# Investigation of a complaint against the Northern Health & Social Care Trust

**Report Reference: 202003606**

The Northern Ireland Public Services Ombudsman
33 Wellington Place
BELFAST
BT1 6HN
Tel: 028 9023 3821
Email: nipso@nipso.org.uk
Web: www.nipso.org.uk

## 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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## SUMMARY

This complaint was about the Northern Health & Social Care Trust's (the Trust) care and treatment of the complainant's late father (the patient) during three periods of admission at Causeway Hospital between 20 April and 12 June 2022.

The complainant said the Trust did not inform the patient's family of its decision not to resuscitate the patient, in the event his breathing or heart stopped. She believed the Trust's decision to move the patient to different wards on multiple occasions during his admission was detrimental to his health and end-of-life experience. She questioned the way in which the Trust managed the patient's discharges from hospital and how it involved the family in the process. The complainant believed the Trust's actions contributed towards the patient's deterioration and eventual death in another hospital. The complainant also raised concerns about how the Trust managed and responded to her complaint.

The investigation identified a failure in care and treatment. Specifically, during his second admission to the hospital, the Trust did not appropriately inform the patient or his family of its decision not to resuscitate the patient, should his heart or breathing stop.

The investigation also identified two instances of maladministration. Specifically, the Trust did not ensure it provided clear information to the patient's family about the continued decision not to resuscitate the patient during his third admission; and the Trust did not manage the complaint in line with relevant guidance.

The investigation established that the Trust appropriately discussed the original decision about resuscitation with the patient and his son during the patient's first admission and appropriately managed each of the patient's discharges.

I partially upheld the complaint.

I recommended the Trust provides the complainant and her family with an apology for the injustices caused by the failure and maladministration. I made further recommendations for the Trust to address under an evidence-supported action plan.

I extend my deepest condolences to the complainant and her family for the loss of their father.

## THE COMPLAINT

1. I received a complaint about the actions of the Northern Health and Social Care Trust (the Trust) in relation to the care and treatment the Trust provided to the complainant's late father (the patient) at Causeway Hospital (the hospital) between 20 April and 12 June 2022.

### Background

2. The patient was an 83-year-old man with a medical history of prostate cancer, chronic heart disease and liver cirrhosis. He presented to the hospital's emergency department (ED) on 20 April 2022 following a referral from his GP. The patient was experiencing fatigue and shortness of breath, and his condition had deteriorated over the previous few weeks. Following assessment by ED clinicians, the Trust admitted the patient for further treatment. He remained in the hospital until 5 May 2022 when the Trust discharged him to his home address. During his stay in the hospital, the Trust moved him to different wards on several occasions.

3. The patient attended the ED again on 11 May 2022 with ongoing vomiting, increased weight loss and lethargy. The Trust admitted him for further treatment. He remained in the hospital until the Trust discharged him to a care home (the Home) on 27 May 2022. The Trust moved the patient from a surgical ward to a medical ward during his admission.

4. The patient returned to the ED on 2 June 2022 after his condition had deteriorated further, with increased frailty and fatigue. After assessing the patient in the ED, the Trust admitted him for further treatment on the morning of 3 June 2022. He remained in the hospital until 12 June 2022, when the Trust discharged him to the Home for rehabilitation. The Trust again transferred the patient between wards during his stay at the hospital.

5. The patient's condition continued to deteriorate, and he attended the ED at Antrim Area Hospital (AAH) on 18 June 2022. The Trust admitted him for further treatment, and he remained in AAH until 22 July 2022, when sadly he passed away.

**Issues of complaint**

6. I accepted the following issues of complaint for investigation:

**Issue 1: Whether the care and treatment the Trust provided to the patient was appropriate and reasonable? In particular, this considered:**

- The management of the 'Do not attempt cardiopulmonary resuscitation[1]' ('DNACPR') process, including communication and consultation with the patient's family;
- The movement of the patient within the hospital; and
- The management of the patient's discharges, including the decision to discharge, discharge planning, and communication and consultation with the patient's family.

**Issue 2: Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards?**

## INVESTIGATION METHODOLOGY

7. 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 handling of the complaint.

**Independent Professional Advice Sought**

8. After further consideration of the issues, I obtained independent professional advice from the following independent professional advisors (IPA):

- Consultant in Emergency Medicine, MBChB, MD, MPH, FRCEM. An active clinician in Emergency Medicine with approximately 20 years' experience as a Consultant working in this field. (ED IPA)
- Gastroenterologist and Hepatologist Consultant, MB ChB with Commendation, FRCP. A full time NHS consultant with over 13 years' experience as a Consultant in this field. (G IPA)

[1] The instruction to a healthcare team not to attempt to resuscitate a patient in the event their breathing or heart stops.

- Social Worker, BA Psychology Honours, Certificate of Qualification in Social Work, Diploma in Applied Social Studies, Practice Teaching Award (Social Work). A social worker for 34 years. (SW IPA).

I enclose the clinical advice received at Appendices three, four and five respectively.

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

**Relevant Standards and Guidance**

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

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

- The Principles of Good Administration
- The Principles of Good Complaints Handling

11. 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.

The specific standards and guidance relevant to this complaint are:

- British Medical Association, Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, 2016. (BMA Guidance on CPR);

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

- The Department of Health, Achieving Timely 'Simple' Discharge from Hospital – a Toolkit for the Multi-Disciplinary Team, August 2004 (DoH MDT Toolkit);
- The Department of Health Guidance: Ready to Go – Planning the Discharge and Transfer of Patients from Hospital and Intermediate Care, March 2010 (DoH Ready to Go Guidance);
- The Department of Health Guidance in relation to the Health and Social Care Complaints Procedure, April 2009 (DoH Complaints Procedure);
- The General Medical Council, Good Medical Practice, April 2013 (GMC Guidance);
- The General Medical Council, Treatment and care towards the end of life: good practice in decision making, July 2010 (GMC End-of-Life Guidance);
- The Northern Health and Social Care Trust Policy 20/1421: Managing Choice for Discharge from Inpatient Beds Protocol, March 2020 (Trust Choice for Discharge Policy);
- The Northern Health and Social Care Trust, Do Not Attempt Cardiopulmonary Resuscitation Policy, 2021 (Trust DNACPR Policy); and
- The Northern Health and Social Care Trust, Complaints and Service User Feedback Policy and Procedure reviewed September 2018 (Trust Complaint's Procedure).

