Investigation of a complaint against the Belfast Health & Social Care Trust

Report Reference: 202003738

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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.

TABLE OF CONTENTS

Page

Case Reference: 202003738
Listed Authority: Belfast Health and Social Care Trust

SUMMARY

I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's late father (the patient) during the period 8 to 30 March 2020. The complainant was concerned about the Trust's decision to prescribe the medication Semaglutide to the patient, and its subsequent management of that prescription. She was concerned about the Trust's application of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Notices for the patient. The complainant was also concerned about the attention the Trust gave to the patient following his cardiac arrest on 30 March 2020.

The investigation established the Trust's prescription and management of Semaglutide, and its consideration of it regarding the patient's hospitalisation and sad death, were reasonable, appropriate and in line with relevant standards. It also established the Trust's decisions to put DNACPR notices in place for the patient, and its handling of those decisions, did not constitute failures in care in treatment in the circumstances. Furthermore, it found the nursing attention the Trust provided to the patient following his cardiac arrest and resuscitation was reasonable, appropriate and in line with relevant standards. However, it established a service failure in record keeping regarding its destruction of the first DNACPR form. It also established a failure in communication regarding the nursing care the patient received that caused the complainant to sustain injustice. I therefore partially upheld the complaint.

I recommended that the Trust apologise to the complainant directly for the failures identified within one month of the date of the final report. I made a further recommendation for the Trust to address service improvements and to prevent future reoccurrence of the failings identified.

Finally, I wish to pass on my condolences to the complainant, and her family, on the loss of her father.

THE COMPLAINT

1. I received a complaint about the care and treatment the Belfast Health and Social Care Trust (the Trust) provided to the complainant's late father during the period 8 March 2020 to 30 March 2020. In particular, the complaint was about the Trust's decision to prescribe the medication Semaglutide[1] to the patient, and its subsequent management of that prescription. The complaint was also about the Trust's application of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Notices[2] for the patient, and the attention the Trust gave to him following his cardiac arrest[3] on 30 March 2020.

Background

2. The patient, an 81 year old gentleman, lived with Type 2 Diabetes Mellitus[4] (Diabetes), and had managed his condition for over 40 years.

3. On 24 February 2020 the Trust prescribed Semaglutide to the patient as part of ongoing treatment for his diabetes. The patient started taking the medication on 8 March 2020.

4. On 16 March 2020 the patient started to feel unwell. He collapsed in his home on 28 March 2020 and travelled to hospital in an ambulance. On arrival at the hospital the Trust put a DNACPR Notice in place for the patient, following a telephone conversation with the patient's wife (the complainant's mother). The Trust tested the patient for COVID-19[5], which came back negative on two occasions.

5. On 29 March 2020 the Trust removed the DNACPR Notice. The Trust explained it destroyed the Notice by placing it into the confidential waste receptacle. It explained it did not keep a copy of the destroyed Notice on file.

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[1] A medicine used for weight loss in specific patients, and to lower blood sugar levels and reduce the risk of major cardiovascular events such as heart attack or stroke in type two diabetes patients.
[2] A specific medical form signed by a doctor setting out that if a patient.
[3] When a person's heart stops pumping blood around their body and they stop breathing normally. Many cardiac arrests in adults happen because of a heart attack.
[4] is a form of diabetes mellitus that is characterised by high blood sugar, insulin resistance, and relative lack of insulin. Common symptoms include increased thirst, frequent urination, and unexplained weight loss. Symptoms may also include increased hunger, feeling tired, and sores that do not heal.
[5] Coronavirus.

6. On 30 March 2020 the Trust discussed a new DNACPR Notice with the patient, but did not put one in place. The patient subsequently suffered a cardiac arrest. Trust staff performed CPR[6] and the patient's heartbeat returned. The Trust put a second DNACPR Notice in place for the patient, who sadly died shortly afterwards. The Trust recorded his cause of death as '*community-acquired pneumonia and kidney injury with sepsis*'.

7. On 3 September 2021 the complainant raised her concerns to the Trust about the care and treatment it provided to the patient. On 22 September 2021 the complainant raised some additional concerns. The Trust provided responses on 29 November 2021 and 25 January 2022. The complainant was dissatisfied with these responses, and the Trust issued its final response on 16 June 2022. The complainant remained dissatisfied with the response, and so raised her concerns with this Office.

Issues of complaint

8. I accepted the following issue of complaint for investigation:

   1) Whether the care and treatment the Trust provided to the patient during the period 8 March 2020 to 30 March 2020 was reasonable, appropriate and in line with relevant standards?
   In particular this will consider:
   - **The prescription and management of Semaglutide;**
   - **The application of DNACPR Notices; and**
   - **The attention the Trust gave to the patient following his cardiac arrest on 30 March 2020.**

INVESTIGATION METHODOLOGY

9. In order to investigate this complaint, the Investigating Officer obtained from the Trust all relevant documentation together with its comments on the issues the complainant raised. This documentation included information relating to the Trust's complaints process.

[6] Cardiopulmonary Resuscitation.

Independent Professional Advice Sought

10. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPAs):
    - **Diabetes Consultant**, MBBS, BSc, MD, FRCP – with nearly 20 years' experience treating patients with diabetes (D IPA);
    - **Consultant Physician and Accredited Geriatrician,** MB, MSc, MD, FRCP, FRCPEdin, FRCPGlasg, FRCP (I) Dip Card RPMS – with over 40 years' experience, including over 20 years' experience as a Geriatrician (P IPA);
    - **Senior Nurse**, Dnur, MSc, MA (Hons), PGdip, RGN – with over 40 years' experience in nursing, including in cardiology (N IPA).

11. I include the information and advice which informed the findings and conclusions within the body of this report. The IPAs provided '*advice*'; however how I weighed this advice, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

12. To investigate complaints, I must establish a clear understanding of the standards, both of general application and those specific to the circumstances of the case. I also refer to relevant regulatory, professional and statutory guidance.

