would not be an indication to delay discharge. This is the sort of fluctuation seen even in general practice, when patients are managed at home.'*

33. Similarly, in relation to the patient's reading for MRSA, the IPA advised, *'A*

[7] **INR** is a calculation made to standardise prothrombin. It is based on the ratio of the patient's prothrombin time and the normal mean prothrombin time. Prothrombin time is a test to learn how fast the blood clots in patients receiving oral anticoagulant medication.

positive MRSA on its own is no indication for prolonging hospital stay (unless there were signs of active infection, which there was not).' The IPA also advised, '*my opinion remains unchanged that it was appropriate for [the patient] to be discharged on 10 July 2014.'*

34. The IPA was further asked about urine test results and whether from the medical records, these results were known to the treating clinicians. The IPA advised, '*There is no documented record of the urine test results by the clinicians*[8]*. This does not prove either way whether they were aware of the result. It is highly likely that they were aware, given that UTI was one of the primary diagnoses.'* The IPA was also asked whether or not the patient had been suffering from a UTI on admission, discharge and/or readmission during the period from 6 to 11 July 2014. The IPA advised (on the basis of the information available to him at that time), '*It is not established as to whether or not she had a UTI – the urinalysis was suggestive but not diagnostic. A sample should have been sent to the laboratory, which would have confirmed an infection. As it was it cannot be stated for sure. In any case she was treated with doxycycline, which was likely to have covered both chest and urinary infections. The relatively low CRP would suggest that there was not serious infection. It would be worth asking the Trust to produce an MSU* [9] [midstream specimen of urine] *result for that admission. Whatever the case I am of the opinion that death was mainly related to her ischaemic heart and COPD, and probably ischaemic gut'.*

35. Following the IPA's comments about a UTI and a MSU test, further information about the patient's MSU tests was sought from the Trust. In response, the Consultant Gastroenterologist advised, *'I have examined [NIECR]. There are zero MSU test results in July 2014 to view on this system. I have examined the Western Trust Laboratory system. There are two MSU results to view in July 2014 on this system … The first sample was obtained on 06/07/14 from Ward 1… The report was entered on to the laboratory system on 07/07/14. …The*

[8] Following this comment by the IPA, urine test results were provided by the Trust (see paragraph 37).
[9] **"Midstream specimen of urine"** - in order to obtain a specimen that is free of contamination, the periurethral area is cleansed and the patient is requested to discard the initial flow of urine before collecting the specimen in a sterile containerwww.encyclopedia.com/caregiving / dictionaries

urine sample shows organisms were seen on microscopy. Culture revealed these organisms to be Coliform, >100,000 organisms per ml… Sensitivities reveal this organism was sensitive to Nitrofurantonin, Meropenen and resistant to Ciprofloxacin… The second sample was obtained on 08/07/14 from Ward 3. The report was entered on to the laboratory system 09/07/14. This urine sample shows zero organisms on microscopy. Culture revealed these organisms to be Escherichia coli, > 100.000 organism per ml. Sensitivities reveal this organism was sensitive to Nitrofurantonin, Gentamycin and Meropenen …'

36. He went on to comment, *'These results indicate that bacteria were grown from samples of [the patient's] urine. The organism isolated was initially described as "Coliforms" but the second urine sample allowed the laboratory to classify the bacteria as Escherichia coli. These bacteria were resistant to some bacteria but sensitive to other antibiotics…The first sample had organisms visible in urine under a microscope. The second sample had zero organisms visible in urine under a microscope. One possible interpretation is to suggest that the tablet antibiotics [the patient] was given in Ward 1 for her COPD may also have affected her urine and reduced the number of bacteria present'.* The Consultant provided screenshots from the Trust's laboratory system, which documented the MSU test results he had described.

37. He also provided further clarification of comments about 'asymptomatic bacteriuria' that he had submitted in response to earlier investigation enquiries. He advised, *'Presence of bacteria on a human or in urine does not always indicate that these bacteria are causing harm [or that such bacteria] are responsible for the illness that has caused a person to enter hospital. [The patient] did not have dysuria nor suprapubic tenderness. These are common manifestations of a urine infection. I believe the urine samples represent asymptomatic bacteriuria, whereby humans have bacteria in their urine but it does not cause an infective, septic illness.*

38. He further advised, *'I believe [she] had asymptomatic bacteriuria on her admission 6th July 2014. She did not describe any of the typical symptoms that*

go with a urine tract infection. She described symptoms that were in keeping with an exacerbation of known diagnosis of [COPD]. She received oral doxycycline to treat her exacerbation of COPD. Doxycycline also has activity against coliforms and could have helped any urine infection if she had one. On the day of her discharge 10th July 2014, her observations were not in keeping with someone suffering with urosepsis. On the day of her discharge 10th July 2014, her CRP of 1.0 was not in keeping with someone suffering with urosepsis. On her readmission day 11th July 2014, her symptoms were again primarily respiratory in nature. Her symptoms evolved over the course of the next 24 hours in hospital to involve abdominal pain and chest pain. Her Tropinin was elevated in keeping with someone suffering acute myocardial damage. In other words, she had suffered a heart attack on that readmission day 11th July 2014. … [her] CRP on the 11th July 2014 was only 0.5 and the day of her death was only 20. This would be most unusual for severe sepsis, but would be consistent if the primary problem were a myocardial infarction or ischaemia.

39. The Consultant concluded his comments, '…*in my opinion [the patient] was admitted initially on the 6th July 2014 with an exacerbation of COPD with asymptomatic bacteriuria. [She] was discharged on the 10th July 2014 with a normal CRP and healthy observations. This is not a picture in keeping with ongoing urosepsis. [She] was readmitted on the 11th July 2014 with symptoms that initially looked respiratory in nature but her blood tests are definitive of a heart attack. She progressed to abdominal pain, a metabolic acidosis with an elevated lactate and this constellation is suggestive of ischaemic gut. She did not describe symptoms in keeping with urine infection. In my opinion, she did not die because of a urine infection that been untreated for months.'*

40. The patient's MSU test results were shared with the IPA who advised, '*The 2 samples taken on 6th and 8th July 2014 both showed a positive urine culture, for infection by the organism E.coli,*[10] *with counts >100,000/ml. This indicates potential infection by the organism, which may or may not be symptomatic.*

[10] Escherichia coli or **E.coli** is a bacterium that can be found in human intestines. Scientists have studied E.coli vey extensively, and know more about how E. coli cells work than any other organism. E.coli is not always harmful.

Asymptomatic bacteriuria[11] in women is defined by the Infectious Diseases Society of America (IDSA) guidelines[12] as two consecutive clean-catch voided urine specimens with isolation of the same organism in quantitative counts of ≥10^5 cfu/mL. Therefore the positive urine culture should be interpreted in light of the clinical presentation. Given that [the patient] had obvious features suggestive of an exacerbation of COPD, it would be reasonable to consider this urine finding to be designated as "asymptomatic bacteriuria".'