Relevant sections of the guidance considered are enclosed at Appendix six to this report.

12. I did not include all the information obtained in the course of the investigation in this report, but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

13. 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.

## THE INVESTIGATION

### Issue 1: Whether the care and treatment the Trust provided to the patient was appropriate and reasonable?

*The management of the 'DNACPR' process*

**Detail of complaint**

14. The complainant said the Trust did not inform the patient's family of its decision to apply a DNAPCR instruction on 23 April 2022 as part of the patient's treatment plan. She said the family did not become aware of the DNACPR until the Home staff told the patient's sons on 16 June 2022. She also said the patient had hepatic encephalopathy[3] (HE) and '*barely engaged*' in conversation in hospital. It was therefore '*inappropriate*' for the Trust to claim he was involved in discussions about applying the DNACPR as he lacked capacity.

**Evidence Considered**

**Legislation/Policies/Guidance**

15. I considered the following guidance:
    - the BMA Guidance on CPR;
    - the GMC Guidance
    - the GMC End-of-Life Guidance; and
    - the Trust DNACPR Policy.

**The Trust's response**

16. The Trust stated the following: - it had '*documented discussions*' with the patient on 23 April 2022 about DNACPR and the '*pros and cons*' of the decision and '*it was agreed*' he was not for resuscitation. In relation to his capacity for decision making, the patient was '*alert and orientated*'. Medical staff updated

[3] An altered level of consciousness caused by build-up of toxins in the body due to liver failure.

the patient's son on his condition '*later that day*' and explained the patient was not for resuscitation, but '*maximum ward management*'. The patient's son was '*happy*' with the update and had '*no more questions*.'

17. The Trust further stated, when it readmitted the patient to the hospital on 3 June 2022, staff discussed '*end of life care*' with his family who agreed with the approach. It referenced the '*summary of communications with patient and relatives*' section of the DNACPR form completed at that time, which recorded '*agrees CPR is not in best interest due to multiple co-morbidities'.*

**Relevant Independent Professional Advice**

20 April 2022 admission

18. The G IPA provided the following advice. The Trust's decision to apply DNACPR was '*correct and appropriate*'. The Trust applied the '*relevant criteria*' when making its decision. It discussed and agreed the DNACPR decision with the patient on 23 April 2022. The patient had HE; therefore, his capacity could '*fluctuate*'. However, there was '*no evidence*' to support the complainant's view that he '*lacked capacity*' at the time the discussion took place. Later that day, the Trust '*explained*' the DNACPR decision to the patient's son who was '*in agreement*'. This approach was '*appropriate*'. While DNACPR are medical decisions, the responsibility for which lies with the medical team, '*it is always expected*' that such decisions are communicated with the family and the next-of-kin. The family and patient have a '*significant role*' in '*guiding*' the decision-making process.

19. The ED IPA advised there was '*no suggestion*' the patient lacked the capacity to make the DNACPR decision on 23 April 2022. He also advised that the Trust '*subsequently*' had the discussion with the patient's son as '*next of kin*'.

11 May 2022 admission

20. The ED IPA provided the following advice. The patient's notes contain an '*incomplete*' DNACPR document dated 12 May 2022. The document contained '*no details*' of a discussion with the patient, his family, or the Multi-Disciplinary

Team (MDT) '*which should be present*'. The Trust's decision making was '*not documented*'. The clinician who completed the document had not signed it, nor was it countersigned by a senior clinician. It was '*impossible to know*', therefore, if the Trust's decision was '*appropriate*' as its previous discussion with the patient and his son may no longer have been '*valid*'.

21. The G IPA advised that the DNACPR decision should be reviewed '*on every admission*', but that it was reasonable to have continued the decision during the 11 May 2022 admission due to the patient's '*gradual decline*'. However, there was an opportunity for the Trust to have '*re-iterated*' its decision to the family, which it did not do.

3 June 2022 admission

22. The G IPA provided the following advice. The patient attended hospital due to liver failure and '*confusion*' because of HE. The original DNACPR decision '*was not discussed again*' during admission, nor when it discharged the patient to the Home. While the decision to continue with the DNACPR was '*appropriate*', the Trust should have re-iterated the decision to the family to '*ensure understanding*'.

23. The ED IPA advised the medical file contained a DNACPR form dated 3 June 2022 but which the Trust had not '*fully*' completed. The section for summarising communication with the patient was '*blank*'. The form details there was communication with relatives, however it does not detail '*which relative or when this occurred'.*

**Responses to the Draft Investigation Report**

24. The complainant and the Trust were given an opportunity to provide comments on the Draft Investigation Report. The responses to the draft of this report have been considered and, where appropriate, comments have been reflected in the report or changes have been made.

*The complainant's response*

25. The complainant disputed that the patient and his son were appropriately informed about the DNACPR. She referenced the Home's records which document the patient and his family stated they did not know anything about the DNACPR. The complainant queried what steps the Trust takes to ensure such decisions are understood by patients and their families.

26. The complainant said it is important that the Trust should check that patients and their families understand the implications of a DNACPR, particularly as patients and family members *'will have a range of cognitive abilities and a 'one size fits all' approach*' is therefore not effective.

*The Trust's response*

27. The Trust acknowledged that the DNACPR, related to the patient's admission of 11 May 2022, was not fully completed. However, it stated there was evidence of *'extensive'* communications about the DNACPR, which IPA advice recognised. The Trust also referenced the GMC Guidance. It stated this stipulates that, whilst discussion about DNACPR with patients and family is good practice, a DNACPR instruction is a medical decision. The Trust queried that the issues with the DNACPR during the patient's second admission, identified in the investigation, were failures in care and treatment. It stated this was a failure in records; therefore, this issue of complaint should not be upheld.

**Further Investigation Enquiries Following Draft Investigation Report Responses**

28. To address the complainant's concerns about how the Trust ensures patients and their families understand DNACPR discussions and associated decisions, we undertook further enquiries. The Trust referenced the Trust DNACPR Policy '*which describes'* such discussions.

**Further Independent Professional Advice Following Draft Investigation Report Responses**

29. Further to the complainant and the Trust's comments on the Draft Investigation Report, the G IPA provided further advice about the Trust's communications with the patient's family about the DNACPR. The further advice is included at Appendix three.