    The general standards are the Ombudsman's Principles[7]:
    - The Principles of Good Administration

13. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

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

The specific legislation, standards and guidance relevant to this complaint are:

- British National Formulary (BNF): Semaglutide (BNF Extract);
- National Institute for Health and Care Excellence (NICE) Guideline NG28: Type 2 Diabetes in Adults: Management, December 2015 (NG28);
- Belfast Health and Social Care Trust's Hospital Medicines Policy and Code, (BHSCT Code);
- Medicines and Healthcare Products Regulatory Agency (MHPRA)'s Yellow Card Scheme: Guidance for Healthcare Professionals, Patients, and the Public, January 2015 (Yellow Card Scheme);
- Medicines and Healthcare Products Regulatory Agency (MHPRA)'s Yellow Card Scheme: Guidance on Reporting for Healthcare Professionals, 2017 (Yellow Card Reporting Guidance);
- Belfast Health and Social Care Trust's DNACPR Policy: Decisions Relating to Cardiopulmonary Resuscitation in Adults, July 2014; (DNACPR Policy);
- British Medical Association (BMA), Resuscitation Council UK (RCUK) and the Royal College of Nursing (RCN) Guidance: Decisions Relating to Cardiopulmonary Resuscitation, 3rd edition, 1st revision, 2016 (Joint Guidance on CPR);
- Extract from NHS Website: Do Not Attempted Cardiopulmonary Resuscitation (DNACPR) Decisions (NHS Extract);
- Directions from the Permanent Secretary for the Department of Health and the HSC Chief Executive: COVID-19 Preparations for Surge, 26 March 2020 (COVID Directions);
- The General Medical Council's Good Medical Practice, April 2019 (GMC Guidance);
- The General Medical Council's Treatment and Care Towards the End of Life: Good Practice in Decision-Making, July 2010; (Decision-Making Guidance);
- The General Medical Council's Good Practice in Prescribing and Managing Medicines and Devices, 2013 (Prescribing Guidance);

- The General Medical Council's Guidance for Doctors: Consent: Patients and Doctors Making Decisions Together, June 2008 (Consent Guidance); and
- The Nursing and Midwifery Council's (NMC) Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates, March 2015 (NMC Code).

14. I did not include all information obtained in the course of the investigation in this report. However, I am satisfied I took into account everything I considered relevant and important in reaching my findings.

15. A draft copy of this report was shared with the complainant and the Trust for comment on factual accuracy and the reasonableness of the findings and recommendations. I gave careful consideration to the comments I received before I finalised this report.

THE INVESTIGATION

Whether the care and treatment the Trust provided to the patient during the period 8 March 2020 to 30 March 2020 was reasonable, appropriate and in line with relevant standards?

In particular this will consider:

- **The prescription and management of Semaglutide;**
- **The application of DNACPR Notices; and**
- **The attention the Trust gave to the patient following his cardiac arrest on 30 March 2020.**

Evidence Considered

Legislation/Policies/Guidance

16. I refer to the following policies and guidance which I considered as part of investigation enquiries:
    - BNF Extract;
    - NG28;
    - BHSCT Code;

- Yellow Card Scheme;
- Yellow Card Reporting Guidance;
- DNACPR Policy;
- Joint Guidance on CPR;
- NHS Extract;
- COVID Directions;
- GMC Guidance;
- Decision-Making Guidance;
- Prescribing Guidance;
- Consent Guidance; and
- NMC Code.

I enclose relevant extracts from the above at Appendix two to this report.

Documentation and records I examined

17. I completed a review of the copy documentation the complainant provided, and those the Trust provided in response to my investigation enquiries. I enclose relevant extracts at Appendix three to this report.

The prescription and management of Semaglutide

Detail of Complaint

18. The complainant said the patient suffered an '*adverse reaction*' to the medication. She said this caused the decline in his health, his collapse, and his hospitalisation.

19. The complainant said when the patient started to experience his '*adverse reaction*' to the medication, he tried to contact the Diabetes Clinic for support. However, he had been unable to speak to anyone, and nobody returned his calls. She considers that if the patient had been able to speak to someone at the Diabetes Clinic, the Trust may have been in a position to treat his symptoms earlier. She considers this may have prevented his collapse and hospitalisation.

20. The complainant said when the patient went to hospital, he brought the Semaglutide with him to show what had caused his '*adverse reaction*' and collapse. She said the Trust did not explore this option, and instead treated him as a COVID-19 patient, despite tests coming back COVID-negative. She was concerned that, as a result, the Trust may have administered Semaglutide to the patient whilst he was in hospital. She explained the description of the patient's decline on 30 March 2020 that led to his resuscitation was very similar to the description of his collapse on 28 March 2020. She considers it is possible this medication contributed to his decline in hospital on 30 March 2020.

21. In addition, the complainant said that following the patient's death, the Trust should have completed a Yellow Card[8] in respect of the patient's '*adverse reaction*' to the medication. The complainant said because the medication was '*new*', the Trust had an obligation to complete a Yellow Card.

The Trust's response to investigation enquiries

22. The Trust stated: it prescribed Semaglutide as part of its treatment of the patient's diabetes. It explained the patient had gained weight and this medication was known to help diabetes patients with weight control. It denied there was any connection between the patient's decline in health and this medication. It also denied it administered Semaglutide to the patient when he was in hospital, despite prescribing the medication.

23. The Trust stated: it provided the patient with the telephone number for its Diabetes Specialist Nurse (DSN) helpline, and an email address for the DSN. The helpline is an '*answering machine*' that enables patients to '*leave a message*'. This is a different number than the general number for its Diabetes Clinic. Its staff document all messages received on the helpline number and respond to them. It reviewed its helpline records and found *'no record of any contacts*' from the patient during the relevant period.

