



Do not attempt CPR

How to talk about this in a better way

Since publishing this report, we have changed our name to the **Public Service Ombudsman**.

Public Service
Ombudsman

Our role and the service we provide remain the same.



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Why we have written this report



We are the Parliamentary and Health Service Ombudsman. Our job is to look at **complaints** about services like the NHS.



A **complaint** is when you tell a service you are not happy about something.



When the **COVID - 19 pandemic** happened we got lots of complaints about the NHS.



The **COVID - 19 pandemic** was when we all had to stay at home to keep safe from the COVID - 19 virus.



Some people got very poorly from the COVID - 19 virus and had to go into hospital. Some people sadly died.



We got a lot of complaints from the families of people who died.



A lot of these complaints were about what happened when disabled or older people died.



Families thought that the person who died did not get their **rights**.

Your **rights** are the things you are allowed to do and how you should be treated.



We wanted to find out what was happening in hospitals and why.

About do not attempt CPR



Sometimes when a person is very poorly, their heart stops beating and they stop breathing.



Doctors and nurses can try to make their heart start beating and help them breathe again. This is called giving someone CPR.



If someone does not give CPR, the person might die.



Sometimes, doctors say that someone is too poorly and should not have CPR.



This could be because:

- the person is already very poorly and would not live much longer



- the person is very weak and starting their heart again could cause more health problems for them



- the person has already told doctors that if their heart stops, they don't want it to be started again



When doctors say a person's heart should not be started again, it is called: **do not attempt CPR**. The short name for this is **DNACPR**.



If someone has asked not to have CPR, doctors write this down so that other people know what the person wants.



Doctors can also make a decision about whether someone should have CPR. The doctor can still decide this even if the person or family don't agree.



But the doctor still has to talk to the person or family about it.

What families told us



Families complained when doctors chose if a person should not have CPR.



The person in hospital and their families were not always asked what they thought.



Families were not always told that their loved one was not going to be given CPR.

They only found out after the person had died.



Patients did not always get good support to help them say what they wanted to happen.

What we did next



To find out what was happening, we looked closely at the complaints families made.



We spoke to doctors and nurses.



We also asked other organisations to do some extra work to help us. They talked to:



- people with learning disabilities

and



- older people



We looked at what everyone told us.

The main things we found out about



1. The law says a person should be told if a doctor says they should not have CPR.

But lots of people are not always told when doctors said they should not have CPR.



Families were very upset when they did not know. They said they did not trust doctors and the NHS anymore.



2. People don't usually talk about death until they or someone close to them is very poorly.



We need to find out earlier what people want to happen if their heart stops beating.



3. Some families don't like having to say if someone they care about should not have CPR.



Families sometimes have to do this if someone is too poorly to say what they want.

This is very hard to do and makes some families feel upset and worried.

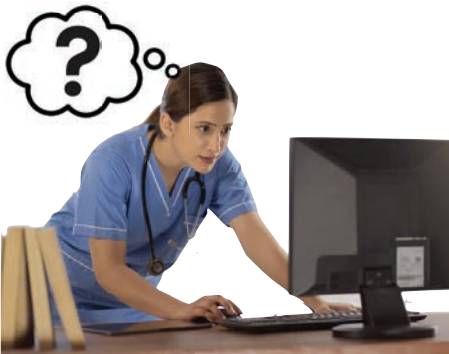


4. There is not enough accessible information about not giving someone CPR.

Things like information in easy read or making it easier to understand.



5. Sometimes if 1 doctor says someone should not have CPR, other health staff don't know this.



This is because if health staff look for information about someone on the computer, it is sometimes not all there.



6. People are not always able to see their information. They cannot see the decisions made about them.



7. People think that the NHS is not treating older and disabled people fairly or making sure they are getting their rights.



8. People don't know a lot about CPR. They don't know who can say if someone should be given it. If it happens to someone in their family, they feel upset.



People think it should just be the person and family's choice.

They don't understand that the law says just doctors can decide too.

What needs to happen now

We want to make sure that:



- everyone gets their rights and people can have their say about what happens to them

It is very important to think about the needs of disabled and older people.

and



- health staff get good training so they can talk to people in the best way



So that these things can happen, we have thought of 4 big ideas.

Big idea 1



All NHS doctors and nurses should have good training in making decisions.

This would be on decisions about what happens when a person will die soon.

Services should talk to older and disabled people about this training.

They can help the organisation plan what the best training looks like.



Big idea 2

There needs to be good communication about decisions not to try CPR.



Doctors and nurses need time to talk to patients and their families. This should happen before someone gets too poorly.





More staff need training about how to talk to people and their families about what they want to happen.



There needs to be more information for patients and families.

The information needs to be easy to find, understand and use.



If a doctor or nurse needs some information, it should be easy to find.

Big idea 3



The **Care Quality Commission** is a big organisation. They check services like hospitals to make sure they are giving people good care and support.



They are called **CQC** for short.



We think the CQC should give clearer rules about making decisions. Then NHS services must follow these rules.



The CQC should then look at how NHS services are following the rules. They should check services are working in the best way.

Big idea 4

Doctors should be given good information about:

- how to make decisions
- what the law says about do not attempt CPR





- rules they should follow

Different health staff need to know if someone should not have CPR.



- how to support patients and families with different needs



This information should be kept safely on the computer for staff to see if they need it.



There should be more space on forms for doctors to write information.



What we will do next

We are going to give training to all Parliamentary and Health Service Ombudsman staff.

The training will be about:

- people with learning disabilities
and
- people who are **neurodivergent**

We say it like this: **new roe die ver jent.**



Neurodivergent means your brain works in a different way to most people. You might be autistic or have ADHD.



This training will help our staff to know if someone with a disability was treated unfairly.



It will help our staff to know more about how having a disability can affect someone's life.



We will keep on working with people on how to make it easier to complain to us.



For more information

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