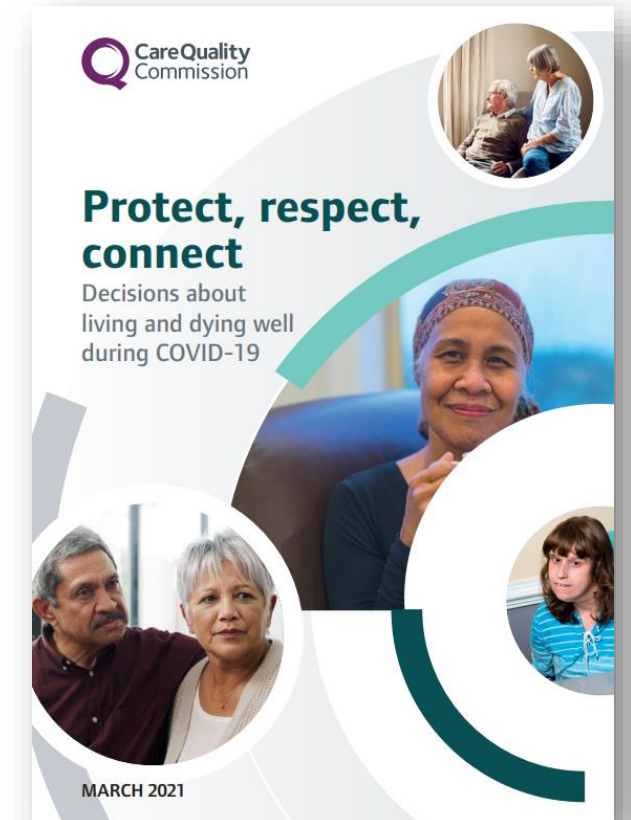


DNACPR – Protect, respect, connect – decisions about living and dying well during COVID-19

Rosie Benneyworth, Chief Inspector of Primary Medical Services
and Integrated Care
The Palliative Care Conference, 20 July 2021



Our role and purpose



The Care Quality Commission is the independent regulator of health and adult social care in England

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve



Background to the report

- In October 2020, the Department of Health and Social Care (DHSC) asked CQC to review how Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were used during COVID-19
- We made our position clear on how DNACPR decisions should be made at the beginning of the pandemic
- We published an interim report in Dec 2020 based on intelligence received from people sharing their experience, stakeholder groups and reviewing existing guidance
- This is the final report



Jim's story



Jim, who was in his 80s, was taken to hospital at the beginning of the pandemic after becoming unwell with a chest infection. Jim, who still worked, had normally been fit, well and active and went out most weeks in his car to visit friends or go to the cinema.

About 12 hours after being admitted to hospital Jim called Melanie, his daughter. He was upset and confused, and told her he had signed away his life and was going to die. He told her that a doctor had put an order in place that they wouldn't restart his heart if it stopped. He was upset that he had agreed to it because he didn't want to die.

Melanie told us that she tried to speak to the medical and nursing staff about this decision. She felt that the conversations were all one way and no one asked about her dad, about what he was like and what his life was like at home. Because Jim was able to make decisions about his care, no one had discussed the decision with her. However, she was concerned that her dad was vulnerable because he was ill, likely to be confused as he had a bad infection, and he was all alone. She felt he would have just gone with what they told him.

Jim died while in hospital. Not being allowed to visit because of the pandemic, and the way in which the DNACPR was applied, made his death even more distressing for Melanie and her family.

- Concerns raised as part of our scoping exercise were confirmed through fieldwork
- A mixed picture around blanket and/or inappropriate use of DNACPRs
- Poor record keeping means that has not been possible to verify the extent of the problem



Information,
training and
support

Consistent
national
approach

Improved
oversight
and
assurance

Summary of findings

- Increased pressure on staff time and resource
- People were involved in decision making but evidence that:
 - people were not always supported
 - there had been ‘blanket’ DNACPR decisions in place
 - people were not supported in advance care planning conversations, or given the information they needed in an accessible way
- There was a lack of awareness and confidence among people, families and care workers about what a DNACPR decision meant, and how to challenge this



It is vital we get this right and ensure better end of life care as a whole health and social care system, with health and social care providers, local government and the voluntary sector working together.

Recommendations

People must always be at the centre of their care

Professionals and patients need support so they all share the same understanding and expectations for DNACPR decisions

There must be comprehensive records of conversations and agreed decisions

Everyone needs to have access to equal and non-discriminatory personalised support

People need to have more positive and seamless experiences of care

Integrated care systems need to be able to monitor and assure themselves of the quality and safety of DNACPR decisions

Clinicians, professionals and workers must have knowledge, skills and confidence to speak with people and families

Support is needed for people to understand what good practice looks like for DNACPR decisions

Health and social care providers must ensure that all workers understand how to speak up

DNACPR decisions need to be recognised as part of wider conversations about advance care planning and end of life care. These decisions need to be made in a safe way that protects people's human rights

Responsible: Department of Health and Social Care

CQC must continue to seek assurance that people are at the centre of personalised, high-quality and safe experiences of DNACPR decisions

Responsible: Care Quality Commission

Thank you and any questions?



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