[8] A scheme, run by the MHRA, which collects and monitors information on suspected safety concerns involving healthcare products, like a side effect with a medicine or an adverse medical device incident. The scheme relies on voluntary reporting of problems to a healthcare product by the public as well as from healthcare professionals.

24. It suggested the patient may have '*inadvertently*' called a different number, such as the general Diabetes Clinic number.

25. The Trust stated: there was no connection between the patient's pneumonia and Semaglutide. Therefore it was not appropriate to complete a Yellow Card. It accepted the patient also experienced loss of appetite and nausea, but said these did not cause the patient to develop pneumonia. As these are '*recognised side effects commonly experienced*' with Semaglutide it did not need to complete a Yellow Card for them. It denied Semaglutide was '*new*' medication, or that the patient had been involved in any trial regarding the drug.

Independent Professional Advice

26. I enclose the D IPA's advice at Appendix four to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

(i) Prescription of Semaglutide

27. Semaglutide is a once weekly injectable drug which binds and activates the GLP-1 [9]receptor and is used in the treatment of type 2 diabetes to improve blood sugar, promote weight loss and has cardiovascular benefits. The D IPA advised "*the patient 's weight had increased from 116.6kg in May 2019 to 122.4kg in April 2020 and HbA1c[10] risen"*. She advised the Trust prescribed Semaglutide to help with weight loss and reduce insulin requirements.

28. Section 1.6.31 of NICE Guidance (2015) states '*in adults with type 2 diabetes, only offer a GLP-1 mimetic in combination with insulin with specialist care advice and ongoing support from a consultant-led multidisciplinary team*'. The D IPA advised the Trust prescribed Semaglutide to the patient in line with this guidance, and its decision was appropriate to reduce cardiovascular risk and weight gain. I accept that advice.

[9] GLP-1 agonists are a class of medications that mainly help manage blood sugar (glucose) levels in people with Type 2 diabetes. Sone GLP-1 agonists can also help treat obesity

[10] HbA1c test is **a blood test that checks your average blood sugar level over the last 2 or 3 months.**

29. The D IPA advised Semaglutide was the correct drug for a patient with a history of atrial fibrillation [11]as research shows "*a reduction of 29% in patients developing atrial fibrillation when taking Semaglutide"* It was also noted the patient's ACR was slightly raised and Semaglutide has been shown *"to reduce urine albumin creatine ratios (ACR)[12]".* I accept the D IPA's advice this was the correct medication for this patient. I find, therefore, the Trust's decision to prescribe it was reasonable, appropriate and in line with relevant standards.

(ii) Adverse Reaction

30. I note the complainant's concern that the symptoms the patient experienced were an adverse reaction to Semaglutide.

31. As per BNF[13] common or very common side effects for Semaglutide are "*Appetite decreased (in patients with type 2 diabetes); burping; cholelithiasis; constipation; diarrhoea; fatigue; gastrointestinal discomfort; gastrointestinal disorders; hypoglycaemia (in combination with other antidiabetic drugs, in patients with type 2 diabetes); nausea; vomiting; weight decreased (in patients with type 2 diabetes).* Of these, I note the patient experienced diarrhoea and vomiting, which "*more than 1:10 patients"* experience on this medication.

32. The medical records document both a doctor and a diabetic specialist nurse at the Diabetes Clinic discussed the side effects of the medication with the patient. In particular, "*S/B DSN Benefits and side effects of Semaglutide discussed. Written literature provided. Demonstration and practice given on pen device".* In addition, the D IPA advised *"The Trust discussed the side effects with the patient".* Having reviewed all relevant records, including the D IPA's advice, I am satisfied the Trust provided the patient with appropriate information on the side effects of Semaglutide.

[11] Atrial fibrillation is **a common heart condition that affects the rhythm and rate of the heart**
[12] ACR is a urine test that measures the amount of albumin and creatinine in the urine. It is used to screen for kidney disease related to diabetes or hypertension.
[13] BNF-British National Formulary

33. The complainant states the patient also had shortness of breath which is not a recorded side effect. D IPA advised "*the shortness of breath would be attributed to the chest infection rather than Semaglutide".* I accept the D IPA's advice regarding the patient's additional symptoms being unrelated to Semaglutide, and that these additional symptoms were therefore not an adverse reaction to that medication.

34. The D IPA advised there is no evidence to suggest Semaglutide contributed to the patient's collapse and hospitalisation. Therefore I do not uphold this element of the complaint.

(iii) Contact with the Diabetic Clinic

35. The complainant advised her father was unable to contact the Diabetic Team when side effects manifested. The Trust confirmed it provided a phone number and email for a Helpline answering machine. Having reviewed the Trust's records, which included the contact details it provided to the patient, I am satisfied the Trust provided relevant contact details to him.

36. D IPA advised the patient suffered side effects from Semaglutide which he found difficult to tolerate, and so he reached out for help. However he was not able to make contact and did not feel empowered to stop the medication himself without seeking advice. It cannot be determined exactly what telephone number the patient called. I note the IPA's advice that the patient may have accidentally contacted an incorrect number, and agree this is a possibility. Nonetheless, having reviewed all relevant records, I am satisfied the Trust provided the patient with adequate contact details for its services at the point it prescribed the medication. I therefore do not uphold this element of the complaint.

37. However, I note the D IPA's observation that the Trust could ensure the contact details are "*more readily available*" generally, and would encourage the Trust to reflect on this observation in its future practice.

(iv) Hospital's consideration of Semaglutide

38. I note the complainant's concern that the patient explained to the Trust he was having an adverse reaction to Semaglutide, but the Trust did not consider this as a potential diagnosis.