**Analysis and Findings**

20 April 2022 admission

30. I reviewed the patient's medical records in which the following are documented. On 21 April 2022, the patient was '*alert and orientated*' and '*able to talk in full sentences*.' On 23 April 2022, the patient's consultant discussed DNACPR with him. The patient '*agreed not for resuscitation*' after discussing the '*pros and cons*'. On 23 April 2022, a doctor discussed the patient's medical issues with his '*NOK*'[4], which was his son and explained the patient was '*not for resuscitation*'. The patient's son was '*happy for update*' and had '*no more questions.*' On 25 April 2022, the patient was '*alert and orientated*'.

31. The notes clearly document the Trust discussed its DNACPR decision with the patient on 23 April 2022. Although these do not document if doctors assessed the patient's cognitive function on that day, the records evidence he was alert and orientated shortly before and after this date. I note the advice of the ED and G IPAs that there was no evidence to suggest the patient lacked capacity when the consultant discussed the DNACPR decision with him. I acknowledge the G IPA's advice that, as the patient had HE, his capacity could '*fluctuate*'; however, on the balance of probabilities, I am satisfied the patient had capacity when his consultant discussed the DNACPR issue with him. I am also satisfied the Trust explained this decision to the patient's next of kin, his son, on the same date and that he accepted the decision.

32. I refer to the BMA Guidance on CPR which states: *'when a person with*

[4] Next of kin

*capacity is at foreseeable risk of cardiac or respiratory arrest, they should be offered information about CPR, about the local resuscitation policy and services, and about their role in decision-making in relation to CPR. In order to determine whether the benefits of CPR would be likely to outweigh the harms and burdens, or whether the level of recovery expected would be acceptable to the patient*.' Similarly, if a patient does not have capacity this guidance states '*whether the benefit would outweigh the harms and burdens for a particular patient must be the subject of discussion and agreement between the healthcare team and whenever possible those close to or representing the patient*'

33. I refer to the Trust DNACPR Policy. I note this states the following: -

*'Neither patients nor those close to them can demand treatment that is clinically inappropriate. Where such demands are made, open honest and frank discussions must take place and be documented …*
*A DNACPR decision will usually only be made after discussion with the patient and their relevant others (unless the patient has requested confidentiality). Any discussion with the patient or their relevant others regarding resuscitation must be documented on the appropriate Trust DNACPR form. If the relevant others are not present for the discussion, they should be informed of the outcome within 24hrs (unless the patient has requested confidentiality) …*

*If the … patient [does] not have capacity to make decisions, the decision not to resuscitate shall be made using a multi-disciplinary team approach, with the best interests of the patient as the only objective. The views of any relevant others should be taken into account, where possible. However, it must be understood that, in the case of an adult, no other person apart from the patient can give or refuse consent to treatment.*

*The overall responsibility for decision-making rests with the consultant/general practitioner in charge of the individual patient's care. In the absence of the treating consultant/general practitioner, an appointed medical deputy may make decisions … Information should be provided in a manner and format which the*

*patient understands …*

*A decision not to resuscitate must be recorded in the medical notes as soon as possible after admission, stating the reasons for the decision. If the patient was not consulted this should also be recorded, together with the reasons for not having done so. Specific forms are available for recording DNACPR decisions. The DNACPR decision must be recorded on a Trust DNACPR form …*

*A completed DNACPR form in the medical records is to be regarded by all staff as the current authoritative statement. It is therefore imperative that this record is reviewed and kept up-to-date. Reviews should be recorded on the DNACPR form.'*

34. I refer to the complainant's comments about ensuring patients and their families understand the implications of a DNACPR when the Trust discusses this. I note the G IPA's further advice in which he reiterated the Trust discussed the DNACPR of 23 April 2022 with the patient and his son. Whilst I acknowledge the Home's records later document the patient and his son appeared to be unaware of the DNACPR, I consider the contemporaneous records of 23 April clearly demonstrate the Trust discussed this with both the patient and his son at that time. In consideration of the clinical records, the relevant guidance and the IPAs' advice, I am satisfied the Trust appropriately discussed and explained the issue of DNACPR with the patient and his next of kin on 23 April 2022.

35. In relation to the complainant's comments about the patient and his son's ignorance of the DNACPR during the patient's residence at the Home from 12 June 2022, I refer to my findings related to the DNACPR of 12 May and 3 June 2022 below.

11 May 2022 admission

36. The patient's medical records document a Physiotherapist (Physio) and Occupational Therapist (OT) separately assessed the patient on 12 May 2022. The Physio documented the patient was '*A+O*' (alert and orientated). The OT carried out a cognitive assessment on the patient and scored him '*34/35*'.

37. The records further document a clinician completed a DNACPR form on 12 May 2022. The question '*does the patient have capacity to make and communicate decisions about CPR?*' has been circled '*Yes*'. The next section lists the patient's medical issues and states there was a '*previous DNACPR*' as a rationale for why '*CPR would be inappropriate*'. The clinician did not complete the sections on communication with the patient, communication with the patient's relatives and the members of the MDT contributing to the decision. The clinician who completed the order has not signed or dated the form. I note the nursing notes from 15 May 2022 document the requirement for medical staff to '*properly complete*' the DNACPR form. However, there is no evidence of a fully completed DNACPR form in the records.

38. The medical records document a consultant '*updated*' the patient's son on 15 May 2022. On 17 May 2022, a doctor spoke to the complainant and advised her of the patient's clinical issues and that he might be approaching end-of-life. However, there was no evidence in the records that the specific issue of DNACPR was ever addressed with the patient or his family at this time.

39. The BMA Guidance on CPR states, in the event of a DNACPR decision where CPR will not be successful and a patient has capacity, '*there should be a presumption in favour of patient involvement and that there needs to be convincing reasons not to involve the patient'.* When patients lack capacity, this guidance states: '*those close to that person must be informed of this decision and of the reasons for it, unless this is contrary to confidentiality restrictions expressed by the patient when they had capacity*'.

