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ACUTE PERSPECTIVE

David Oliver: Improving DNACPR discussions, decisions, and documentation

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On 18 March the Care Quality Commission (CQC) published a report on the quality of decision making, discussion with patients and families, and documentation on DNACPR (do not attempt cardiopulmonary resuscitation) decisions in the covid-19 pandemic.

*Protect, Respect, Connect—Decisions about Living and Dying well during Covid-19*¹ was commissioned by the government in response to news stories, complaints, and campaigns about perceived failings.² The report acknowledged that the extreme demands of the pandemic response had increased pressure on clinical and care staff and services, which may have hampered decisions and communication. The CQC said that DNACPR decisions don't exist in isolation but are part of a broader spectrum of care planning for long term conditions, advance care planning for end-of-life decisions, and emergency treatment escalation plans.

I was glad to see the clear acknowledgment that we should be doing more of all these things. Inevitably, some news reporting and activism tended to weaponise this and paint these important and patient centred planning processes as some kind of scandal—but we do need to do more of them all. Helping people to live well with medical conditions and self-manage them, together with clinical teams, unpaid carers, or paid care staff, is a good thing. Open discussion and advance care planning can help improve choice, symptom control, and dignity near the end of life.^{3 4}

Ensuring that people in nursing and residential homes have a clearly structured emergency care and treatment escalation plan can help reduce unnecessary acute admissions.⁵ In hospitals, this planning can stop excessive medicalised intervention that may worsen distress, ignore a patient's own priorities, or add little value. It can also guide critical care outreach, resuscitation, or on-call medical teams as to necessary levels of intervention for deteriorating patients.⁶

As for DNACPR itself, we need more discussions, not fewer.⁷ If these don't happen until patients present in an acute crisis we need to discuss and make decisions there and then, although "upstream" planning is preferable. The CQC highlighted examples of good practice in all of these areas—but also failings that we shouldn't seek to play down. It found a big gap between accepted, law compliant best practice and reality.

Despite some news stories the CQC found few examples of "blanket DNACPR" policies for whole

categories of patients and care settings, and these had often been withdrawn after challenge. However, it found that around a third of DNACPR decisions were inadequately discussed with patients or families, and documentation was often poor or lacking. Often the reasons doctors gave for DNACPR were too vague or just unacceptable—such as a learning or physical disability or age—rather than based on the chances of a good outcome or the patient's own priorities. The report also found no national consistency in documentation or processes (although a series of legal rulings and guidance from professional organisations is available). Staff knowledge and awareness, and public understanding, were also very patchy.

The CQC has recommended ministerial oversight of a change programme including some key elements: better information for the public and patients; better staff training and support; a more standardised national approach to documentation, communication, and decisions; and better oversight, assurance, and governance—nationally and locally—with a particular focus on inequalities, to ensure that people in certain demographic groups or care settings aren't systematically disadvantaged.

I've often been critical of the CQC, but this is a set of actions and priorities that we as professionals should support.

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