41. The IPA was asked for an opinion, in light of the microscopy results, on whether she had been suffering from a UTI on admission and/or discharge from SWAH during the period 6 to 11 July 2014 The IPA advised, '*I am not convinced (though cannot be sure) that [she] had a true UTI during this admission. I would qualify that by saying that doxycycline may well have treated UTI in any case. The relatively low CRP of 7[13] also reassures me that there was no cause to suspect a serious infection.'*

42. The IPA was asked what would be the recommended course of treatment for the patient in light of the microscopy results. The IPA advised, '*If [she] had presented with features suspicious of UTI, then this result would have warranted a course of antibiotics, to which the organism was sensitive on the culture. However, given her chest symptoms and signs she would have warranted an appropriate antibiotic – in this case doxycycline was used, which was a reasonable choice. As it happens that drug is also quite useful for treating E.coli UTI.'*

43. The complainant, in commenting on a draft of this report, queried why the IPA's advice on the reasonableness of his mother's discharge from hospital on 10 July 2014 had not taken account of the results of other urine tests that had been conducted. However, further review of her clinical notes did not disclose any record of other urine samples having been tested prior to her discharge on

[11] **Asymptomatic bacteriuria** is a condition in which larger than normal numbers of bacteria are present in the urine but symptoms do not result.
[12] [Infectious Diseases Society of America. Guidelines for the diagnosis and treatment of asymptomatic bacteriuria in adults. Nicolle LE, Bradley S, Colgan R, Rice JC, Schaeffer A, Hooton TM, Infectious Diseases if America, American Society of Nephrology, American Geriatric Society, Clin Infect Dis. 2005;40(5):643]
[13] The patient'CRP level on 6 July 2014, the day of her first July 2014 admission to SWAH

10 July 2014. This is in keeping with the Consultant's response to investigation enquiries that the two results recorded in the Trust's Laboratory system are those relating to the MSU samples taken on 6 and 8 July 201. While I have no reason to doubt the complainant's or his family's recollection of other urine samples having been taken, the IPA's advice can be based only on the clinical records available to him.

44. The IPA was informed by the Investigating Officer that urosepsis was recorded as the cause of the patient's death. The IPA was also informed that the Consultant had stated that he believed the cause of the patient's death to have been a combination of ischaemic gut and myocardial infarction. The IPA's view was that, '*[She] died due to a combination of medical causes, namely systemic sepsis, myocardial infarction and probable ischaemic bowel, superimposed on COPD. It is arguable as to the correct ranking of the conditions, but in any case, academic'.* At a later stage of the investigation, the IPA advised, '*I find no reason to alter my earlier conclusions that [the patient] died due to a combination of her co-morbidities. I could find no evidence of sub-standard management, or evidence of untreated UTI leading to her demise.'*

Analysis and Findings

45. There is evidence that there was an improvement in the patient's medical condition with antibiotics (doxycycline), steroids and nebulisers and that, as she made a good recovery, she was discharged on 10 July 2014. I accept the IPA advice that she '*was clinically assessed and deemed fit for discharge.*' The samples of urine that were taken showed that she was asymptomatic, producing or showing no symptoms of a urinary infection. I note that the Consultant stated, in response to investigation enquiries that, '*[The patient] did not have any of the markers of severe sepsis syndrome, she did not require broad spectrum intravenous antibiotics.*' I note also that it is recorded in her medical notes that on discharge on 10 July 2014, her condition, '*was improved and* [she was] *feeling fine*.' Further, the IPA advised that, '*the blood test taken on 10 July 2014 shows a CRP (marker of infection) of 1mg/l, which is entirely normal',* and that, '*it was appropriate for [her] to be discharged from hospital on 10 July 2014.'* I accept the IPA's advice that it was appropriate to discharge the

patient from hospital on 10 July 2014.

46. I note the complainant's concerns about the UTI and the provision of antibiotics as inadequate treatment during this admission, and that this was a cause of death. However, I also note the IPA's advice that, *'It is not established as to whether [she] had a UTI – the urinalysis was suggestive but not diagnostic. As it was it cannot be stated for sure. In any case she was treated with doxycycline, which was likely to have covered both chest and urinary infections. The relatively low CRP would suggest that there was not a serious infection.'* I further note the results from the MSU tests and the IPA advice that, '*the positive urine culture should be interpreted in light of the clinical presentation. Given that [the patient] had obvious features suggestive of an exacerbation of COPD, it would be reasonable to consider this urine finding to be designated as "asymptomatic bacteriuria".* I accept that any UTI may well have been treated by doxycycline. I further accept the IPA's advice that, '*I find no reason to alter my earlier conclusions that [the patient] died due to a combination of her co-morbidities. I could find no evidence of sub-standard management, or evidence of untreated UTI leading to her demise.'*

47. The General Medical Council (GMC) Good Medical Practice Guidelines 2013, '*describes what is expected of all doctors registered with the [GMC]*'. Standard 15(a) states that good clinical care must include, '*adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patients view, and where necessary examining the patient'.* Standard 15(b) states that doctors must, '*promptly provide or arrange suitable advice, investigations or treatment where necessary*'. I am satisfied the patient's care and treatment was reasonable and in keeping with these standards. **I do not, therefore, uphold this issue of complaint.**

Issue 2: **Whether the administration of doxycycline to the patient in hospital was appropriate, given that the complainant claims that his mother was allergic to that antibiotic**

48. The patient's son complained that on admission to hospital on 6 July 2014, the antibiotic, doxycycline was prescribed and administered to his mother. He claims his mother was allergic to that antibiotic and that although this allergy was highlighted in her medical notes, it was ignored by clinicians. He questions why the doctor in charge of his mother's care allowed her to receive this antibiotic. He asserts that his mother should never have been prescribed or administered doxycycline.

Evidence Considered

(i) The Trust's response to investigation enquiries

49. In response to investigation enquiries about this issue of complaint, the Trust provided responses from the Consultant and a Ward Sister. The Consultant's response referred to information he had obtained from NIECR[14] and EVOLVE[15] document management systems. He stated, ''*The patient] had been in* [hospital] *in December 2013 with a non-ST elevation myocardial infarction. There is no mention of doxycycline allergy on any of the preceding hospital letters. The discharge letter records drug allergies as beta-blocker, phenoxymethylpenicillin. [She] had been in hospital in January 2014. The discharge letter records drug allergies as beta-blocker and phenoxymethylpenicillin. [She] had been in hospital in January 2014. The discharge letter records drug allergies as penicillin. [She] had been in hospital in* [Altnagelvin Area Hospital] *in January 2014. The discharge letter records drug allergies as penicillin and bisoprolol. [She] had been in hospital in SWAH on 14th March 2014. The discharge letter records drug allergies as penicillin, doxycycline and erythromycin. ***This is the first recording of Doxycycline ever in drug allergy section***'.* In support of his comments, he provided copies of the discharge letters to which he had referred. These records substantiated his

[14] The Northern Ireland Electronic Care Record **(NIECR)** is a computer system that health and social care staff can use to get information about a patient's medical history.

