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Divergence in DNACPR and resuscitation policies: institutional survey in England

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Received 11 November 2024
Accepted 6 February 2025

To cite: Fitton E, Chumbley K, Barry C, *et al*. *BMJ Supportive & Palliative Care* Epub ahead of print: [please include Day Month Year]. doi:10.1136/spcare-2024-005263

ABSTRACT

Objectives Our objective was to analyse the policies of hospitals and care homes in England as regards the use of do not attempt cardiopulmonary resuscitation (DNACPR) recommendations. We sought to identify (i) variations among policies at different institutions, and (ii) divergence of local policies from national guidance, particularly with reference to decisions either (a) to initiate cardiopulmonary resuscitation (CPR) despite the presence of a DNACPR recommendation, or (b) not to initiate CPR in the absence of a DNACPR recommendation.

Methods We conducted a survey of 14 DNACPR and/or resuscitation policies, drawn from care homes, NHS trusts and hospices.

Results Many of the policies we surveyed diverge significantly from national guidance. Some require that CPR be administered in all cases where no DNACPR recommendation has been made. Others fail to specify that CPR may be appropriate even in the presence of a DNACPR recommendation.

Conclusions Local DNACPR policies currently place both patients and healthcare professionals at significant risk.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Healthcare professionals who decide not to initiate cardiopulmonary resuscitation risk professional sanctions, even when their decisions conform to authoritative national guidelines.
⇒ Previous research has revealed a high degree of variability among institutional do not attempt cardiopulmonary resuscitation (DNACPR) policies nationally, and particularly in relation to the review of DNACPR recommendations.

WHAT THIS STUDY ADDS

⇒ Institutional resuscitation and DNACPR policies diverge significantly from authoritative national guidance.
⇒ Local divergence from national guidance compromises patient safety and dignity and leaves healthcare professionals vulnerable to sanctions

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ In order to reduce the risk of harm to patients and professionals, national bodies should provide support to those responsible for the development and implementation of DNACPR and resuscitation policies at the organisational level.

INTRODUCTION

The Nursing and Midwifery Council (NMC) maintains a website of materials relating to hearings conducted by its Fitness to Practise Committee.[1] Where sanctions are imposed, the committee's report is made publicly available for as long as the sanctions remain in place. Examining the records available in the Summer of 2022, we identified at least a dozen cases in which nurses working within care homes faced sanctions because of decisions not to perform cardiopulmonary resuscitation (CPR) in the absence of a do not attempt cardiopulmonary resuscitation (DNACPR) recommendation. Many of these nurses had concluded that CPR was not clinically appropriate or in their patient's interests.

Spearpoint[2] has noted that a common factor in some such cases was an institutional policy that CPR should always be administered unless a written DNACPR recommendation is in place. Such policies do not reflect national guidelines, which specify that CPR should not be performed where, for example, there are signs of advanced and irreversible death.[3 4] Nevertheless, these policies are sometimes cited in NMC Fitness to Practise hearings as

evidence that the nurse has acted improperly. Consequently, healthcare professionals can find themselves facing an impossible choice, between actions they believe to be best for the patient and actions that will afford the greatest protection against sanctions. At least one organisation has advised that, to shield themselves from liability, nurses working within care homes should always perform CPR where no DNACPR recommendation has been made, regardless of circumstances.[5]

Healthcare professionals may face an analogous dilemma when there has been a DNACPR recommendation. DNACPR recommendations are made where cardiac arrest is anticipated, and it is thought that CPR will not be successful or, given the circumstances, is otherwise not in the patient's interests. Where cardiac arrest arises due to unforeseen circumstances, the reasoning behind the initial DNACPR recommendation may not apply, and CPR may be of benefit. It is therefore sometimes appropriate to administer CPR even when a DNACPR recommendation has been made. Where institutional policies do not make clear the circumstances under which it is appropriate to administer CPR to a patient with a DNACPR recommendation, there is a risk both to patient safety and to the professional. In 2021, the Senior Coroner for East Sussex made a Regulation 28 Report to Prevent Future Deaths after an ambulance was not called when a care home resident was choking, due to the presence of a DNACPR recommendation. The Coroner concluded:

> [I]t is apparent that no one involved understood that there are circumstances when the DNACPR should not be applied. I am concerned that this may potentially be an issue elsewhere in the country and further training and clarification is therefore necessary.[6]

The nursing home made modifications to its DNACPR policy in response to the Coroner's report.[7]

The Court of Appeal ruled in 2014 that no national policy on DNACPR is required under the European Convention on Human Rights,[8] and individual organisations continue to draw up their own DNACPR and resuscitation policies. Nevertheless, authoritative national guidance has been jointly produced by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.[3] Previous reviews have revealed variation among regions and institutions when it comes to how this guidance is incorporated. In particular, Freeman *et al* found significant variation in terms of the forms used to record DNACPR recommendations; review processes for DNACPR recommendations; criteria for the validity of DNACPR recommendations and portability of DNACPR recommendations.[9] However, we are not aware of any studies examining variations in policy recommendations on the two issues recent cases highlight: not undertaking CPR in the absence of a DNACPR recommendation, and undertaking CPR in the presence of a DNACPR recommendation. The purpose of our study was to determine the extent to which institutional policies vary, and to what extent they adhere to national guidance. Given the dilemmas outlined above, we were especially interested in whether, and to what extent, policies allowed for the exercise of clinical judgement in decision-making around CPR at the point of arrest, both in the absence and in the presence of a DNACPR recommendation. Two key research questions were: under what circumstances do individual policies allow a healthcare professional to decide against CPR in the absence of a DNACPR recommendation? And under what circumstances do individual policies require that CPR be administered even in the presence of a DNACPR recommendation?

METHODS

53 documents were collected. Of these, 45 documents were in the public domain and were identified via an online search. A further eight documents not in the public domain were provided to us by affiliates of organisations with local resuscitation or DNACPR policies in place. 12 documents were excluded because they were not policies, or because they did not pertain to resuscitation or DNACPR. Four were excluded on the basis that they were published prior to 2010. Two were excluded because they were no longer available for download at the time of review. Of the eight policies not in the public domain, we included only the one for which we had express permission from the authoring organisation. A further 14 policies were excluded because they had a date of scheduled review that was prior to 2023, which may indicate that they were not active policies at the time of our analysis.

Overall, we identified 14 policies to be reviewed (see table 1).

A thematic framework was developed after discussion by the research group, informed by a review of the academic literature, Fitness to Practise panel reports, professional experience and media reporting on issues surrounding DNACPR. During the study, further themes emerged, and we have included analysis and discussion of these in our report.

RESULTS

Findings are grouped below by theme. Where findings were prompted by the survey, we state the number of policies in which the issue was discussed. Where themes emerged during the survey, we provide examples but do not attempt to determine frequency.

CPR when a DNACPR recommendation has been made

Only three policies (P044, P048 and P052) stated that DNACPR recommendations are not legally binding, and only eight policies (P016, P031, P051, P048, P020, P012, P044 and P007) described

circumstances under which CPR may be administered when a DNACPR recommendation has been made. One of those eight policies (P044) stipulated that the decision to administer CPR could be made only by a 'suitably qualified' professional. Seven policies referenced DNACPR 'orders'.

Only eight policies (P031, P016, P048, P035, P032, P020, P012 and P007) described circumstances under which it might be appropriate to suspend a DNACPR recommendation, for example before a planned surgery. In total, five policies did not state or indicate that there are circumstances under which it might be appropriate to administer CPR even where a DNACPR recommendation has been made.

The 'validity' of DNACPR forms

12 policies (all but P044 and P023) referred to the 'validity' of a DNACPR recommendation. However, only 10 policies provided guidance on distinguishing between a valid and an invalid DNACPR form. In most cases, this took the form of examples rather than an exhaustive list of criteria. No policy specified what should be done where a form is not valid. While 12 policies (all but P036 and P023) outlined procedures and requirements for the review of DNACPR recommendations, no policy directly specified what to do when faced with a recommendation past its review date, though P016 did specify that:

> The last recorded decision on the original form is the current decision and should be treated as such.