39. Having reviewed the Outcome Focused Management Plan in the patient's medical records I note the Trust recorded *" 81yo → feels unwell 2/52, attributed to started GLP1 receptor Semaglutide, no dyspraxia, some myalgia, ↓ appetite, rigors + sweats was self-isolating'.* The D IPA advised this record demonstrates the medical team considered the patient's perspective on Semaglutide, but determined the symptoms were not related to this medication. She advised this demonstrated reasonable and appropriate consideration of the patient's perspective. I accept this advice, and therefore do not uphold this element of the complaint.

(v) Hospital's administration of Semaglutide

40. The complainant was concerned the hospital administered Semaglutide to the patient whilst he was in hospital, and that this may have caused the deterioration in his health.

41. I reviewed the medical records and note Semaglutide was included in the patient's Medicine Prescription and Administration Record (appendix three refers). It appears scored out on one occasion, and accompanied by a question mark on another occasion. I note Paragraph 3.1.38.3 of the BHSCT Code (appendix two refers) states if the Trust is not giving a specific medication, it should strike a line through that entry in a patient's administration record.

42. The D IPA referred to the patient's medical records and advised "*there is nothing to suggest Semaglutide was given during admission".* She further advised when the Trust administers a drug, it places a signature next to the drug with the date and time. The D IPA advised that as Semaglutide is given once weekly and the day due was unknown the prescriber wrote *"?day"* to reflect this unknown. On foot of this information, she advised this indicated the Trust did not administer the medication.

43. The D IPA also referred to the post take ward notes on 29 March 2020. She advised this record states *"hold antidiabetes sliding"* which meant the patient did not receive Semaglutide, and instead received insulin on a sliding scale (variable rate insulin infusion).

44. Having reviewed all relevant records, including the D IPA's advice, I accept the Trust did not administer Semaglutide to the patient whilst he was in hospital. I therefore do not uphold this element of the complaint.

(vi) Yellow card

45. I reviewed the BHSCT Medicines Code, the Yellow Card Scheme and the Yellow Card Reporting Guidance (appendix two refers). I note the Yellow Card scheme is a voluntary scheme, through which healthcare professionals and patients can notify the Medicines and Healthcare products Regulatory Agency (MHRA) / Commission on Human Medicines (CHM) of suspected Adverse Drug reactions (ADR). In particular, I refer to the black triangle set out in the Yellow Card Scheme, which forms part of that wider scheme. It states clinicians "*should report all suspected ADRs*" for medications marked with black triangle in its package leaflet. New medications under "*additional monitoring*" are marked with a black triangle.

46. The complainant believes the Trust should have completed a yellow card to report the "*adverse reaction*" the patient had to Semaglutide. The Trust states the side effects attributable to the medication that the patient reported were already recognised and therefore it was not necessary to make a report.

47. The D IPA advised Semaglutide is marked with a black triangle, but that alone "*does not mean the medicine is unsafe"*. Furthermore it does not mean any and all symptoms experienced whilst taking the medication must be treated as a side effect or an ADR for that drug. She advised the medical team did not suspect the e coli sepsis was an adverse reaction to Semaglutide and therefore did not report it under the Yellow Card Scheme. The D IPA further advised that, given the circumstances, "*I would not have completed a yellow card"* and *"I do not believe the pneumonia and sepsis can be attributed to side effects of Semaglutide*". Having reviewed the relevant standards I accept the D IPA's advice in this respect. I therefore do not uphold this element of the complaint.

Summary

48. In respect of the complainant's concerns regarding Semaglutide I found:
    - the Trust's decision to prescribe this medication was appropriate, in line with relevant standards, and took into consideration the patient's medical history;
    - the Trust appropriately discussed side effects with the patient at the time or prescribing;
    - the symptoms that caused the patient's hospitalisation were not related to Semaglutide, or an adverse reaction to that medication;
    - the Trust provided the patient with relevant contact details for its services;
    - the Trust gave reasonable and appropriate consideration to the patient's perspective that Semaglutide was the cause of his symptoms
    - the Trust did not administer Semaglutide to the patient when he was in hospital; and
    - the Trust's decision not to submit a yellow card report was reasonable, appropriate and in line with relevant standards.

49. On foot of these findings, I do not uphold this element of the complaint.

Observation

50. I note the D IPA's observation that the Trust could have responded to episodes of hypoglycaemia and hypotension the patient experienced whilst in hospital in a more timely manner. In particular that the Trust could have used an intravenous insulin infusion to do so. Whilst it is not appropriate to further investigate this matter or to make any findings in respect of it as it is outside the scope of the investigation, I would nevertheless strongly encourage the Trust to examine and reflect upon the IPA's advice in this respect within the context of its practices moving forward.

The application of DNACPR Notices

Detail of Complaint

51. The complainant said that on the patient's arrival at the emergency department (ED), the doctors explored a DNACPR notice for him. She explained that because the Trust considered the patient to be '*confused*' it called his wife to discuss it. She explained the Trust put this DNACPR in place without her mother's specific consent. The complainant was concerned about both the timing of this discussion, and the decision the Trust made.

52. The complainant said that during the patient's first 24 hours in hospital the Trust kept asking the patient about DNACPR notices. She said that on the day of his death the Trust told the family the patient had consented to the second DNACPR. She felt this was out of character for the patient, and was concerned about the Trust placing undue pressure on him to consent to it.

53. The complainant was concerned the Trust put the second DNACPR in place on the morning of the patient's death against his wishes, and without consulting with the patient and the family.

The Trust's response to investigation enquiries

54. The Trust stated: DNACPR decisions ultimately rest with medical teams. However, clinicians '*will endeavour to seek*' patient views and the views of families, and consider these as part of the decision-making process. Medical teams will put a DNACPR in place if it is in the patient's '*best interests*'. Staff review DNACPR decisions '*on each ward round*'.