40. I note the GMC Guidance states, '*clinical records should include … the decisions made and actions agreed, and who is making the decisions and agreeing the actions [,] the information given to patients'.* The Trust DNACPR Policy states, '*any discussion with the patient or their relevant others regarding resuscitation must be documented on the appropriate Trust DNACPR form. If the relevant others are not present for the discussion, they should be informed of the outcome within 24hrs (unless the patient has requested confidentiality) … If the patient was not consulted this should also be recorded, together with the reasons for not having done so.'*

41. I also note the GMC Guidance states, *'you must give patients the information they want or need to know in a way they can understand … You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'.*

42. I note the G IPA's advice, while it was an '*appropriate*' decision for the Trust to have continued with the DNACPR, it had opportunities to '*re-iterate*' its decision to the family. I note the ED IPA's advice the Trust's original discussion with the patient and his son may no longer have been '*valid*'.

43. I refer to the Trust's comments on the Draft Investigation Report. I note the G IPA's further advice that, although the Trust engaged with the patient's family throughout his admissions, these communications *'do not correlate with the DNACPR decisions for the second admission and are unclear for the third admission'*. Further, the Trust DNACPR Policy requires review and update of an existing DNACPR but '*it is not clear the reviewed/new DNACPRs were communicated to the patient and his family'.*

44. I consider there is no evidence the Trust discussed, explained or re-iterated the review and update of the DNACPR to the patient and his family during his admission between 11 and 27 May 2022. I consider this does not accord with either the BMA Guidance on CPR, the Trust DNACPR Policy or the GMC Guidance. I consider this constitutes a failure in care and treatment.

45. I refer to the complainant's comments that the Home's records of 12 and 16 June 2022 indicate that neither the patient nor his son knew about the DNACPR. Although the Trust's communication of the original DNACPR on 23 April 2022 to the patient and his next-of-kin is evidenced, I consider it is reasonable to conclude that the Trust's failure to communicate the second DNACPR decision correlates with the patient and his son's lack of awareness of the renewed decision.

3 June 2022 admission

46. The patient's nursing records document, at 07.30 on 3 June 2022, a nurse noted the patient was '*not able to comprehend information*.' The medical

records further document a doctor's note from 09.41 on 3 June 2022 that the patient had a '*poor verbal response*' and was '*not obeying commands*'. I note the G IPA's advice the patient attended the hospital due to '*confusion*'. The records also document a clinician completed a DNACPR form on 3 June 2022. The question '*does the patient have capacity to make and communicate decisions about CPR?*' has been circled '*No*'. The section on communication with the patient's relatives states '*agrees that CPR not in best interest due to multiple co-morbidities'*.

47. The patient's management plan from a medical review on 3 June 2022 listed '*DNACPR*' and '*D/W* (discuss with) *family/NOK*'. The management plan subsequently indicated the Trust contacted his next of kin who '*agree*[d] *approaching EOL*' (end-of-life). The nursing notes document a nurse '*updated*' the patient's son at 15.00 and again at 18.30 on 3 June 2022 but the nurse did not record the details of the update. It is unclear if the nurse addressed the issue of DNACPR during the call. I reviewed the patient's records and there is no evidence that the Trust raised the issue of DNACPR at any subsequent stage of his admission between 3 and 12 June 2022.

48. I examined the patient's records from the Home following his discharge from the hospital on 12 June 2022. The Home staff noted a DNACPR '*in situ'* and spoke to the patient who told the Home staff, he '*didn't know what it was and hadn't heard tell of it*' and staff were '*to forget about it*'. The Home records further document, on 16 June 2022, the Home staff spoke to the patient's sons about the DNACPR order who informed the Home staff that they were '*not aware of it*' and they did not '*want it in place*'.

49. Having reviewed the patient's records, it is apparent doctors did not inform the patient of the DNACPR order during his admission between 3 and 12 June 2022. However, I note when the Trust put the DNACPR order in place, it did not consider the patient had capacity to discuss the issue. Having reviewed the medical records and the G IPA's advice I consider, on the balance of probabilities, the patient did not have capacity at that time.

50. I note the BMA Guidance on CPR states, if the patient lacks capacity to discuss the DNACPR decision, '*those close to that person must be informed of this decision and of the reasons for it'.* I also refer to the Trust DNACPR Policy which states*, 'the views of any relevant others should be taken into account, where possible'*. The GMC Guidance states*, 'you must be considerate to those close to the patient and be sensitive and responsive in giving them information and support'.*

51. The Trust DNACPR Policy states, '*any discussion with the patient or their relevant others regarding resuscitation must be documented on the appropriate Trust DNACPR form. If the relevant others are not present for the discussion, they should be informed of the outcome within 24hrs (unless the patient has requested confidentiality).'*

52. It is unclear from the medical records if the Trust discussed the third DNACPR decision with the patient's family. I am therefore unable to definitively conclude if, on this occasion, the Trust acted in accordance with the relevant guidance. However, I note the G IPA's advice the Trust had the opportunity to re-iterate the decision to the family to '*ensure understanding*'. Further, I refer to the complainant's comments about the documented discussions at the Home with the patient and his son, later in June 2022. I consider these indicate at least a lack of understanding that there was a DNACPR in place at that point. I consider this does not accord with the third Principle of Good Administration, '*Being open and accountable'* which requires public bodies to ensure '*information, and any advice provided, is clear, accurate and complete'.* Therefore, I consider this maladministration.

Summary

53. Having considered the medical evidence, the relevant guidance and both IPAs' advice, I am satisfied the Trust appropriately discussed the DNACPR decision with the complainant and his family during his first admission, between 20 April and 5 May 2022.

54. I was unable to conclude if, having established the patient lacked capacity, the

Trust discussed the second DNACPR decision with his family during his admission which commenced on 3 June 2022. However, I am satisfied the Trust did not provide clear information to the patient's family about this decision to ensure understanding. I am satisfied the Trust did not act in line with the third Principle of Good Administration and this, therefore, is maladministration.

55. I am also satisfied that the Trust did not discuss the issue with the patient or his family when it completed a DNACPR decision during the patient's admission between 11 and 27 May 2022.

56. The GMC Guidance states, '*all patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able to. You must start from the presumption that all adult patients have capacity to make decisions about their treatment and care*'. It requires doctors to '*give patients the information they want or need in a way they can understand. This includes information about*: … *the options for treating or managing the condition(s), including the option to take no action … the potential benefits, risks of harm, uncertainties about, and likelihood of success for each option*.' Further, the GMC End-of-Life Guidance clearly states, for those patients who lack capacity, clinicians are required to '*consult with those close to the patient…take account of their views about what the patient would want and aim to reach agreement with them'*.