[15] **EVOLVE** provides rapid, repeatable care pathway automation enabling healthcare networks to transform at a pace not possible before. Using this computer system heath staff are enabled to deliver high-quality, patient-centric efficient care through better visibility of patient information and management of care pathways

comments about the patient's recorded allergies.

50. He went on to comment that, '*My involvement came in an admission 6th July 2014*. [The patient] *was short of breath. Her chest x-ray did not show pneumonia. She had recently received antibiotics from her GP. The Western Trust Antibiotic guidelines utilise Doxycycline for such an event.'* He also stated, '*I looked at NIECR plus checked through the notes to see where this doxycycline allergy came from. NIECR does not have doxycycline recorded as an allergy. The GP referral letter does not have doxycycline recorded as an allergy. It records penicillin and bisoprolol only. I spoke to the patient to clarify history. Doxycycline allergy first appeared from an admission in March 2014 when she was prescribed Doxycycline for COPD. A ward round on 16 March 2014 records, "some nausea with doxycycline". The junior doctor has then written this as an allergy on the drug chart. With regret, this is inaccurate and is not an allergy. From this episode onwards, she has erroneously been called doxycycline-allergic, and this has sadly led to distress for her family.'* In support of his comments, he provided copies of screen shots from NIECR, the GP referral letter, the notes of the ward round in hospital on 16 March 2014 and the drug chart completed during her admission on that occasion, to which he had referred. These records substantiated his comments about allergies recorded on NIECR and the GP referral letter, and his account of the recording of her reaction to doxycycline on 16 March 2014.

51. The Consultant also pointed out in his response to investigation enquiries that the patient '*[had] received Doxycycline on multiple occasions within the hospital, community and nursing home settings'*. He highlighted a number of her medical records which noted Doxycycline use, as follows:

- Erne Hospital discharge letter of 17 January 2010;
- Erne Hospital discharge letter of 22 January 2010;
- Erne Hospital drug chart, January 2010;
- Erne Hospital consultant ward round notes of 5 February 2012;
- Springlawn Nursing Home drug chart, February 2012;
- Altnagelvin Area Hospital discharge letter of 12 February 2012;
- SWAH drug chart, August 2013;

- SWAH drug chart, September 2013; and
- Three Rivers Nursing Home drug chart, December 2013

52. He provided copies of the medical records to which he had referred, which substantiated his assertion that doxycycline had been prescribed and administered to her on a number of previous occasions.

53. The Ward Sister, in her response to investigation enquiries, stated, '*[The patient] was admitted to Ward 1 (Assessment Unit) at 2am on Sunday 6 July 2014. Allergy history recorded on the GP referral letter (and [Northern Ireland Ambulance Service] report assessment form) referred to allergies to penicillin & bisoprolol only. There was no reference to an allergy to Doxycycline. On being clerked in by medical staff, these two allergies were recorded on the Medicine Prescription Chart in the Allergy/Sensitivity section.'*

54. She added, *'An entry has been added to this section by the 'Medicines Reconciliation Pharmacist', the day following admission 7th July, re Doxycycline and clarithromycin causing vomiting following a previous discharge in March 2014. However, vomiting is not considered an allergy, but rather it is a known side effect of doxycycline, as with many antibiotics. [The patient] tolerated the doxycycline over 5 days with no ill effects, which was also recorded in the medical notes on 8th July. This supports the fact that [she] did not have an allergy to this medicine. Given that [she] has an allergy to penicillin, the scope of suitable antibiotics to prescribe is significantly reduced and doxycycline is the preferred drug of choice of treatment of a chest infection. [She] was transferred to Ward 3 at 18.45 on 7th July, having already received and tolerated three doses of doxycycline.'*

(ii) Clinical Records

55. The Investigating Officer reviewed the patient's medical records and established that, prior to her admission to hospital in July 2014, Doxycycline was prescribed and administered on the following occasions:

Date	**Source of Information**
15 January 2014	SWAH record

December 2013	Three Rivers record
September 2013	SWAH record
August 2013	SWAH record
12 February 2012	Altnagelvin Area Hospital record
5 February 2012	Erne Hospital record
10 November 2011	GP record
16 May 2011	GP record
18 January 2010	Erne Hospital record
23 August 2006	GP record

56. The medical notes relating to a ward round on 16 March 2014, during her admission to hospital on that occasion, record that she had *'some nausea with doxycycline'*. The nursing notes from that admission do not record any nausea or vomiting issues. However, the discharge letter of 16 March 2014 recorded doxycycline as an allergy, with *'Vomiting'* having being recorded as *'Type of Reaction'*. From that date, the drug chart recorded an allergy to doxycycline.

57. The patient's hospital records indicate that she was prescribed doxycycline on admission to SWAH on 6 July 2014, with the first dose given at 18.00 hours on that date. A further six doses of doxycycline were administered up to the time of her discharge on 10 July 2014. Her hospital records and nursing notes do not record any incidences of vomiting during that admission period. Following a review at 9:25am on 7 July 2014, the doctor recorded in the medical notes, '….. *During review today – chest symptoms not too bad…' 'Main complaint from patient is abdo discomfort…' 'Slight nausea. No vomiting. Managed to eat porridge for breakfast…'* The nursing notes for 8 July 2014 record, '… *Tolerated oral diet and meds independently...'.* On 9 July 2014, nursing notes recorded, *'…medications tolerated as prescribed...'.*

(iii) Independent Clinical advice

58. The IPA advised, '*On 6 July 2014, an entry by an FY1 doctor under Allergies/ Medical sensitivities, documented doxycycline as one of a number of drugs, with the reaction being 'vomiting'. Nevertheless doxycycline was commenced on the Consultant ward round the same day. In view of the fact that [the*

patient] had had a number of previous documented courses of doxycycline, I am of the opinion that she was not allergic to that drug. I found no evidence in the records that support the contention that she was allergic.'

59. The Investigating Officer asked the IPA what adverse effect the patient would have sustained, if allergic to doxycycline, and whether the prescribing and administering of it have played any part in her eventual death? The IPA advised, '*If she was really allergic to doxycycline, she would have developed a number of symptoms which are likely to have included vomiting, diarrhoea, bloating, skin rash, and rarely circulatory and respiratory distress. There was no evidence of any of this in this case'.*

Analysis and Findings

60. I note the complainant's concerns about the administration of the antibiotic, doxycycline, to his mother. I accept the advice of the IPA who found no evidence in the patient's medical records to '*support the contention that she was allergic'* to doxycycline. I also accept the IPA advice that *'If she was really allergic to doxycycline, she would have developed a number of symptoms which are likely to have included vomiting, diarrhoea, bloating, skin rash, and rarely circulatory and respiratory distress. There was no evidence of any of this in this case'.*

61. I also note that her medical and nursing notes do not record any of the symptoms associated with an allergy during her admission to hospital during the period 6 to 12 July 2014. I note too that the Consultant has concluded that the record made by the junior doctor on 16 March 2014, during a previous admission to hospital, is inaccurate, in that the patient was not allergic to doxycycline, and it was appropriate to administer that antibiotic to her.