Table 1 Overview of policies reviewed

Policy code	Policy type	Applicable to/ within	Date of publication
P007	DNACPR	NHS settings within specified region	2015
P012	DNACPR	Unclear	2021
P016	DNACPR	NHS Trust	2020
P020	Combined	NHS Trust	2020
P023	Resuscitation	NHS settings within specified region	2021
P030	DNACPR	NHS Trust	2022
P031	DNACPR	Unclear	2015
P032	Combined*	NHS Trust	2016
P035	Resuscitation	Hospice	2020
P036	Resuscitation	NHS settings within specified region	2022
P044	Combined	All care homes within network	2021
P048	DNACPR	NHS Trust	2023
P051	Combined	NHS Trust	2020
P052	Resuscitation	NHS Trust	2022

*Resuscitation policy with DNACPR policy included in appendices.

DNACPR, do not attempt cardiopulmonary resuscitation; NHS, National Health Service.

Deciding against CPR in the absence of a DNACPR recommendation

Two of the policies we surveyed contained a statement to the effect that CPR should always be performed where no DNACPR recommendation has been made. P044, which applies to a group of care homes, stated that:

> CPR will be performed unless there is a DNACPR in place.

And P036 that:

> CPR should be commenced for all patients/visitors/staff who suffer a cardiac arrest unless there is a valid DNACPR decision in place.

Two further policies were more ambiguous. Policy P007 made this statement only in relation to 'unexpected cardiac arrest', implying that CPR should be administered even where there are signs of irreversible death such as rigor mortis.

> In the event of an unexpected cardiac arrest, every attempt to resuscitate the individual will take place … unless a valid DNACPR decision or an ADRT is in place and made known.

Policy P051 stated that:

> Where there is no time to establish the medical history and / or in the absence of a prior decision not to resuscitate, CPR must be initiated.

Whether this constitutes an instruction to administer CPR in all cases where no DNACPR recommendation has been made, hinges on how the 'and / or' is interpreted. '*[O]r* in the absence of a prior decision not to resuscitate…', implies that CPR must always be performed where no DNACPR recommendation has been made.

There was also some evidence, in the policies we surveyed, of conflation of decisions based on a lack of clinical benefit with decisions based on best-interests. In particular, policy P012 states:

> In the event of registered healthcare staff finding a patient with no signs of life and clear clinical signs of prolonged death and with no DNACPR decision or an ADRT to refuse CPR, they must rapidly assess the case to establish whether it is appropriate to commence CPR. Consideration of the following will help to form a decision based on their professional judgement which can be justified and later documented: … Is there recent evidence of a clearly maintained verbal refusal of CPR? This needs to be carefully considered when making a best interests decision on behalf of the patient.

Where a person already has signs of prolonged death, a decision not to commence CPR will be based purely on clinical judgement of lack of effectiveness. It is not therefore a best-interests decision as P012 suggests.

Who is qualified to exercise clinical judgement in the case of cardiac arrest?

Where no prior DNACPR recommendation has been made, several policies specified which roles are

permitted to exercise clinical discretion at the bedside. P032, for example, specified that a doctor is qualified to make these decisions, implying that nurses would not be so qualified:

> A doctor capable of making the decision and attending a patient who has suffered a cardiorespiratory arrest may decide not to start CPR even in the absence of a DNACPR order, where the circumstances make it clear that this is appropriate.

One policy (P020) specified that only those 'qualified to certify death' could decide against CPR where signs of irreversible death were present:

> In the event of an unexpected cardiac arrest, every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council unless [a DNACPR or ADRT is present] or irreversible death is confirmed by an appropriately qualified healthcare professional (ie, qualified to certify death).