57. I refer to my findings at paragraphs 34, 44 and 45 and 52 to 56; therefore, I partially uphold this element of the complaint.

*Injustice*

58. I considered carefully whether the failures identified caused the patient and his family injustice. I consider, in relation to the failure in care and treatment of not discussing the DNACPR with the patient and his family in May 2022, they sustained the injustice of the loss of opportunity to be involved in discussions about the Trust's decision to apply DNACPR orders. In relation to the Trust's failure to provide clear information to the patient's family in June 2022 about the continued DNACPR, I consider the patient's family sustained the injustice of the

loss of opportunity to fully understand the Trust's decision.

*The movement of the patient within the hospital*

**Detail of Complaint**

59. The complainant had concerns about the Trust's movement of the patient to a different ward on '*multiple occasions*' during his admissions to the hospital. She also said the Trust '*often*' placed the patient in a different ward to the one in which his '*overall*' consultant was based. She was concerned about the impact the moves had on his '*health and end of life experience*'.

**Evidence Considered**

**Legislation/Policies/Guidance**

60. I considered the following guidance:
    - GMC Guidance.

**The Trust's response**

61. The Trust stated, due to daily '*bed pressures*' it was '*not always possible*' to admit patients to a consultant-based ward. However, it '*tried*' to reduce the number of transfers a patient may undergo when in hospital.

**Relevant Independent Professional Advice**

62. The G IPA advised, when a patient is admitted to hospital via the ED, a hospital may not have an available bed on the '*desired speciality ward*' for a '*variety of reasons*'. Further, moves within a hospital were '*unfortunately a necessity of hospital bed capacity*'. The G IPA considered each of the patient's three admissions and advised, on each occasion, the patient experienced no '*apparent harm*' or '*impact*' from the transfers. The handover sheets were '*adequate*', or '*acceptable*', the medical reviews were '*consistent*' and the care '*appropriate*'.

63. The ED IPA advised that multiple movements within a hospital can lead to '*poor patient experience*' and '*potential loss*' of continuity of care. However, in the

patient's case, the handover was '*appropriate*'.

**Analysis and Findings**

64. I examined the patient's medical records for each admission. On his second admission on 5 May 2022, the Trust appears to have transferred the patient once between surgical one ward and medical two ward. On his third admission on 3 June 2022, the patient spent most of his stay in the Medical Assessment Unit before the Trust transferred him to a surgical ward for discharge planning. In considering this element of the complaint, I have therefore focused on the patient's first admission on 20 April 2022. I wish to highlight that the records for the patient's first admission were in poor order and it was often difficult to keep track of the patient's transfers. However, it is clear from the time of his admission, the patient underwent multiple moves within the hospital. I note the ED IPA's advice that multiple moves can lead to a '*poor patient experience*'. Although there is no record of the patient's reaction to the transfers, I consider it reasonable to conclude, given the frequency with which the Trust moved him, the patient found the experience unsettling.

65. I examined the patient's clinical notes which document medical staff reviewed or assessed him on 24 occasions during his first admission. In addition, hospital therapists also carried out reviews and assessments. The medical notes document clear treatment plans and a continuity of care. There were also regular reviews led by the consultant overseeing the patient's care, as well as other senior clinicians. I acknowledge the complainant's concerns about the number of moves. However, I accept the G IPA's advice the Trust's reviews were '*consistent*', the care it provided was '*appropriate*' and the patient experienced no '*apparent harm*'.

66. The GMC Guidance requires doctors to '*promptly share all relevant information about patients (including any reasonable adjustments and communication support preferences) with others involved in their care, within and across teams, as required*'. It also states, '*if patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should first protect patients and put the matter right if that's possible*'. Having reviewed the

medical records and considered the relevant guidance, I accept the G IPA's advice.

67. While I acknowledge that multiple moves within the hospital, especially during the first admission, would have been a poor experience for the patient, the care the Trust provided appears to have been reasonable and appropriate. I acknowledge the ED IPA's advice that multiple moves can lead to a *potential loss*' of continuity of care; however, there is no evidence in the patient's records to suggest he suffered any detriment from the transfers. On this basis, I do not uphold this element of the complaint.

*The management of the patient's discharge on each of the three occasions*

**Detail of Complaint**

68. The complainant raised several issues connected to the Trust's decisions to discharge the patient from the hospital on 5 and 27 May and 12 June 2022. The complainant said the Trust '*decided*' to discharge the patient to his home address without a care package on 5 May 2022. She said, after his readmission on 11 May 2022, she spoke to the Trust and asked that it stop the '*cycle of discharge and readmission*'. She said the Trust '*ignored*' her request and discharged the patient to the Home on 27 May and 12 June 2022. Shortly after the last of these, he was admitted to hospital again, where he passed away. The complainant believed, overall, the Trust's Social Work Team did not discuss the patient's care arrangements with the family, but instead '*informed*' the family what the Trust was going to do. She also believed her father was not '*competent*' to '*agree*' with the discharge planning and subsequent care.

**Evidence Considered**

**Legislation/Policies/Guidance**

69. I considered the following guidance and policies:
    - MDT Toolkit;
    - Ready to Go Guidance; and
    - Trust Choice for Discharge Policy

**The Trust's response to Investigation enquiries**

70. The Trust stated the following: - the patient's consultant decides when a patient no longer needs consultant-led care in an acute setting. At this stage, Social Workers, '*based within the ward,*' will commence discharge planning. The Social Worker '*liais[ed]*' with the patient's next-of-kin. The patient and his sons '*were in agreement*' with the discharge plan to the Home on 12 June 2022. The complainant did not agree with the discharge decision; however, a member of the medical team spoke to her and advised her the patient '*had capacity to make an informed decision*' and the discharge proceeded as planned. The patient's health was deteriorating '*gradually*'. He experienced acute episodes and, when these occurred, he was admitted to hospital. Once the Trust had treated the acute episodes it discharged him. '*Unfortunately*', because of his health issues, the patient required '*frequent*' admissions to hospital for acute care. The Trust did not specifically address the other discharges.

**Relevant Independent Professional Advice**

71. The G IPA advised discharge decisions were '*complex*', often involving a multidisciplinary approach and input from the patient and family. There was '*no guarantee*' a discharge would not result in readmission, '*particularly*' if someone is frail with an '*irreversible*' clinical condition like the patient. The G IPA confined his advice to the '*medical aspects*' of the Trust's decisions to discharge the patient.