62. Having considered the available evidence, I am satisfied that the patient was not allergic to doxycycline and that consequently, it was appropriate that that antibiotic be prescribed and administered to her. **As such, I do not uphold this element of the complaint.**

63. That said, I have no doubt that the erroneous recording of an allergy to doxycycline caused confusion and distress to the patient's family on viewing her medical records in the aftermath of her death, and I am pleased to note that the Consultant, in his response to investigation enquiries, acknowledged that this error *'sadly led to distress for [the patient's] family'.* However, the actions of the Trust in relation to the erroneous recording of a doxycycline allergy during the patient's admission to hospital in March 2014 does not fall within the scope of the issues of the complaint that I accepted for investigation; those issues of complaint concern the care and treatment the patient received during her subsequent hospital admissions in July 2014. Although I have not therefore made any finding in this report with regard to the erroneous record, it would be my expectation that Trust shares learning, as appropriate, from this disclosure of the erroneous recording of a drug allergy.

Issue 3: Whether it was appropriate to place a DNACPR order on the patient's medical file in July 2014, and whether the Trust's policy for putting that DNACPR order in place was followed in this case

64. The complainant said that when he obtained a copy of his late mother's medical records from the Trust, he discovered that a DNACPR order had been placed in them in July 2014. He complained that this document had not been signed by his mother, who had her full faculties before she passed away. Furthermore, the DNACPR order had not been discussed with, or signed by, any member of her family. He believes that this document, which he claims was signed by two doctors, should not have been placed in his mother's medical records. He also complained that the doctors had no right to make such a decision without discussing the implications with his mother and members of her family.

65. My investigation of this issue of complaint has examined two separate aspects of the making of the DNACPR order:
a) Whether it was appropriate to place a DNACPR order on the patient's medical file in July 2014; and
b) Whether the Trust's policy for putting the order in place was followed in this case.

a) Whether it was appropriate to place a DNACPR order on the patient's medical file in July 2014

Evidence Considered

(i) Relevant Policies, Standards and Guidelines

66. The following documents were reviewed:

(i) Western Health and Social Care Trust – Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy, December 2012 (referred to in this report as 'the DNACPR Adult Policy'); and.

(ii) Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2007) (referred to in this report as 'the Joint Statement').

67. The DNACPR Adult Policy is based on the guidance set out in the Joint Statement. It also reflects the requirements of the Human Rights Act (1998) that are relevant to the putting in place of a DNACPR order. Relevant extracts of the DNACPR Adult Policy and the Joint Statement are set out below.

68. Section 5.0 of the DNACPR Adult Policy, *'Roles and Responsibilities'*, states, *'The overall clinical responsibility for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order lies with the most senior clinician in charge of the patient's care as defined by local policy. This may be the Consultant (Acute Hospitals), General Practitioner (Community based hospitals, Care Homes or the patient's home) or other Health Care Professional in charge of the patient's care in other settings. In the Acute hospital setting the order should be made by the Consultant's deputy in his/her absence, i.e. Registrar or Staff Grade or, in specialties without a Registrar, by the most senior SHO but, in this case, only after discussion with a Consultant in charge of the patient's care. As part of the admission process the Framework for Decisions Relating to CPR (Appendix II) must be reviewed and decision made documented in the patient's medical notes/records'.'*

69. Section 6.1 of the DNACPR Adult Policy states, *'It is appropriate to consider a*

DNACPR order in the following circumstances:

- *Where the patient's condition indicates that effective CPR is unlikely to be successful.*
- *Where CPR is not in accordance with the recorded, sustained wishes of the adult patient who is deemed mentally competent. (Adults are assumed to have capacity if able to comprehend and retain information).*
- *Where CPR is not in the patient's best interests i.e. where successful CPR is likely to be followed by length and quality of life that would not be acceptable to the patient (provided they have the mental capacity). The patient and their relatives should, if possible, be consulted and informed about the benefits or risks of CPR.*

  ….
- *For situations outside the above conditions e.g. the incapacitated adult, special attention should be paid to* [Section] *5.0 Roles and Responsibilities…..'*

70. Section 6.3 of the DNACPR Adult Policy states, '*Discussion of CPR with all patients would be inappropriate but, where competent patients are at foreseeable risk of cardiopulmonary arrest, sensitive exploration of the patient's wishes should be undertaken. Although it is the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of illness or for whom the burdens of the treatment clearly outweigh the potential benefits. In these circumstances the guidance in 5.0 will apply and refer to the Framework for decisions in CPR (Appendix II). If such a discussion occurs it should be documented in the patient's medical notes/records and a patient leaflet, "Decisions about cardiopulmonary resuscitation" is available if the patient or relatives/next of kin requires further information (Appendix III)'.*

71. At section 6.7, the DNACPR Adult Policy continues,*'… Documentation should contain details of the decision and how it was made, who was involved, the date and reason and the name of the responsible person'.*

72. Paragraph 6 of the Joint Statement, *'Clinical decisions not to attempt CPR',*

states*, 'In some cases, the decision not to attempt CPR is a straight forward clinical decision. If the clinical team believes that CPR will not re-start the heart and maintain breathing, it should not be offered or attempted. CPR (which can cause harm in some situations) should not be attempted if it will not be successful'.*

(ii) The Trust's response to investigation enquiries

73. In its response to investigation enquiries, the Trust provided comments about this issue of complaint. The Trust advised, '*The overall clinical responsibility for a DNACPR order lies with the most senior clinician in charge of the patient's care as defined by local policy. This may be the Consultant (Acute Hospitals), General Practitioner (Community bases hospitals, Care Homes or the patient's home) or other Health Care Professional in charge of the patient's care in other settings. The opinion of other members of the Multidisciplinary Team, the patient if appropriate, and with due regard for patient confidentiality, the patient's relatives or close friends in the absence of family may all be valuable in informing the decision of the Consultant / General Practitioner / Health Care Professional in charge of the patient's care. It is appropriate to consider a DNACPR order in the following circumstance: Where the patient's condition indicates that effective CPR is unlikely to be successful'.*

74. The Trust also stated that *'Within the Western Health and Social Care Trust's "Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy" published in December 2012, CPR is undertaken in an attempt to restore breathing (sometimes with support) and spontaneous circulation in a patient in cardiac and/or respiratory arrest. CPR is a relatively invasive medical therapy. The survival rate to hospital discharge after cardiorespiratory arrest and CPR is relatively low, about 15-20% where cardiac arrest occurs in hospital. In some cases it is clear that the patient is in the terminal phase of their illness and that attempted CPR would not be successful and would therefore be inappropriate because they would be unlikely to survive. There is also a risk that the patient will be left with very severe brain damage and resulting disability.'*

75. The Trust further stated, '*[The patient] had multiple comorbidities including*

severe Chronic Obstructive Pulmonary Disorder (COPD) and congestive heart failure and multiple frequent admissions to hospital with exacerbation of her COPD. This made the CPR unlikely to be successful which was why the decision for the DNACPR was taken by the clinician.'