55. The Trust stated: the patient was '*critically unwell*' upon admission to the ED on 28 March 2020. The ED doctor '*assessed*' the patient's '*clinical presentation*' and his medical history and decided '*a resuscitation attempt should not be made*'. The ED doctor did not consult with the patient because he was '*confused*'. However, the doctor spoke with the patient's wife on the telephone. The doctor could not discuss this in person due to COVID-19 restrictions in place at the time. It acknowledged '*resuscitation was addressed on several occasions*' during the patient's time in hospital, which resulted in the medical team removing the first DNACPR notice on 29 March 2020.

56. The Trust stated: on 30 March 2020 the respiratory consultant '*spoke with*' the patient to '*discuss his care options*' prior to his cardiac arrest. The patient '*clearly communicated he would not want anything invasive*'.

57. The Trust stated: '*events moved very quickly*' following this and staff did not have time to discuss the second DNACPR with the patient's family. The patient went into cardiac arrest while the respiratory consultant was '*in the process of fully assessing him*'. Staff resuscitated the patient, but decided the '*chance of a successful long-term outcome or prognosis*' was '*extremely poor*' because his '*blood was very acid*'; and his '*oxygen levels were profoundly low*'. As a result, if his heart stopped again another resuscitation attempt '*would be unsuccessful*'. Staff considered the patient's age, diabetes, current condition, and treatments available to him when making the second DNACPR decision.

Independent Professional Advice

58. I enclose the P IPA's advice at Appendix four to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

59. The complainant raised concerns about the Trust's decisions and actions in placing two separate DNACPR notices for the patient following his arrival at hospital on 28 March 2020.

60. Paragraph 4 of the BHSCT Policy (appendix two refers) states "*It is not uncommon for difficult decisions about CPR to arise in respect of patients for whom it may be possible to re-start the heart after cardiac arrest but for whom admission to an ICU for continued organ support would be clinically inappropriate because they would be unlikely to survive*". It goes on to state that "*advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest*". Paragraph 4.12 states "*If it is believed that CPR would not re-start the heart and breathing, it should not be attempted*". This position it also reflected in paragraph 9 of the Joint Guidance on CPR (appendix two also refers).

61. Regarding the DNACPR decision itself, paragraph 4.9 of the BHSCT Policy sets out that this is "*primarily a clinical decision"* for which *"the responsibility rests with the Consultant in charge of the patient's care".* Clinicians "*must*" make DNACPR decisions on the "*basis of an individual assessment of each patient's case".* This is also reflected in section 14 of the Joint Guidance on CPR.

62. The BHSCT Policy is clear that whilst it is primarily a clinical decision, the clinician is still required to communicate with the patient, and in certain circumstances, "*those close to*" to the patient about the decision. This is also reflected in paragraph 10 and section 14 of the Joint Guidance on CPR.

63. Where the clinician has determined CPR would not be successful, paragraph 4.12 of the BHSCT Policy requires them to "*discuss*" a DNACPR decision with a patient who has sufficient capacity to engage in the discussion. It further states if a patient has sufficient capacity to discuss this matter, the clinician should not involve the patient's family or carer without that patient's consent. Paragraph 4.12.3 states that if a patient lacks capacity, the clinician "*should inform those close to the patient about the DNACPR decision and the reasons for it*". There is no requirement for a clinician to seek the consent or agreement of those close to the patient in advance. This is also reflected in paragraph 10 of the Joint Guidance on CPR.

64. Where the clinician has determined CPR "*may*" be successful, they should "*offer*" a patient with sufficient capacity "*the opportunity*" to discuss a DNACPR notice, and the benefits and risks of CPR. It remains a clinical decision, but gives the patient the opportunity to express if they would rather not be resuscitated. If the patient does not have sufficient capacity, paragraph 4.13 of the BHSCT Policy states a clinician should "*involve*" those close to the patients in this discussion to "*explore the patient's wishes, feelings, beliefs and values".* The BHSCT Policy is clear that those close to the patient should reflect the patient's views, and not provide their own. It is not the responsibility of those close to a patient to make a clinical decision about CPR.

65. Paragraph 4.6 states clinicians should consider the "*likely benefits, burdens and risks of CPR"* as *"early as possible"* in a patient's care where they are *"acutely unwell"* or at *"foreseeable risk"* of cardiac or respiratory arrest. This is also reflected in paragraph 11 of the Joint Guidance on CPR.

66. In addition paragraph 4.20 of the BHSCT Policy states that where the Trust cancels a DNACPR notice, "*the cancelled form must then be filed in the patient's chart, in a place other than the front pocket".*

First DNACPR

67. Upon review of the medical records, I note the Trust put this DNACPR in place for the patient following his arrival in the ED on 28 March 2020. I further note the Trust determined the patient was "*confused*", and therefore did not have sufficient capacity to discuss the DNACPR. As a result, the Trust contacted the patient's wife to discuss it with her. The Trust cancelled the DNACPR the following day.

68. The complainant was concerned the Trust discussed this DNACPR shortly after the patient's arrival at the hospital. The P IPA advised there was "*nothing wrong in principle*" with this. This reflects the position in the BHSCT Policy and the Joint Guidance on CPR that where a clinician has concerns about cardiac or respiratory arrest, they should seek to explore a DNACPR "*as early as possible*". I appreciate it may have been unexpected for the patient's family for the Trust to have had this discussion at this stage in the patient's care. I also appreciate this would have been a frightening time for the family. However, having considered all relevant evidence, including the P IPA's advice, I am satisfied the Trust's timing of its discussion did not conflict with relevant standards in place at the time.