72. The G IPA provided the following advice. On 5 May 2022, the date of the first discharge, the patient's clinical condition had '*improved*' and his observations had '*stabilised*'. The Trust's decision to discharge him was '*appropriate*'.

73. The G IPA advised the '*timing*' of the Trust's decision to discharge the patient on 12 June 2022 was '*appropriate*'. The Trust carried out '*regular*' physiotherapy assessments and reviews and his observations and clinical condition were '*stable*'.

74. The SW IPA provided the following advice. In relation to the discharge on 5 May 2022, the Hospital Social Worker (HSW) met the patient and his son on

two occasions and discussed '*potential discharge*' arrangements. The HSW identified a plan of care for the patient; however, he '*must have rejected*' this plan though the notes are not '*absolutely clear*' on this issue. The Trust had assessed the patient as '*largely independent*' and the HSW agreed with the patient's son that he would support the patient following the discharge to his home address. There was '*nothing to suggest*' the patient lacked capacity at the discharge planning stage, and it was '*his choice*' to return home without a care package.

75. In relation to the discharge on 12 June 2022, the SW IPA provided the following advice. The HSW met with the patient and his son on the ward on 11 June 2022. The family '*were agreeable*' for the Trust to discharge the patient to the Home. The HSW spoke to the complainant by telephone. The complainant was unhappy with the decision and the HSW '*paused*' the discharge so the complainant could speak to the medical team. The medical team then spoke to the patient and his son, who both confirmed they were happy for the Trust to discharge the patient to the Home. A doctor subsequently spoke to the complainant and informed her the discharge would proceed.

76. The SW IPA advised there '*was evidence*' the HSW liaised '*appropriately*' with the patient and his son. She took '*appropriate action*' by pausing the discharge to allow the complainant to speak to medical staff about her concerns.

77. The SW IPA concluded, the Trust '*appropriately planned*' these discharges and considered the '*patient's wishes*'. The Trust also included the patient's sons in discussion about the discharges, who raised '*no concerns*.'

**Responses to the Draft Investigation Report**

78. The complainant challenged the Trust's assessment that, when planning the patient's discharge from his first admission, the patient was *'independent'*. She said the patient's health was deteriorating and he was not able to remain at home. He required rapid readmission to the hospital; therefore, he *'clearly did not 'do even better at home''.* The complainant said the patient '*would have agreed to anything in order to be at home';* consequently, he did not have the capacity to make informed decisions about what was in the best interests of his

health. The complainant also queried the management of the patient's discharge on 27 May 2022.

**Further Investigation Enquiries Following Draft Investigation Report Responses**

79. The Trust provided a response to further enquiries about how it considers and balances a patient's desire to return home with the level of their independence, and consequently, their informed capacity to make such a decision in the best interests of their health. The Trust reiterated, when a patient is deemed to be medically fit to be discharged from an acute setting, it will explore discharge options. Further, when a patient has the cognitive capacity to make an informed decision and wishes to return home, the Trust is required to respect that decision and '*work towards this goal, considering all potential risks and ways to minimalise any such risks'.*

**Further Independent Professional Advice Following Draft Investigation Report Responses**

80. Further to the complainant's comments on the Draft Investigation Report, the G IPA provided further advice about the patient's discharge on 27 May 2022. This further advice is included in Appendix three.

**Analysis and Findings**

Fitness for discharge

81. I examined the patient's medical records for his admission between 20 April and 5 May 2022. The records document the following: an OT who assessed the patient on 3 May 2022 found he '*appears to be at baseline*' and that he did not require any additional '*acute OT'*. On 5 May 2022, a doctor reviewed the patient on the ward. The patient reported '*feeling well, no new complaint*s.' The discharge summary noted the patient's '*inflammatory markers have improved…fit for discharge*'. I note the G IPA's advice the patient's clinical condition had improved at the point of discharge.

82. The patient's records indicate the HSW completed a NISAT assessment on 14 May 2022, in which she determined the patient required additional support. The records also indicate an OT, a physio, nursing and medical staff contributed to the patient's assessment for discharge. I note the G IPA's advice the Trust discharged the patient following an MDT assessment which was '*the correct approach'.* Further, the Home was suitable both for the rehabilitation the patient required and because the HSW's NISAT assessment described the patient as '*struggling'* at home. The G IPA advised that the patient *'was medically fit for discharge from the acute hospital setting … he did not require acute hospital care at this point'.*

83. I reviewed the patient's medical records during his admission between 3 and 12 June 2022 which document the Trust carried out medical, physio, OT and dietetic assessments. The assessments document an improvement in the patient's condition over the course of his admission. The notes also document a conversation between a clinician and the complainant (undated) in which the clinician advised the complainant that the patient's condition was *'progressively declining*' and he might require '*admission*' if he deteriorates '*in the community*'. I note the G IPA's advice that the patient's observations and clinical condition were '*stable*'.

84. I refer to the MDT Toolkit which states '*the patient is fit for discharge when physiological, social, functional and psychological factors or indicators have been taken into account following a multidisciplinary assessment if appropriate…the patient who is fit for discharge no longer requires the services of acute or specialist staff within a secondary care setting*'.

85. Having considered the patient's medical records and the relevant guidance, I accept the G IPA's advice and I am satisfied the patient was medically fit for discharge on each occasion; therefore, the decision to discharge was appropriate.

Discharge planning and communication

86. I examined the patient's social work records for his admission between 20 April and 5 May 2022. The records document the following: on 30 April 2022, the HSW recorded the patient was '*not keen*' on a package of care upon discharge. The HSW telephoned the patient's son to discuss bringing the patient's bed downstairs as the Trust had not carried out a stair assessment at that time. The notes document the patient's son spoke to the patient about what support the family could provide if the patient decided he wanted discharged with a package of care. However, on 1 May 2022, the HSW recorded that there was '*no package of care available*' and spoke to the complainant about the patient's requirements once discharged. The HSW noted an OT assessment indicated the patient could be independent in relation to some food preparation, but he would also require carers as he had not been eating or taking his medication. The HSW noted the patient's requirements which could be '*reviewed by Community SW Team*'. On 4 May 2022, the HSW discussed the '*downstairs arrangement*' for his discharge home '*with patient and family'*.