76. The Trust went on to comment that *'The patient was continued on full active treatment and it is noted in the medical notes that she required daily bloods and daily review by the Medical Team and Surgical Team. […] there is a difference between DNACPR and active maximal treatment which [the patient] had been receiving until she deteriorated on 12 July 2014 and the DNACPR was then palliative treatment. This was then discussed with the family who agreed to this intervention*.'

77 The Trust's response to investigation enquiries about this issue of complaint also included a written statement from a doctor who was involved with the patient's care and treatment between 6 and 10 July 2014, and on her re-admission to hospital on 11 July 2014. In her statement, she advised that, in July 2014, she was coming to the end of her first year in Core Medical Training at the hospital. She commented, *'[The patient] was readmitted on the morning of 11th July 2014. She had been admitted directly to Ward 3 from the Emergency Department. I reviewed her around 10am. Only a limited history was obtained from [the patient] due to dyspnoea. From my initial assessment which was based on her examination findings and investigations (chest and abdominal X-rays, bloods, arterial blood gas, ECG, urinalysis) I believed that she had sepsis which was likely secondary to a urinary tract infection and possibly an exacerbation of COPD. … I made the decision to put a DNA CPR order in place on 11th July 2014 at 10:10am. [She] was extremely unwell. In view of her underlying co-morbidities including severe COPD, I believed CPR would be extremely unlikely to be successful. In the unlikely case that it was successful, there would have been a high risk of injury such as rib fractures, hypoxic brain injury and heart failure. I discussed the DNA CPR order with the [Consultant Physician] over the telephone while discussing the case in general. [He] agreed that the DNA CPR order was appropriate. He later countersigned the DNA CPR after reviewing [the patient], at 12:55.'*

(iv) Independent Clinical advice

78. The IPA provided advice in relation to the DNACPR order that was put in place on 11 July 2014. The IPA stated, *'I would say that it was appropriate – there was a very significant deterioration in* [her] *condition, being complicated by features of systemic sepsis (suspected urosepsis), with superadded myocardial infarction and probable ischaemic bowel. Under these circumstances the likelihood of recovery from a cardiac or respiratory arrest would have been almost zero, thereby justifying the DNACPR decision'*. The IPA also confirmed that he was satisfied that the Trust's DNRCPR Adult Policy had been followed in this case.

Analysis and Findings

79. The complainant said that the doctors providing care and treatment to his mother had no right to put a DNACPR order in place without discussing the implications with her and members of her family.

80. I note that Section 5.0 of the Trust's DNACPR Adult Policy refers to Roles and Responsibilities. This makes it clear that '*The overall clinical responsibility for a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order lies with the most senior clinician in charge of the patient's care as defined by local policy*.' I note that the DNACPR Communication Sheet that is held in the patient's medical records indicates that the doctor completed the DNACPR order at 10:10am on 11 July 2014 and that the Consultant countersigned the order at 12.55pm on the same date. I am satisfied that her medical records indicate that, in accordance with the Trust's policy, responsibility for the decision taken on 11 July 2014 to put a DNACPR order in place, rested with the most senior clinician in charge with her case.

81. I note that in response to investigation enquiries, the Trust stated that the Consultant had advised, '*it is appropriate to consider a DNACPR order in the following circumstance: Where the patient's condition indicates that effective CPR is unlikely to be successful.'* I note too that the Consultant had commented that, *'[The patient] had multiple comorbidities including severe*

Chronic Obstructive Pulmonary Disorder (COPD) and congestive heart failure and multiple frequent admissions to hospital with exacerbation of her COPD. This made the CPR unlikely to be successful which was why the decision for the DNACPR was taken by the clinician'. I also note the doctor's comments that the patient *'was extremely unwell. In view of her underlying co-morbidities including severe COPD, I believed CPR would be extremely unlikely to be successful'.*

82. I further note, and accept, the advice of the IPA, who stated that *'I would say that* [the DNACPR order put in place on 11 July 2014] *was appropriate – there was a very significant deterioration in* [her] *condition, being complicated by features of systemic sepsis (suspected urosepsis), with superadded myocardial infarction and probable ischaemic bowel. Under these circumstances the likelihood of recovery from a cardiac or respiratory arrest would have been almost zero, thereby justifying the DNACPR decision'.* I also note that the IPA confirmed that he was satisfied that the DNACPR Adult Policy had been followed correctly in this case.

83. I note too that paragraph 6 of the Joint Statement states*, 'In some cases, the decision not to attempt CPR is a straight forward clinical decision. If the clinical team believes that CPR will not re-start the heart and maintain breathing, it should not be offered or attempted. CPR (which can cause harm in some situations) should not be attempted if it will not be successful.'* Having examined the patient's medical records, I find that there is sufficient documentary evidence to demonstrate that her medical condition on her readmission to hospital on the morning of 11 July 2014 resulted in a clinical decision that CPR should not be attempted should she require resuscitation. In light of her deteriorating medical condition and multiple co-morbidities, I support the decision to put a DNACPR order in place on 11 July 2014. **Consequently, I do not uphold this element of the complaint.**

b) Whether the Trust's policy for putting the DNACPR order in place was followed in this case?

Evidence Considered

(i) Relevant Policies, Standards and Guidelines

84. The following documents were reviewed:

(i) Western Health and Social Care Trust – Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy, December 2012 (referred to in this report as 'the DNACPR Adult Policy');

(ii) Decisions Relating to Cardiopulmonary Resuscitation: a joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2007) (referred to in this report as 'the Joint Statement'); and

(iii) Decisions Relating to Cardiopulmonary Resuscitation: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') 3rd edition (1st revision) 2016 (referred to in this report as 'the 2016 Guidance').

85. The DNACPR Adult Policy states in section 5, *'If a DNACPR decision is recommended this should be clearly documented in the patient's medical notes/ records and nursing notes. In these instances the DNACPR Communication Sheet (Appendix I) should also be completed and then be placed inside the front cover of the patient's medical notes/records and nursing notes.… The opinion of other members of the multidisciplinary team, the patient if appropriate, and, with due regard to patient confidentiality, the patient's relatives or close friends in absence of family, may be valuable in informing the decision of the* [clinician] *in charge of the patient's care. If there is no discussion with the patient or their next of kin, the reasons for this should be clearly documented.'*

86. In section 6.7, the DNACPR Adult Policy states: '*The DNACPR order and the reasons for it must be documented, signed and dated in the patient's medical notes/records by the most senior member of the medical team and then*

documented in the DNACPR Communication Sheet (Appendix I). If appropriate and in line with the patient's wishes, this decision should be discussed with the patient's family or next of kin. Section 6.7 further states: *'Documentation should include the expression, "Do Not Attempt Cardiopulmonary Resuscitation" and be documented in the patient's notes as well as completing the DNACPR Communication Sheet. The DNACPR Communication Sheet should be placed inside the front cover of the patient's medical notes/records. Documentation should contain details of the decision and how it was made, who was involved, the date and reason and the name of the responsible person'.*