In total, 11 policies outlined circumstances in which it is appropriate to decide against CPR even when no prior DNACPR recommendation or advance decisions to refuse treatment (ADRT) is in place. Eight policies (P007, P012, P020, P032, P048, P016, P030 and P031) cited cases of catastrophic injury or signs such as rigor mortis, indicating irreversible loss of life, as circumstances in which it may not be appropriate to administer CPR. Policies P030 and P032 stated that a decision not to administer CPR may be made in cases where the patient is in the advanced stages of a terminal illness. While only written refusals, recorded in the form of an ADRT, are binding in the case of life-saving treatment such as CPR, some policies stated that where there has been a prior verbal indication by a patient that they would not wish to receive CPR, this can be taken into consideration when deciding whether CPR would be in the patient's interests:

> In the event of an unexpected cardiac arrest CPR will take place in accordance with the current Resuscitation Council (UK) guidelines unless … there is clear evidence of a recent refusal of CPR as this will need to be carefully considered when making a best interests decision. (P031 and P016)

Impact on other care and treatment

In general, the policies we surveyed made clear that a DNACPR recommendation should not affect other forms of care and treatment, with 12 policies (P007, P012, P016, P020, P023, P030, P031, P032, P035, P048 and P051) stating this explicitly.

Disagreement around a DNACPR recommendation

10 policies provided guidance about what to do in the case of disagreement between healthcare professionals and the patient or (in the case where the patient lacks decision-making capacity) their family. In most cases, the recommendation was that a second opinion, and in some cases legal advice, be sought. One policy (P016) advised that the DNACPR recommendation be suspended while this happens.

Some policies, however, suggested that the wishes of the patient be accommodated as far as possible:

P032:

> A patient may request CPR to be attempted even where clinical evidence suggests it will not be successful, and this has been made clear to the patient. The patient's request for CPR may be able to be accommodated, but no doctor can be required to give treatment against their clinical judgement. Where possible, transfer of the patient to the care of another medical team, which feels able to deliver CPR, should be considered.

P007:

> Although individuals do not have a legal right to demand that doctors carry out treatment against their clinical judgement, the person's wishes to receive treatment should be respected if possible.

Equality and non-discrimination

While mention of equality and/or discrimination was made in most of the policies we surveyed, the language was superficial and formulaic. It gave no guidance to practitioners about how the risk of discrimination might arise, nor did it provide any guidance on how that risk could be avoided or mitigated. The string 'equality' appeared in a total of 11 policies. In all but one (P012) of the documents, this related solely to mention of an Equality Impact Assessment or Screening, or Equality and Diversity Risk Assessment having been conducted. Even in the case where equality is discussed, the policy (P012) stated simply that:

> [Redacted]NHS Trust is committed to the principle of Equality and Diversity and Strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff.

The string 'discrim*' appeared in a total of five policies (P012, P020, P031, P036 and P048), but there was little in the way of elaboration in terms of how to avoid discrimination. For example, P012 stated that:

> this policy and DNACPR decisions are non-discriminatory documents and a DNACPR cannot be made against a person's Human Rights as detailed within the Human Rights Act 1998, or be implemented for reasons of discrimination (Equality Act 2010).

P020 specified that the decision-making process in relation to CPR should be:

> free from any element of discrimination on the grounds of gender, religion, sexuality, ethnic group or age.

DISCUSSION

CPR when a DNACPR recommendation has been made

A subset of the policies fail to guard adequately against the common misconception that DNACPR recommendations are legally binding, rather than advisory and subject to the discretion of the attending healthcare professional.[10] While ADRTs, when completed in line with the Mental Capacity Act 2005 s. 24, are legally binding on health professionals, DNACPR recommendations should be distinguished from these. Even where a DNACPR recommendation has been made, it is accepted that there are circumstances in which CPR may be judged appropriate.[3] These circumstances tend to relate to acute, unforeseen events, such as choking, which are unrelated to the medical conditions leading to the DNACPR recommendation. Terminology may also be misleading. Although use of the term 'DNACPR orders' is commonplace in clinical discourse,[11] it may suggest an instruction, and so give the impression that a DNACPR recommendation must be followed under all circumstances.

The 'validity' of DNACPR forms

Some of the policies we surveyed made reference to the validity of DNACPR recommendations without sufficient explanation of what constitutes validity. In order to be useful to practitioners, any guidance that refers to the 'validity' of a DNACPR recommendation should also include specific guidance on (a) how to distinguish between a valid and an invalid DNACPR form and (b) how to proceed when confronted with a form the validity of which is doubtful.