87. The social work records further document that the MDT assessed the patient as '*independent*'. The HSW offered the patient a '*contingency bed*' as a full care package was not available on discharge. The patient refused. He was '*keen to return home*', where he would '*do even better*'. The HSW spoke to the patient's son who agreed to provide support with medication and meals '*as required*'. I note the SW IPA's advice there was nothing to suggest the patient lacked capacity to be involved in the discharge planning process and the Trust '*appropriately planned*' the discharge.

88. There were no detailed social work records for the patient's discharge of 27 May 2022 other than the NISAT assessment and the discharge referral to the Home.

89. I reviewed the patient's social work records for his admission between 3 and 12 June 2022. The records document the following: the HSW introduced herself to the complainant on 8 June 2022; he was '*sleepy*' and '*not keen to talk'*. The HSW noted, on 10 June 2022 following physio and OT assessments, she had referred the patient for a '*rehab bed*' and, on 11 June 2022 noted a bed was

available in the Home. The HSW met with the patient and his son on 11 June 2022 to discuss discharge to the Home. The patient's son was '*agreeable*' to the discharge to the Home and informed the HSW that the complainant also wanted to speak with her. The HSW spoke to the complainant by telephone. The complainant said she did not think it was '*appropriate*' to discharge the patient to the Home as she was '*98% certain*' he would be readmitted again.

90. The social work records document the HSW '*paused*' the discharge so the medical team could answer the complainant's '*questions*'. The HSW discussed the situation with the patient and his son. The HSW explained that, once the medical team spoke to the complainant, the family could make an '*informed decision*' on the discharge. On 12 June 2022, the HSW recorded a consultant had spoken to the complainant and had informed the complainant that, if the patient and his son were happy with the discharge plan to the Home, the discharge could proceed. The consultant '*confirmed*' the discharge with the patient and his son. I note the SW IPA's advice the HSW '*appropriately*' liaised with the patient and his son and took '*appropriate action*' by pausing the discharge to allow the complainant to speak to medical staff about her concerns.

91. I refer to the Trust Choice for Discharge Policy which requires Trust staff to '*consult with the affected patient and his/her relative or carer in respect of future care arrangements following discharge from hospital*'.

92. I refer to the Ready to Go Guidance which states, when a patient has complex needs, the Trust should involve the patient and any carers in discharge decisions so that patients and carers can make '*informed decisions and choices*' regarding discharge. It states the Trust should *'involve patients and carers in all stages of care planning'.*

93. Having considered the patient's medical and social work records and the relevant guidance, I accept the SW IPA's advice. I am satisfied the Trust appropriately planned the patient's discharge on 5 May and 12 June 2022 and involved the patient and his family in the process. I acknowledge the complainant's objection to the Trust's decision to discharge the patient;

however, it is evident for the discharges on 5 May and 12 June 2022, the HSW and the medical team obtained consent from the patient and his son before confirming the discharge.

94. I refer to my finding at paragraph 85 above. Although I am satisfied the Trust's decision to discharge the patient on 27 May 2022 was appropriate, and the Home was an appropriate placement for the patient's needs at that time, in the absence of detailed HSW records, I am unable to conclude whether the Trust's discharge planning and associated communications with the patient and his family were appropriate for this discharge.

Summary

95. I am satisfied the Trust's decisions to discharge the patient on each of the three occasions were appropriate. I am also satisfied the discharges of 5 May and 12 June 2022 followed the relevant guidance for discharge planning and communication. I am unable to determine whether the discharge planning and communications for the discharge of 27 May 2022 were appropriate. Therefore, I do not uphold this issue of complaint.

*Residual Issue*

96. Although the length of time the patient spent in the ED on 20 April 2022 is not a matter the complainant raised in bringing her complaint to me, it is important I highlight it in this report, particularly in the context of the ED IPA's advice. Specifically, 'o*verall the care given in ED falls below a reasonable standard… the patient waited approximately 9.5 hours from presentation to being met by a treating nurse and moved into a clinical area from the waiting room. This waiting time was not appropriate as a triage category 3 should be seen within 1 hour and as with all cases, assessment & treatment & admission, if required, should be completed within 4 hours.'*

97. I acknowledge the difficulties the Trust faces in meeting timeframes within the ED, particularly given the current pressures it faces. However, I do not consider it acceptable that an elderly, chronically ill patient must wait over nine hours in a waiting room before being moved to a clinical area. I am concerned that this issue continues to be a feature in complaints to my office. While I acknowledge

that Trust staff try, where possible, to make patients and their families awaiting assessment and admission comfortable, the ED waiting room is not an environment designed for a nine-hour stay. It is my expectation the Trust will give careful consideration to this matter.

**Issue 2**: **Whether the complaints handling by the Trust was appropriate and in accordance with relevant standards**

**Detail of complaint**

98. The complainant said the Trust's response to her complaint was '*incomplete and factually inaccurate'.* She also believed the response did not sufficiently address the impact of the Trust's actions on the patient's '*health and end of life experience*'.

**Evidence Considered**

**Legislation/Policies/Guidance**

99. I considered the following guidance:
    - Trust Complaints Policy.

**The Trust's response**

100. The Trust acknowledged it had not met the '*recommended timeframes*' in responding to the complaint. It stated it had suffered '*immense pressures*' over the previous three years and apologised '*again*' to the complainant for the delay.

**Trust Records**

101. I reviewed the Trust's complaint file. The records document the complainant first submitted an email to the Trust informing that she wanted to find out about the '*medical situation*' of a family member undergoing treatment in Causeway Hospital. She sent a written enquiry to the Trust on 18 June 2022 regarding the Trust's DNACPR policy. The Trust issued a consent form on 21 June 2022, which the complainant returned on 21 July 2022. The Trust provided its response on 3 August 2022. The complainant reverted to the Trust on 20

August 2022 expressing her dissatisfaction with the response. She noted the Trust had taken '*58 days*' to provide a response to her complaint. She said the Trust had not provided specific information in its response. She also raised several other issues she wanted the Trust to consider. The Trust acknowledged the complainant's letter on 22 August 2022, informing her it would investigate the matters she had raised and respond as quickly as possible. The complainant contacted the Trust again on 21 September 2022, noting it had not responded to her and requested the Trust escalate her complaint. The Trust did not acknowledge or respond to the complainant's email and made no further contact with the complainant until it sent its final response on 29 November 2022, some two months later.