87. Paragraph 6.1 of the Joint Statement states, *'When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR'.* The guidance further states, *'Careful consideration should be given as to whether or not to inform the patient of the decision. Although patients should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases the patient should be informed but for some patients, for example those who know that they are approaching the end of their life, information about intervention that would not be clinically successful will be unnecessarily burdensome and of little or no value.'*

(ii) Clinical Records

88. The patient's medical records were reviewed. Relevant extracts of her hospital notes for 11 and 12 July 2014 are set out below:

11 July 2014: *'09.45: [Patient] readmitted to Ward 3 direct from A+E following her arrival there @ 08.30am this morning…. Ambulance called to PNH 3 Rivers c/o SOB, chest tightening and wheeze +++…. 10.30: … S/B* [seen by] *Dr […]* … *DNAR* [Do Not Attempt Resuscitation] STATUS …. *Plan: (1). d/w* [discuss with]

[Consultant]. (2).? Ischaemic colitis – d/w surgical team. Await surgical review.
13.00: Family contacted. S/B [Consultant] … Main problem abdo pain – ischaemic colon /?urosepsis.

23.05: Observations stable. Oral medication taken. Some refused. Oral fluids taken … At 22.34 S/B JHO {…}, ∆ ischaemia 2° to sepsis, being treated for urosepsis and metabolic / respiratory acidosis… Plan: (1)…(2)…(3)…(4) Discussed with family (5)…(6)…(7)… Family in attendance.'

12 July 2014: *'01.15: Complaining of shortness of breath …*
06.55: … Alert, condition is weak…. Slept for short periods. Family in attendance….
10.10: … Too drowsy to take medication. Refused nebuliser therapy. Family in attendance….
14.35: Seen by Dr […] … D/W [discussed with] Family. DNA CPR – not for ↑ level of care…
15.10: MRSA restarted – previous pathway in N/Home.
17.20 Patient passed away peaceful @17.00. Family in attendance...'

89. The DNACPR Communication Sheet held in the patient's medical records, which was completed in respect of the DNACPR order put in place on 11 July 2014, records at section 3 that the *'Basis on which* [the] *DNACPR decision* [was] *reached'* was: *'Comorbidities, Frailty'.* Section 5 of the DNACPR Communication Sheet, asks, *'Has this decision been communicated with either the patient or their next of kin. If so please list. If no communication has occurred, please state the reason(s)'.* This section was left blank. The DNACPR Communication Sheet includes an instruction to clinical staff that *'This DNACPR is invalid if sections 1 – 6 are not completed'.*

(iii) The Trust's response to investigation enquiries

90. As I have recorded above, the Trust, in responding to investigation enquiries about the DNACPR order, provided a written statement from the doctor. In her

statement, she advised that she had been involved with the patient's care and treatment between 6 and 10 July 2014, and on her re-admittance to hospital on 11 July 2014. She also advised that she had reviewed the patient around 10.00 am on 11 July 2014, and had made the decision to put a DNACPR order in place at 10.10 am.

91. She stated, '*As [the patient] was very short of breath and anxious, it was difficult to obtain a detailed history from her. Due to this and the risk of increasing distress, I thought it would be inappropriate to discuss the DNACPR decision with [her], particularly as family members were not with her at that stage*. *It would be my normal practice to document this on the DNA CPR Communication Sheet and state that the plan is to discuss with family members when present. However, Section 5, was not completed by me or the authorising consultant.'*

92. She further stated, *'Although I have not documented it in my notes, I recall having various discussions with family members regarding [the patient's] condition, treatment and prognosis. Discussing DNA CPR orders during conversations regarding my prognosis is part of my usual practice'.*

93. In its response to investigation enquiries as to why the DNRCPR Communication Sheet was not fully completed, the Trust stated, '*…at the time of her last admission, on review, [the patient] was short of breath and distressed. At this time, it was difficult to obtain a detailed history from [her] as documented by the admitting doctor. It was believed to be not appropriate to discuss the issue of DNACPR with [her] as it can make patients more distressed. As there was no family member present […] to discuss the DNACPR with her, this discussion did not take place, however the relevant documentation was completed'.*

94. Enquiries were also made of the Trust as to why it had informed the complainant in its response of 25 May 2016 to his complaint of 1 March 2016 that '[the DNACPR] *decision is primarily made by the clinician looking after the patient',* and that a doctor had advised *'that DNACPR forms do not require a signature from patient or family',* given that there is a specific section on the

DNACPR Communication Sheet to record whether the decision has been communicated with the patient or next of kin (and the form states the DNACPR will be rendered invalid if that section is not completed). In response, the Trust provided written comments from a Consultant Physician.

95. The Consultant advised that his only contact with the patient had been over the weekend of 12 to 13 July 2014. He advised that on the morning of 12 July 2014, he *'assessed [the patient] alongside blood, x-rays, etc. to establish as full a picture as possible. Record of discussion with family at this point is detailed by the accompanying junior doctor, with mention of DNACPR within medical notes from this encounter, in addition to a note from myself detailing explanation of manner in which the infection had resulted in heart damage, with kidney damage and lung compromise also. A poor outlook was given, and at that point, the priority being one of comfort was described, with medication prescribed for restlessness. However, despite this, there was clear decision made to escalate antibiotics further at this review to maximize our efforts in fighting her infection'.*

96. He referred to the Trust's written response of 25 May 2016 to the complaint of 1 March 2016 having stated that the Consultant had advised that '*The Western Trust "Do Not Attempt Resuscitate Forms" do not require a signature from patient or family'.* He provided a copy of the DNACPR Communication Sheet, pointing out that it did not include a *'section for signature of patient or family'.* He further advised that *'Documentation of communication with the patient or next of kin where possible is good practice',* and that *'Record of discussions having taken place as per [Trust] policy should be documented within patient notes'.*

97. He also stated, '*… the medical records from the morning of the12th* [July 2014] *when I reviewed [the patient], did report a discussion surrounding severity of illness and resuscitation. This would have been in the context of [the patient] having multiple organ failure as a result of her sepsis, and a palliative approach being adopted as conceded by the complainant in his communication to your office from 18 July 2016. With such severity of illness and organ failure, as I*

reported in communication to Trust, I may have used the term, "Should her heart stop, we would be unable to restart it," as part of my communication, a simplified term I have found most to understand, rather than discussing forms and policies in the hours prior to a relative's expected death. She had been severely ill from re-presentation on the 11th July, and was deteriorating despite appropriate treatment. Severe sepsis can present rapidly – over hours on occasion, and carries a significant mortality in older patients with multiple other medical conditions as was the case with [the patient]. I believe I was truthful with the family from point of contact on the 12th and in communication since'. He commented further, *'Witnessed documentation of my discussion with [the] family including DNACPR from my ward round of the morning of the 12th resides within my notes. I accept this was at a late stage, but however, the earliest opportunity available to myself'.*

98. He summarised his involvement in the patient's care and treatment by stating, '*I attended [the patient] on the morning of 12 July 2014, and had no dealings with her in the months preceding. At this point on my ward round I spoke with family members present, where severity of illness and palliative approach and discussion on resuscitation was documented by accompanying witness*[16]*.*

(iv) IPA Advice

99. The IPA was asked if the DNACPR order put in place on 11 July 2014 was invalidated by reason of the fact that some sections of the form had not been completed fully and the family claim they were not consulted about the order. The IPA stated, '*Yes, the Order would have been invalidated by the fact that the form was not properly completed. However failure to consult the family is strictly not a criterion for invalidation'.* The IPA was also referred to the medical notes for 11 and 12 July 2014 and the further limited clarification within them, which states, '*not for ↑ (increased) level care'.* In light of that clarification, he was asked whether the DNACPR was still valid. In response the IPA advised that, '*The DNACPR would be valid, not invalid.'*

Analysis and Findings

100. The complainant said that the DNACPR order put in place on 11 July 2014 was not discussed with, or signed by, his mother or any member of her family.