Deciding against CPR in the absence of a DNACPR recommendation

While there is a strong presumption, in law, in favour of preserving life,[10] national guidance makes clear that this does not mean that CPR should be administered where not clinically appropriate. Just as there are cases where it is appropriate to set aside a DNACPR recommendation, there are also cases where it may not be appropriate to administer CPR even though no DNACPR recommendation has been made. In particular, CPR should not be administered where it is clear that the person has already died, or where it is clear, for other reasons, that CPR will not be successful.[3] In these cases, a decision not to administer CPR is based on the need to preserve the dignity, and in some cases, bodily integrity of the deceased. Policies that fail to provide clarity on these points pose a risk both to patients and to healthcare professionals.

For patients, such policies can result in CPR being administered where it is not clinically appropriate. In 2017, nurses at HMP Chelmsford were criticised by the Prison and Probation Ombudsman for administering CPR to an inmate who was already showing signs of advanced and irreversible death.[12] In a statement on the case, the Resuscitation Council noted that health professionals 'need to know and be able to recognise when CPR would be of no benefit to a person and will either deprive them of a dignified death or potentially cause them harm'.[13]

For healthcare professionals, such policies may become the basis for sanctions if they decide against administering CPR where it would not be clinically appropriate. In the NMC Fitness to Practise hearing relating to the Nasiri case, for example, the panel referred to the policy of the care home in determining the course of action that should have been taken.[14]

These cases demonstrate that, where there is good reason to think that CPR has no chance of success, nurses and organisations can face criticism and sanctions both for deciding to administer CPR and for deciding not to. Where organisational policies are in conflict with national guidelines, this leaves healthcare professionals particularly vulnerable.

Who is qualified to exercise clinical judgement in the case of cardiac arrest?

In most organisations, only certain grades and roles of clinicians are authorised to complete DNACPR recommendations. However, decisions about whether to administer CPR when cardiopulmonary arrest occurs may fall to a much broader group of professionals.

In 2017, concerns were raised after an NMC Fitness to Practise panel imposed sanctions on a nurse who decided against administering CPR to a patient who had signs of irreversible death. In that case, the NMC report cited the fact that the nurse was not qualified to certify death as a basis for its decision and was criticised for doing so. The Resuscitation Council released a statement in which they drew attention to BMA *et al* guidelines, which specify that 'while death can be certified only by a registered doctor with a licence to practise or by a coroner, death may be confirmed by other health professionals, including paramedics and nurses'.[3 15] Ultimately, the NMC themselves confirmed that CPR should not be administered in cases where it 'is of no benefit and not in a person's best interests' or where there are 'features of irreversible death'.[16]

Some of the policies we surveyed made reference to a narrow group of professionals, such as doctors, when providing guidance on the use of DNACPR recommendations. Policies should avoid any language suggesting that qualified professionals such as paramedics and nurses lack the authority to exercise their clinical judgement in making decisions about the initiation of CPR.

Our methodology means that we do not have a means of determining how particular policy decisions are arrived at, at an institutional level. Institutions may be heeding advice from medicolegal organisations; nurses in particular have been encouraged to administer CPR under all circumstances in order to shield themselves from sanctions, including criminal charges of wilful neglect.[5] Where this advice is incorporated

within the policies of individual institutions, there may be a compounding effect: a statement within an organisation's policy to the effect that CPR must be administered where no DNACPR recommendation has been made may become a basis for imposing sanctions where a healthcare professional within that setting decides not to administer CPR in the absence of a DNACPR recommendation. The imposition of sanctions in such cases may in turn lead other organisations to implement more restrictive policies as a defensive measure.

Impact on other care and treatment

There is evidence that the presence of a DNACPR recommendation may limit the other care and treatment that a person is offered.[6 17] We welcome the trend, reflected in the surveyed policies, towards the use of 'DNACPR', rather than 'DNR' or 'DNAR.' This reinforces the message that DNACPR recommendations apply narrowly to one specific form of resuscitation.