**Responses to the Draft Investigation Report**

*Complainant's Response*

102. The complainant said the Trust's responses did contain factual inaccuracies. Specifically, she referenced the SW IPA's advice that information the Trust provided about the patient's transfers within the hospital and his discharges was inaccurate. The complainant said, *'this undermines trust and confidence*'.

**Analysis and Findings**

103. In its final response letter to the complainant, dated 29 November 2022, the Trust apologised for the delay in responding to the complainant's '*initial complaint*' as the complaints manager had been on sick leave. I note it did not acknowledge that it had not contacted or updated the complainant since 22 August 2022.

104. The Trust Complaints policy requires that *'if it has been identified that there will be a delay in the response being prepared or forwarded within the 20 working days it is important that the relevant Directorate Investigating Officer, Assistant Director or Director notify complaints/service user experience staff so that the complainant can be advised of the reason for the delay. Any additional delays should be notified to complaints/service user experience staff to allow them to keep the person making the complaint informed of progress. Any delay in*

*issuing the written response should not normally exceed an additional 20 working days.* I acknowledge the Trust's response to this office that it faced '*immense pressures*' which were principally due to Covid and staffing issues. However, I consider it is unacceptable the Trust did not update the complainant or provide her with an explanation of why the delay occurred. I consider this to be extremely poor practice.

105. I note the complainant's concern that the Trust's response was '*incomplete and factually inaccurate'* and did not consider the impact of its actions on the patient's health. Further, I refer to the complainant's comments at paragraph 102 related to the SW IPA's advice. I reviewed the complainant's records, the complaint and the Trust's response to the complainant of 29 November 2022. The records evidence that, in its response to the complainant, the Trust did not accurately outline the patient's history of admission and discharges. Specifically, the Trust did not include the patient's re-admission and discharge on 11 and 27 May 2022 respectively. The SW IPA also referenced this in his advice. In the complainant's correspondence with the Trust, in addition to her general concerns about the frequency of the patient's transfer to multiple wards across all his admissions, she specifically cited similar concerns and queries about the patient's discharge of 27 May 2022 as those raised about each of the other discharges. Consequently, the Trust's response to the complainant did not address all the issues she raised in her complaint of 20 August 2022.

106. I also note the Trust provided generic responses to the complainant's queries about the patient's allocation to a different ward from his consultant, communication between different medical teams and communication between medical and social care. The responses did not address the patient's situation specifically; therefore, I do not consider it effectively addressed these concerns.

107. The first Principle of Good Complaint Handling, '*Getting it right',* requires public bodies to '*act in accordance with the law and relevant guidance and with regard for the rights of those concerned*'. The third Principle of Good Complaint Handling, *'Being open and accountable*', requires public bodies to both provide '*honest evidence-based explanations … giv[e] reasons for decisions'* and

ensure *'information, and any advice provided, is clear, accurate and complete'.* I also refer to the fourth Principle of Good Complaint Handling, *'Acting fairly and proportionately'.* This stipulates that public bodies should ensure *'complaints are investigated thoroughly and fairly to establish the facts of the case'*. I consider the Trust did not meet these standards in failing to update or explain to the complainant the reason for ongoing delay in responding to her complaint and to specifically address all her concerns in its response. I consider these failures constitute maladministration; therefore, I uphold this element of the complaint.

*Injustice*

108. I considered carefully whether the maladministration identified caused injustice to the complainant. I consider the complainant sustained the injustice of frustration, uncertainty and time and trouble of bringing a complaint to this office.

## CONCLUSION

109. I received a complaint about the Trust's care and treatment of the patient and its management of the complaint. I partially upheld the complaint for the reasons outlined in this report.

110. The investigation established the Trust did not appropriately discuss its DNACPR decision with the patient's family during his time as an in-patient from 11 to 27 May 2022.

111. I recognise the Trust's failure to discuss the DNACPR decision in May 2022 caused the patient and his family to sustain the injustice of a lost opportunity to be involved in discussions about this decision. I also recognise the upset and distress this caused the patient and his family.

112. Although I could not conclude whether the Trust discussed the DNACPR decision with the patient's family in June 2022, the investigation established that any communications about this decision were not clear.

113. I recognise this failure caused the patient's family to sustain the injustice of a

lost opportunity to fully understand the DNACPR decision.

114. The investigation also identified maladministration in the Trust's management of the complaint. Specifically, the Trust failed to keep the complainant informed about delays in responding to her complaint and did not fully and accurately address all her concerns.

115. I recognise the maladministration caused the complainant to sustain the injustice of frustration, uncertainty and time and trouble in bringing a complaint to this office.

116. The investigation established the Trust appropriately discussed the DNACPR with the patient and his son during his first admission, made appropriate discharge decisions for each of his discharges and managed the discharge planning and communications with the patient and his family for the discharges of 5 May and 12 June 2022.

**Recommendations**

117. I recommend that the Trust provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the injustice caused as a result of the failures identified within **one month** of the date of this report

118. I further recommend, for service improvement and to prevent future recurrence, the Trust: -

- Reminds relevant staff of the importance of the BMA Guidance on CPR; the Trust DNACPR Policy; and the GMC Guidance, Domain three, clauses 31 to 33. In particular, this should include the importance of detailed recording of information provided to and discussions with patients and/or their next-of-kin and consider any decision has been understood. This should be evidenced by records of information sharing and/or training.
- Carry out a sample audit of patients' records within the Gastroenterology service who have had a DNACPR form added to their treatment plan from 1 January 2024 to the date of issue of this final report. This is to ensure staff

have had clear and effective discussions with patients and/or their next of kin when deciding a DNACPR order is appropriate. The Trust should take action to address any shortcomings identified and update this office about the outcomes;

- The Trust reminds all staff involved in complaints handling of the importance of meeting response times and, where this is not possible, to update the complainant and provide fulsome explanations for the delay; and
- The Trust should also remind all staff involved in complaints handling of the importance of ensuring all concerns raised in complaints are fully investigated and responses should accurately address all aspects of the complaint.

119. I recommend that the Trust implements an action plan to incorporate the recommendations in paragraph 118 and should provide me with an update within **six** months of the date of my final report. The action plan should be 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).

**MARGARET KELLY**
**Ombudsman** **May 2025**