101. I note that the Trust's DNACPR Adult Policy states, *'The DNACPR Order and the reasons for it must be documented, signed and dated in the patient's medical notes/records by the most senior member of the medical team and then documented in the DNACPR Communication Sheet'.* There is evidence to show the Trust's compliance with this requirement of the policy, in that the reasons for putting a DNACPR order in place, *'Comorbidities, Frailty',* are recorded in the appropriate section of the DNACPR Communication Sheet. The DNACPR order is signed and dated by the most senior clinician dealing with the patient and documented in the DNACPR Communication Sheet.

102. In relation to the Trust not having discussed the DNACPR order with the patient or her family, I note that paragraph 6.1 of the Joint Statement states, *'When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR'.* I note that the Joint Statement further states *'Careful consideration should be given as to whether or not to inform the patient of the decision. Although patients should be helped to understand the severity of their condition, whether they should be informed explicitly of a clinical decision not to attempt CPR will depend on the individual circumstances. In most cases the patient should be informed but for some patients, for example those who know that they are approaching the end of their life, information about intervention that would not be clinically successful will be unnecessarily burdensome and of little or no value'.*

103. I note that the Trust's DNACPR Adult Policy states, '*The opinion of other members of the multidisciplinary team, the patient if appropriate, and, with due regard to patient confidentiality, the patient's relatives or close friends in absence of family, may be valuable in informing the decision of the* [clinician] *in*

charge of the patient's care. If there is no discussion with the patient or their next of kin, the reasons for this should be clearly documented'. I note too that the Trust's DNACPR Adult Policy states*, 'If appropriate and in line with the patient's wishes, this decision should be discussed with the patient's family or next of kin'.* There was no discussion with the patient or her next of kin at the time the DNACPR order was put in place (that is, at 10:10am on 11 July 2014). I note that the medical staff were of the view that discussion of DNACPR would add to the patient's distress, and that no family members were present at that point in time.

104. I accept the clinicians' views that it was not appropriate to discuss the issue of DNACPR with the patient as to do so may have made her more distressed. I also accept that no family members were with her at the time the DNACPR order was put in place, which meant that it was not possible for clinicians to discuss the DNACPR decision with them at that time.

105 I am satisfied that there is evidence in the patient's medical notes of her condition and prognosis having been discussed with family members during the period 11 to 12 July 2014, and that those notes also refer to the DNACPR decision that was taken on 11 July 2014. Specifically, the nursing notes for 12 July 2014 record, '*14.35: Seen by Dr […] … D/W [discussed with] Family. DNA CPR – not for ↑ level of care…'* The notes of the junior doctor who accompanied the doctor on his ward rounds on 12 July 2014 also record, *'DNA CPR. Not for ↑ level care'*. However, I note that, in his response to investigation enquiries, the doctor stated '*… the medical records from the morning of the12th* [July 2014] *when I reviewed [the patient], did report a discussion surrounding severity of illness and resuscitation. This would have been in the context of [her] having multiple organ failure as a result of her sepsis, and a palliative approach being adopted … With such severity of illness and organ failure … I may have used the term, "Should her heart stop, we would be unable to restart it," as part of my communication, a simplified term I have found most to understand, rather than discussing forms and policies in the hours prior to a relative's expected death'.* Furthermore, although a further doctor has stated that she recalls having '*various discussions with family members regarding [the*

patient's]' condition, treatment and prognosis' and that *'Discussing DNA CPR orders during conversations regarding my prognosis is part of* [her] *usual practice'*, I have found no evidence that she specifically discussed the DNACPR decision during any such conversations with members of the family on either 11 or 12 July 2014. Consequently, on the basis of the available evidence, I am unable to conclude that the decision taken on 11 July 2014 to put a DNACPR order in place was specifically communicated to the patient and/or other members of her family.

106. The First Principle of Good Administration requires bodies to, 'Get it right'. Compliance with this Principle requires a public body to have regard to the rights of others, which includes the rights of a patient and his/her family. The Trust had an obligation to have regard to the human rights of the patient and her family in the context of the DNACPR decision making; the Participation Principle is a key tenant of a Human Rights Based Approach to patient care. Although the Trust's DNACPR Adult Policy did not expressly require discussion of the DNACPR decision with the patient and/or her family, it states, '*The opinion of other members of the multidisciplinary team, the patient if appropriate, and, with due regard to patient confidentiality, the patient's relatives or close friends in absence of family, may be valuable in informing the decision of the* [clinician] *in charge of the patient's care'*. The policy also states that where it is '*appropriate and in line with the patient's wishes',* the decision *'should be discussed with the patient's family or next of kin'.* In my view, any decision of this nature, given its potential impact on the patient, ought to have been discussed with her and, if that was not possible (as was the case here), a discussion ought to have taken place with her next of kin and/or members of her family. The Trust's failure to discuss the DNACPR order with the family impacted on their ability to participate in a decision that affected them and the patient. I find that the Trust's failure to ensure the family's participation in the DNACPR decision did not meet the First Principle of Good Administration, in that it did not have regard to the patient;s, and her family's, rights under article 8 of the ECHR.

107. I note also that section 5 of the DNACPR Communication Sheet was not

completed to record the reason why the DNACPR decision was not communicated to either the patient or her next of kin at the time the order was put in place. The doctor has stated that in cases where a DNACPR decision has been made without discussion with the patient or their next of kin, *'it would be* [her] *normal practice to document this on the DNACPR Communication Sheet and state that the plan is to discuss with family members when present'* but that in this case*, 'Section 5* [of the DNACPR Communication Sheet] *was not completed by* [her] *or the authorising consultant'.* This failure to complete section 5 of the DNACPR Communication Sheet was not in keeping with the DNACPR Adult Policy, which states, *'If there is no discussion with the patient or their next of kin, the reasons for this should be clearly documented'*. The reasons for not discussing the DNACPR decision with the patient or her family have been explained by the doctors involved in that decision and, in my view, are acceptable in the circumstances. However, it is clear that the doctors provided that explanation only in response to my investigation of the complaint; the explanation was not recorded on the DNACPR Communication Sheet.