69. The complainant was concerned about the Trust's decision to put the DNACPR in place. The P IPA advised that given the patient's "*sepsis and co-morbidities*", he was "*less likely*" to "*survive*" if he went into cardiac or respiratory arrest. He advised there was "*nothing wrong in principle*" for the Trust to have explored a DNACPR for the patient and the Trust to discuss this with his wife. The P IPA advised that, in his opinion, the Trust did not need to put a DNACPR in place for the patient at the time of his admission to hospital. However, I note the P IPA did not raise any concerns about the Trust's decision to put one in place or identify it as a failure in care and treatment. The BHSCT Policy and the Joint Guidance on CPR both state it is the responsibility of the clinician to use their discretion to make DNACPR decisions, based on their assessment of the patient's condition and to spare the patient traumatic and invasive treatment which is not in their best interests. However, there is a requirement to take the time to properly speak with those close to the patient. Having considered all

relevant records, including the P IPA's advice, I am satisfied the Trust's decision in and of itself that a DNACPR was medically appropriate for the patient at that time was not a failure in the care and treatment it provided to the patient.

70. The complainant was also concerned about the Trust's discussion with the patient's wife. I note the P IPA advised the patient's medical records reflected the Trust discussed the DNACPR with the patient's wife and her agreement to it, rather than an objection on her part. I also reviewed the patient's medical records and note two separate records documented the medical staff's discussion of the DNACPR with the patient's wife and documented "*wife in agreement*".

71. However, I note the P IPA's advice, the BHSCT Policy and the Joint Guidance on CPR each say the purpose of the call with those close to the patient, (in this case the patient's wife) was for the Trust to discuss and explain why it made the clinical DNACPR decision and the basis for it. I am satisfied the Trust's duty in this case, was to inform those close to the patient. It did so, and recorded her agreement. Having reviewed all relevant records, including the P IPA's advice, I am satisfied the Trust's actions did not constitute a failure in the care and treatment it provided to the patient in these circumstances. However, despite this finding I will make an observation about the Trust's record-keeping and communication with the patient's family about this DNACPR later in this report, for it to consider in its practice going forward.

72. I note on 29 March 2020 a Consultant Physician (Consultant A) decided to cancel the DNACPR. Consultant A disposed of the original DNACPR form after cancelling it, instead of retaining the cancelled document in the patient's medical records. The P IPA advised "*this was an error*". I also note it was contrary to the BHSCT Policy which states " *If the DNACPR decision is cancelled it should be crossed through with two diagonal lines in black ball-point ink and 'CANCELLED' written clearly between them signed and dated by the healthcare professional cancelling the order"* The form must then be filed in the patient's chart. I consider this to be a failure in record-keeping that

constitutes a service failure. The P IPA advised the Trust's stated reasoning for putting the first DNACPR in place is not included in the patient's medical records. This information is typically found on the DNACPR form itself. I consider it is more likely than not that in destroying the original form, Consultant A also destroyed the Trust's recorded rationale for putting the DNACPR in place. However, I am satisfied this had no impact on the care and the treatment it provided to the patient, and note the Trust did resuscitate him following his cardiac arrest on 30 March 2020. Despite not impacting the patient's care and treatment, I consider Consultant A's actions fell short of standard 19 of the GMC Guidance. This requires clinicians to keep clear, accurate and legible records of their work, including the rationale for clinical decisions.

73. On foot of the above findings, I partially uphold this element of the complaint to reflect that whilst the care and treatment the Trust provided regarding this DNACPR was reasonable and appropriate, there was a service failure in record-keeping regarding its cancellation. However, I am satisfied there was no injustice to the patient as a result of this service failure.

Consultation with the patient regarding DNACPR

74. I note the P IPA's advice that following the cancellation of the first DNACPR notice, the patient's Respiratory Consultant (Consultant B) "*discussed*" DNACPR issues with the patient directly on 30 March 2020. The Trust stated it considered the patient had sufficient capacity at this stage to have such a discussion, and I note neither the complainant or the P IPA disputed this. The P IPA advised the medical records document Consultant B had a "*frank*" discussion with the patient about this. I reviewed the medical records and note Consultant B recorded the patient was "*open minded*" about CPR, but "*did not want anything invasive and did not want to go to ICU*".

75. The complainant was concerned the Trust placed undue pressure on the patient to give this opinion during that discussion. I asked the P IPA about this, who advised there was no evidence to suggest Consultant B put any pressure on the patient. I am satisfied that, in line with the BHSCT Policy and the Joint Guidance on CPR, it was appropriate for Consultant B to discuss DNACPR matters with the patient directly once he had sufficient capacity to engage in the conversation. Having reviewed the record of this discussion, and the P IPA's advice, I am also satisfied the Trust did not place any undue pressure on the patient during that discussion. I therefore do not uphold this element of the complaint.

Second DNACPR

76. On 30 March 2020 at 10:45 the patient sadly suffered a cardiac arrest and whilst resuscitation was successful in returning circulation, the medical team believed the patient was unlikely to maintain circulation long term and unlikely to survive a further arrest. I note that at 11:25 the patient's test results showed E.coli in his blood. Based on these assessments and observations the Trust decided to put a second DNACPR in place at 11:26.

77. The P IPA notes "*it was an appropriate decision to reinstate the DNACPR*" following the return of spontaneous circulation (ROSC)[14] because the Trust believed the patient's condition was not sustainable and he would not survive a further arrest. The patient sadly died at 12:55. The BHSCT Policy and the Joint Guidance on CPR are clear that a clinician should not carry out CPR on a patient where they do not believe the patient would be able to maintain spontaneous circulation following an attempt. Having reviewed all relevant records and the P IPA's advice, I am satisfied the Trust decision to put the second DNACPR Notice in place was in line with relevant standards.

[14] ROSC (return of spontaneous circulation) is **the resumption of sustained perfusing cardiac activity associated with significant respiratory effort** after cardiac arrest

78. The complainant was concerned that the Trust did not discuss the second DNACPR with the patient's family before putting it in place. I note the Trust apologised that the medical team were unable to discuss the DNACPR with the family, explaining that as the patient's condition deteriorated rapidly following the initial attempt at resuscitation it had been unable to do so.