Disagreement around a DNACPR recommendation

The issue of what to do in the case of disagreement between the patient and healthcare professionals in relation to a DNACPR recommendation is complex. Patients do not have a right to demand treatment that is not clinically appropriate.[10 18] This means that, where CPR will not be clinically effective, a DNACPR recommendation can be made on a purely clinical basis, and independently of the wishes of the patient. However, unless there is reasonable certainty that CPR would not be effective, the DNACPR recommendation goes beyond a merely clinical judgement; the beliefs, wishes and values of the patient should, therefore, be considered. Indeed, the most recent draft of the MCA Code of Practice specifies that DNACPR recommendations made on grounds other than clinical ineffectiveness should be made according to the principles of best-interests decisions as set out in the Mental Capacity Act 2005.[19]

This makes DNACPR recommendations unusual. In most cases, best-interests decisions are taken at the point treatment is required because the patient does not have the capacity to make the decision for themselves. In the case of CPR, however, while the patient will not have the capacity to make a decision at the point at which treatment is required, the DNACPR recommendation is often made when the patient does have decision-making capacity. Where there is a small chance of success, a doctor may make a DNACPR recommendation even though the patient themselves believes that the small chance that CPR will be successful outweighs any potential harms.

There is no simple solution to this dilemma. Legally speaking, the doctor holds ultimate responsibility for decisions about DNACPR, even where that decision is made on bases other than clinical ineffectiveness, although, as was established in Tracey,[8] the patient has the right to a second opinion. We suggest this as an area for further research.

Equality and non-discrimination

National guidance[3] states that decisions around DNACPR and CPR must be made on an individual basis and not in a blanket fashion in relation to, for example, age or disability. Nevertheless, concerns have been raised, particularly during the COVID-19 pandemic, that DNACPR recommendations may sometimes be made in a blanket fashion.[17] It is vital that DNACPR and resuscitation policies make clear that individualised assessment is essential and provide guidance on avoiding even unintended discrimination.

CONCLUSIONS

Our study found evidence of significant divergence among institutional resuscitation and DNACPR policies, as well as inconsistencies between these policies and authoritative national guidance. On two key issues—deciding against CPR in the absence of a DNACPR recommendation, and the possibility that a DNACPR recommendation be set aside under certain circumstances—we suggest that the inconsistencies are such that they pose a risk to the patient and/or to the healthcare professional. Where policies do not outline circumstances under which a DNACPR recommendation should be set aside, for example where cardiac arrest is due to an easily reversible cause, there is a risk that patients do not receive life-saving treatment. Where policies make unqualified statements that CPR should be administered unless a DNACPR recommendation is in place, there is a risk that CPR that has no chance of success is administered, violating the dignity of the patient. By failing to allow for clinical discretion, such statements also present ethical and professional challenges to the healthcare professional, who may be forced to choose between local policies and broader ethical guidelines, with the possibility of professional sanctions for whichever choice they make. While the courts have established that no national policy is required in the case of DNACPR, we suggest that more detailed support and guidance for organisational policy-makers is required if the well-documented issues surrounding DNACPR recommendations are to be addressed.

Contributors All coauthors contributed to the design of the study. Design of the survey instrument was by EF, with feedback from CB, KC, BT and WM. Data gathering by EF and AB. The paper was drafted jointly by EF, CB and WM and reviewed by all coauthors. EF is the guarantor.

Funding This work was funded by Arts and Humanities Research Council (AH/V012770/1 Ensuring Respect for Human Rights in).

Competing interests None declared.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available on reasonable request. Data may be obtained from a third party and are not publicly available. Data used in this study were extracted from Resuscitation and/or DNACPR policies adopted by care organisations in England. All but one of the policies were downloaded from public sources at the time the survey was initiated, but not all are publicly available at the time of publication. One of the policies analysed was provided by a third party and was never publicly available. It is used here with permission of the organisation that produced it. The Essex Autonomy Project holds copies of all policies reviewed. Data are available from the corresponding author on reasonable request.

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