108. I consider the failure to complete the relevant section of the DNACPR Communication Sheet to be a failing in record keeping, contrary to GMC 2013 standard 19 which requires, '*documents you make (including clinical records to formally record your work) must be clear, accurate and legible'.* I also consider this failing in record keeping to be contrary to the Third Principle of Good Administration, which requires a public body to be, 'open and accountable'. This Principle involves keeping full and accurate records to ensure that information is clear, accurate and complete. I consider the failure to keep a full and accurate record relating to the DNACPR decision taken on 11 July 2014 to be evidence that the Trust did not to meet the standards required by the Third Principle of Good Administration and, as such, to constitute maladministration. **Consequently, I uphold this element of the complaint.**

109. That said, I note and accept the Trust's statement that the patient *'was continued on full and active treatment and it is noted in the medical notes that she required daily bloods and daily review by the Medial Team and Surgical Team'.* I note that it advised, *'There is a difference between DNACPR and*

active maximal treatment which [the patient] had been receiving until she deteriorated on 12 July 2014 and the DNACPR was then palliative treatment'. I am satisfied that the placing of a DNACPR order into the patient's medical records did not impact adversely in her overall care and treatment.

110. I should also record that the Joint Statement referred to in this report was the document that was current at the time of the patient's admission to hospital (July 2014). The Joint Statement was updated in October 2014, and again in March 2016. (The most recent version is referred to in this report as 'the 2016 Guidance'). It should be noted that the 2016 Guidance explicitly identifies the need for patient involvement in the DNACPR decision process. Specifically, paragraph 5.2 of the 2016 Guidance, which addresses '*DNACPR decisions where CPR will not be successful and patients have capacity'*, states, *'In relation to decisions about CPR the courts have stated that there should be a presumption in favour of patient involvement and that there needs to be convincing reasons not to involve the patient.'* In support of this, is a judgment by the Master of the Rolls, in the Court of Appeal, who stated, *'In my view, doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them. Many patients may find it distressing to discuss the question whether CPR should be withheld from them in the event of a cardio-respiratory arrest. If however the clinician forms the view that the patient will not suffer harm if she is consulted, the fact that she may find the topic distressing is unlikely to make it inappropriate to involve her. I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find such decisions, if conscientiously taken, violate a patient's rights under article 8 of the Convention'.*

111. I welcome the clarity provided by the 2016 Guidance. I recommend to the Trust that adopt the 2016 Guidance in relation to participation of the patient or next of kin in DNACPR decisions.

112. I should also record that the DNACPR order did not play any part in the patient's sad death. Her family was made aware of her deteriorating medical

condition, treatment and prognosis. The family were present when she died during the evening of 12 July 2014. I extend my sympathies to her son and the wider family circle.

CONCLUSION

113. The complainant submitted a complaint to me about the actions of the Trust in relation to the care and treatment it provided to his late mother at the South West Acute Hospital, Enniskillen during the period 6 to 12 July 2014.

114. I have investigated the complaint and I have found the following instances of maladministration on the part of the Trust:

(i) A failure to ensure participation by the patient's family in the DNACPR decision, in accordance with the Trust's obligations under article 8 of the ECHR; and

(i) A failure in record keeping in relation to the completing of the DNACPR Communication Sheet placed on the patient's medical file on 11 July 2017.

115. I have concluded that the patient was admitted to hospital during the period 6 to 10 July 2014 for an exacerbation of COPD. There is evidence that there was an improvement in her medical condition with antibiotics (doxycycline), steroids and nebulisers and that she made a good recovery. I am therefore satisfied that it was reasonable for the Trust to have discharged her from hospital on 10 July 2014.

116. I have concluded, from the medical evidence available, that the patient was not allergic to doxycycline, and that this antibiotic was appropriately prescribed and administered to her. The evidence considered during this investigation indicates that during a previous hospital admission in March 2014, the side effects of this antibiotic were misinterpreted as an allergy. Consequently, there was an inaccurate reference within her medical notes to her being allergic to doxycycline, an error that has been acknowledged by the Trust.

117. I have concluded that the patient's condition deteriorated significantly overnight following her discharge from hospital on 10 July 2014, requiring her to be readmitted to hospital on 11 July 2014. On review, a DNACPR order was put in place, following consultation with the Consultant in charge of the patient's overall care and treatment. I accept that the DNACPR order was appropriate in the circumstances. However, there was no discussion of the order with her family, which denied them the opportunity to participate in that decision and impacted on her and her family's human rights.

118. The DNACPR Order was correctly countersigned and placed in the patient's medical record, according to the Trust's DNACPR Adult Policy. The failure to complete section 5 of the DNACPR Communication Sheet was an administrative failure. I consider this failure to be maladministration. I cannot conclude, however, that even if the DNACPR decision had been discussed with her family, a different decision would have been reached, given the patient's co-morbidities. I am satisfied that the placing of a DNACPR order into her medical records did not impact adversely in the care and treatment provided to her.

119. I have concluded that the complainant and the other members of the patient's family, have suffered the injustice of distress and uncertainty caused by the provision of misleading information about resuscitation. They also suffered the injustice of a loss of opportunity to participate in the DNACPR decision. I am also satisfied that the complainant sustained the further injustice of having to take the time and trouble to bring his complaint to my Office. I note that the Trust, in responding on 25 May 2016 to his complaint to it about the care and treatment it had provided to his mother, apologised to him and to the family *'for the distress caused and the negative experience'*.

Recommendations

120. I recommend that the Trust apologise for the failings identified in this report and that it provide the complainant with a payment of £500 within **one month** of the date of this report by way of solatium for the injustice sustained.

121. I also recommend the following service improvements:

(i) The Trust adopt the 2016 Guidance in relation to participation of the patient or next of kin in DNACPR decisions.

(ii) The Trust remind all relevant clinicians of the importance of good communication and record keeping, particularly in relation to a matter as critical as the putting in place of a DNACPR order.

122. The Trust should implement an action plan to incorporate these service improvement recommendations and provide me with an update within **four months** of the date of this report, supported by evidence to confirm that appropriate action has been taken (including, where appropriate, records of any relevant meetings, training records and/or self-declaration forms which indicate that staff have read and understood any related policies).

123. I should also record that in commenting on the first draft of this report, the Trust advised that its DNACPR Adult Policy was to have been reviewed in 2014 but that the intended review had been put on hold when the Trust became aware that a regional DNACPR policy was being drafted. In March 2019, the Trust informed me that the drafting of the regional DNACPR policy was complete but that an implementation date was still awaited from the Department of Health. The Trust further advised that pending the implementation of the regional DNACPR policy, the 2016 Guidance in relation to the participation of patient or next of kin in DNACPR decisions was being *'reiterated at Adult Life Support training within the Trust'.*

MARIE ANDERSON

Marie Anderson

Ombudsman **July 2019**

APPENDIX ONE

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.

- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.