79. I asked the P IPA about this. He advised that, by this stage, the Trust had already discussed DNACPR matters with the patient's wife on 28 March 2020, which was sufficient to meet the requirements of the BHSCT Policy about communication with family members. He advised the Trust could have discussed this with those close to the patient when it updated them on the patient's condition. However, the medical team's focus at the time was on caring for the patient. He advised the Trust cannot be criticised for this. He further advised there were "*no failings identified*" in the manner in which the Trust handled the second DNACPR. Having reviewed all relevant records, I accept this advice.

80. On that basis I do not uphold this element of the complaint. I recognise the difficult circumstances the complainant and her family experienced. I hope that knowing staff made the DNACPR decision in accordance with guidelines and in the patient's best interests brings some reassurance for the complainant and her family.

Summary

81. I found the Trust's decisions regarding instating both the first and second DNACPR notices, and the manner in which it engaged with the patient and those close to him on each occasion, did not constitute failures in the care and treatment it provided to the patient in the circumstances.

82. However, I found a service failure in record-keeping in relation to the destruction of the first DNACPR in breach of the Trust policy. Whilst this did not impact on the care and treatment the patient received, I nonetheless partially uphold this sub-issue of the complaint to reflect this failure.

Observation

83. The decision to put a DNACPR in place is often very challenging and frightening for patients and their families. It is unsurprisingly families wish to feel involved in these decisions and to have their views considered.

84. I acknowledge that under relevant standards the Trust was not required to seek the patient's wife's consent or agreement to put the first DNACPR in place. The Trust was required, however, to speak with those close to the patient about the decision. While I note the Trust did speak with the patient's wife, the medical records contained very little detail about the content of that discussion, beyond *'wife in agreement*'. I consider it is in the spirit of the relevant standards, and in line with a doctor's duty to patients and their loved ones, for this conversation to be meaningful, empathetic and for the doctor to take appropriate time to explain the circumstances to families. This ensures families feel included in their patient's care.

85. On this occasion, given the sparse detail in the medical records, I have been unable to determine whether the Trust took sufficient time to have that meaningful and empathetic discussion with the patient's wife. I consider this is particularly pertinent, given the P IPA's advice he would not have put the first DNACPR in place in the circumstances, and given the Trust removed it the following day.

86. Whilst I am satisfied the Trust's actions in putting the first DNACPR in place for the patient did not constitute a failure in the care and treatment it provided in the circumstances, I nonetheless strongly urge the Trust to reflect on this observation about communication and record-keeping in its practice going forward regarding DNACPRs.

Attention following the patient's cardiac arrest

Detail of Complaint

87. The complainant said the Trust '*left*' the patient '*in a side room to die*' following his cardiac arrest and resuscitation on 30 March 2020. The complainant queried whether the patient received all appropriate care and attention during this period prior to his death.

88. In addition, the complainant considered the Trust should have invited the family to attend the hospital to see the patient before he sadly passed away.

The Trust's response to investigation enquiries

89. The Trust stated: given the patient's prognosis following his resuscitation the '*goal*' of care and treatment '*moved to ensuring his comfort and dignity*'. It was '*not possible*' to contact the patient's family to arrange for them to come to the hospital before he died due to '*the speed of*' the patient's '*deterioration*', both before and after his cardiac arrest.

Independent Professional Advice

90. I enclose the N IPA's advice at Appendix four to this report. I have outlined my consideration of the advice in my analysis and findings below.

Analysis and Findings

Decision to transfer the patient to a side room

91. Having reviewed all relevant documentation provided by the complainant and the Trust, I am satisfied that following the patient's cardiac arrest and resuscitation on 30 March 2020 the Trust transferred him to a side room for ongoing care until he sadly passed away.

92. Regarding the reasonableness of this decision, I note the N IPA's advice that following the patient's cardiac arrest and resuscitation his '*medical and nursing care*' changed to '*focus on comfort and support*'. She advised the Trust transferred the patient to single room for his own '*privacy*', and to allow him to pass away '*peacefully*' without being '*disturbed*' by activity on the ward. The N IPA advised this was a reasonable decision for the Trust to have made in the circumstances. She further advised this decision '*does not seem to have impacted on the nursing care that he was given*'. Given the patient was very near the end of his life at the point the Trust made this decision, I accept this advice.

93. *Standard 1* of the NMC Code (Appendix two refers) requires nurses to uphold the dignity of their patients. Standard 5 requires nurses to respect a patient's right to privacy in '*all aspects of their care*'. Having considered all relevant documentation, including the N IPA's advice, I am satisfied the Trust's decision to place the patient in a side room following his cardiac arrest and resuscitation was reasonable and appropriate. Furthermore, it allowed the nurses to attend to the patient with privacy and dignity in line with relevant standards.

Nursing care and attention

94. I reviewed the patient's medical records, including his nursing records. I note the patient went into cardiac arrest shortly after buzzing for assistance at 10:30. A nurse started CPR, and a doctor attended at 10:45. The Trust stopped administering CPR at 11:00 because staff had resuscitated the patient. The Trust transferred the patient to a side room. A nurse subsequently administered lorazepam[15] to the patient on three occasions, being at 11:15, 11:30 and 11:45. At 12:00 a nurse assessed the patient and found him to be '*very agitated and very unwell clinically*'. A nurse was with the patient when he passed away '*peacefully*' at 12:35.

95. I note the N IPA referred to this timeline and advised nurses were '*at*' the patient's '*bedside*' on '*at least four occasions in the 95 mins between him recovering from his arrest and dying*' – at times at 15-minute intervals. She advised the nursing care the Trust provided to the patient during this period was '*entirely appropriate and reasonable*' and '*met all professional guidance*'. Furthermore that '*there was nothing additional that would have provided benefit*' to the patient at that time.

