Written evidence from Anonymous (HCS0016)

DNACPR documentation.

Introduction.

The opinions expressed below are mine and are based on my experiences when I was POA for my friend until his death in January 2021. The information is taken from my notes, emails, correspondence and other documentation including some which may have been acquired by Subject Access Requests.

It relates to the process of DNACPR decisions and its documentation. I wish to draw your attention to the way this is being managed in some quarters and particularly that, patients and/or their lawfully appointed representatives are not being included in the decision making and, the existence of the documentation is not always being declared and, those who are supposed to regulate the process are not doing so.

Background.

Between 2016 and 2021, I held Power of Attorney for my friend who had a number of health conditions which could be treated but not cured. His health deteriorated over time and he was eventually immobile and unable to anticipate or express his needs and was entirely dependent on others. He spent time in hospital and lived in 3 nursing homes moving due to safety concerns about the care he was provided with including a life changing injury and on another occasion being taken to hospital in a coma.

My friend had given written instructions to the effect that his POA would make decisions about any DNACPR instructions (if he could not) and these had been made available to those who needed to know this. He wanted any DNACPR to be associated with his health at the time and did not want one on the basis of what I will call a 'blanket ' approach to his health. At that time he was still well enough to make that decision.

In September 2018 in his second nursing home I was told by his GP he had organ failure and had between days and weeks left to live. He was too ill to participate in the decision and so on his behalf at the request of and on the advice from the GP, I consented to a DNACPR on the basis that there was nothing which could be done for him. He started end of life care.

He recovered and the end of life care stopped but nothing was said by anyone way of explanation. It is a long story but I discovered that the diagnosis had been a mistake and actually he had an infection made worse by a delay in the provision of antibiotics. The nursing home had

made a Safeguarding referral to the AST about it but not notified anyone else as far as I know.

When I took this up with the GP (we spoke in January 2019) I was told that the mistake had been made due to inadequate information from the nursing home staff who had called the GP out to examine my friend but failed to divulge information about the delay in medication.

That GP did not tell me then (in January 2019) that there had been a review of the DNACPR in November 2018 and it had been continued. I found out about this later by chance in a conversation with a nurse at the nursing home (when my friend was once again ill with a urine infection) and challenged the situation with his GP who was by then different but from the same practice.

I intervened and requested its removal pending discussions with my friend about his wishes. There was correspondence about it between me and the GP and I received an email from the matron of the nursing home confirming its existence. Also I met with my friend and the GP who indicated that he had tried to discuss the situation with my friend but the latter had been too unwell to participate in the procedure. I can appreciate this may have been the case but my point is that, at that stage the POA should have been again invited to participate and I was not.

I referred this matter to the GMC expecting them to investigate. Initially they told me to take it up with a solicitor. When I pushed the complaint later, they asked for details and I gave them as much as I could. Their reply was to ask me to provide the DNACPR documents and details about the circumstances when it was made - who was there for example. Of course, I can provide evidence that the review was undertaken without consultation but I can't provide all the details in respect of the November review as this is the essence of the complaint - my friend was excluded from the whole process and the documents never revealed - on that basis the GMC declined to take the matter further stating the following:-

"Based on the information provided, there is insufficient detail to indicate Dr(redacted by me) or Dr (redacted by me) acted in a way to raise potential fitness to practise concerns. This is because there is currently no evidence to suggest that Dr (redacted by me) was involved in the review of the DNACPR on 13 November, and there is very little information as to what Dr (redacted by me)'s role was, particularly in regard to the decision to extend the DNACP.

We have asked for further detail on this from you but unfortunately you couldn't provide this. We note that you do not have any documentation relating to the DNACPR, or the decision to extend.

Our medically qualified colleague has advised that the initial DNACPR decision does not raise any concerns. However, there are potential concerns around the extension of the decision, and the lack of discussion with you or the patient, there is no information provided to indicate who

was involved in the decision.

In the absence of this information (ideally a copy of the review decision document or relevant medical record to show whose decision this was) we don't know who was involved and this does not therefore raise concerns about these doctors, specifically.

If in future you are able to obtain this information, and return to us with it, we would be able to review the matter. If Dr (redacted by me) or Dr (redacted by me), or any other doctor, was found to have reviewed and extended a DNACPR decision without discussion then we can look at the issue again then. It would be important to have details of the doctor(s)' rationale for any decision also."

It seems to me than that the GMC are content with a situation where DNACPR decisions are being made by persons who should be consulting with patients and/or their representative (and are ignoring this) and, are refusing to investigate when these circumstances arise leaving the patient or their representative to do all the detective work if they are able to. There is no point running an investigation along the lines of expecting the complainant to provide all the evidence when clearly they may never be able to do so this as it was concealed from them. It should not be up to the patient to gather the evidence in these circumstances and the GMC should be able to assist in this respect. If this situation continues as it is there will be wider public interest implications involving the inappropriate management of DNACPR decisions and its documentation and investigation.

I know you can't look into this individual case and I am not asking you to but I would like to ask that there is a general review of the management of and regulation of the DNACPR process including but not limited any breach of the Human Rights Act for the sake of the wider public interest.

31/10/2021