96. Having reviewed all relevant documentation, including the N IPA's advice, I am satisfied the care and attention the Trust provided to the patient during the 95 minutes between his resuscitation and sad death was reasonable and appropriate.

[15] An anti-anxiety medication used to treat anxiety and breathlessness in palliative care.

Family attendance at the Hospital

97. I reviewed the patient's medical records. I note a nurse attempted to contact the patient's wife at 11:05, following his cardiac arrest and resuscitation, but was unsuccessful. At 11:26 a doctor documented '*Call made to family…I'm told they are on their way – I will see them*'. I am satisfied, therefore, that the Trust subsequently contacted the family. At 12:25 the doctor documented '*family not present yet*'. At 12:43 the doctor documented [the patient's son]*'called ward on phone. I spoke to him and explained all while we were on the phone patient died & I broke the news to the family on the phone immediately*'. The doctor further documented '*I have said they can attend and I will see them to answer questions asked. They know ward essentially closed to visitors but we will check policy on visiting under these circumstances*'. I note the family chose not to attend in person that day following the patient's death.

98. I note the complainant's position that the Trust failed to '*invite*' them '*to attend*' the hospital to see the patient before he died. The Trust confirmed in its response to this Office that it did not do so. In addition, the N IPA advised it was '*unclear*' from the records whether or not the Trust invited or encouraged the family to attend. The N IPA advised it would have been reasonable for the Trust to have done so. However, she acknowledged that COVID-19 restrictions at that time changed rapidly, and that there may have been some uncertainty about the rules for hospital visits at that time.

99. Regarding COVID-19 restrictions, the guidance in place on 30 March 2020 was set out in the COVID Directions (Appendix two refers). It stated '*all general hospital visiting across Northern Ireland*' would stop as of 26 March 2020. However, there was an exception for patients receiving '*end of life care*'. Such a patient could have one visitor for one hour at a time, '*agreed in advance with the Ward Sister or Charge Nurse*'. Paragraph 2 of the Decision-Making Guidance (Appendix two also refers) is clear that end of life care includes '*life-threatening acute conditions caused by sudden catastrophic events*'. It would, therefore, have been possible for a family member to visit the patient without contravening government guidance in place at the time.

100. The N IPA advised the patient's doctor '*believed*' the family had been invited to attend, but this may have been an internal '*miscommunication*'. She further advised that even if the Trust had invited the family to attend, it cannot be concluded that they would have made it in time, given the patient's rapid deterioration.

101. I acknowledge the Trust's position that the patient's condition deteriorated rapidly following his cardiac arrest and that he lived for only 95 minutes following his resuscitation. I appreciate this was a very tight timeframe for the family to attend the hospital before he sadly passed away – particularly in the context of the early stages of the COVID-19 pandemic.

102. However, I accept that N IPA's advice that it would nonetheless have been reasonable for the Trust to have informed the family that they could attend. It would then have been the family's choice as to whether a member wished to try their best to visit the patient in time. I consider this to be a failure in communication on the Trust's part. The Second Principle of Good Administration, '*being customer focused*', requires a local authority to communicate effectively with service users and to respond flexibly to their needs. I consider the Trust failed to adhere to this Principle in this respect.

103. I find this failure constitutes maladministration that caused the patient's family to lose the opportunity to take all possible steps available to them to visit the patient before he died. It also caused the patient's family, including the complainant, to sustain the injustice of upset at not being able to see the patient before he died.

Summary

104. I found the nursing care and attention the Trust provided to the patient (including the decision to transfer him to a side room) was reasonable, appropriate and in line with relevant professional standards. However, there was a failure in communication that caused the patient's family, including the complainant, to sustain injustice. Therefore, I partially uphold this element of the complaint.

CONCLUSION

105. I received a complaint about the care and treatment the Trust provided to the patient during the period 8 March 2020 to 30 March 2020.

106. The investigation established:

- The Trust's prescription and management of Semaglutide, and its consideration of it regarding the patient's hospitalisation and sad death, were reasonable, appropriate and in line with relevant standards.
- The Trust's decisions to put DNACPR notices in place for the patient, and its handling of those decisions, did not constitute failures in the care and treatment it provided to the patient in the circumstances. However, there was a record-keeping failure regarding its destruction of the first DNACPR form that constitutes a service failure. I found, however, this failure did not result in an injustice to the patient or the complainant.
- The nursing attention the Trust provided to the patient following his cardiac arrest and resuscitation was reasonable, appropriate and in line with relevant standards. However, there was a failure in communication which constitutes maladministration. This caused the complainant to sustain the injustice of uncertainty and frustration. It also caused the complainant to take the time and effort to bring her complaint to my office.

107. On foot of the above findings, I partially uphold this complaint.

Recommendations

108. I recommend the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (August 2019), for the injustices caused as a result of the failures identified within **one month** of the date of the final report.

109. I further recommend, for service improvement and to prevent future reoccurrence, that the Trust brings the contents of this report, and the learnings identified in it, to the attention of relevant staff in the Belfast Trust regarding the removal of DNACPR Notices and communication with patient families so they can reflect on the findings. In addition to these recommendations, I made observations I strongly urged the Trust to consider in its practice going forward.

110. Finally, I wish to pass on my condolences to the complainant, and her family, on the death of her father. Throughout my examination of this complaint I fully recognise the evident care, love and devotion shown by the complainant to ensure that her father received appropriate care and attention. I fully acknowledge the pain and distress her father's passing has had for the complainant. I hope that my report has gone some way to address the complainant's concerns and provide some reassurance for her and her family.

32. The Trust accepted my findings and recommendations.

MARGARET KELLY
Ombudsman
28 November 2024

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.