# The NMC and CPR Decisions: Careful, Considered Judgment Expected from Nurses


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A recent fitness to practise decision has resulted in concerns among the nursing profession about attempting CPR, where there is no Do Not Attempt Resuscitation (DNAR) order in place. Mrs Nasiri was an experienced nurse working in a residential nursing home. She was suspended from the NMC register for 12 months following a fitness to practise hearing held in January 2020, for failing to perform CPR on a resident who stopped breathing.

## The facts

On 12 July 2017, the resident, an 89 year old lady, was admitted to the home following discharge from hospital. The resident had "*multiple debilitating health problems*". On 2 August 2017, the resident became unwell, was diagnosed with a chest infection and prescribed antibiotics. The GP stated, around that time, that a DNAR needed to be discussed with the resident as she was weak. There was a delay in the discussion taking place, due to language barriers and the home needed to speak to the resident's family about the DNAR order.

On 6 August 2017, the resident's health rapidly deteriorated. Mrs Nasiri, the only nurse on shift at the time, left the resident with a care assistant whilst she contacted 111 and the family. The care assistant later alerted Mrs Nasiri to that fact that the resident was unresponsive. Mrs Nasiri attended the resident and informed the care assistant that the resident had indeed passed away. Mrs Nasiri did not try to perform CPR on the resident at any stage, despite the fact that there was no DNAR in place at the time.

An inquest was held in June 2018, following which the Coroner referred Mrs Nasiri to the NMC, as he was concerned that her knowledge and skills were not up to the required standard in relation to the care of critically unwell patients and resuscitation.

An NMC investigation was opened and Mrs Nasiri did provide an initial response to the NMC but, at a later stage, she decided to retire from nursing and move abroad. Mrs Nasiri did not attend the fitness to practise hearing and was not represented. The panel considered three charges against Mrs Nasiri. The first two were not found proved, but the panel determined that Mrs Nasiri did not attempt CPR when the resident stopped breathing and further, that Mrs Nasiri had not made a carefully considered clinical decision not to perform CPR. The panel

determined that this amounted to misconduct and a 12 month suspension was the appropriate sanction.

## Commentary

Many healthcare professionals have taken to social media to voice their concerns following this decision. The NMC has already reacted to the case, via Andrea Sutcliffe's blog on the website – click here to read the full response.

Although this is a controversial topic, the panel's decision is based on the specific facts of Mrs Nasiri's case and it is important to read the full determination before casting doubt on the decision.

In Mrs Nasiri's case, the panel did not find any evidence of the careful, considered clinical judgment expected of a healthcare professional. That is not to say that Mrs Nasiri did not make a careful and considered clinical judgment, but the panel did not have the benefit of hearing her evidence before making their decision. Other evidence available to the panel, including the transcript of Mrs Nasiri's evidence from the inquest, indicated that Mrs Nasiri had not been able to explain how she reached her clinical decision not to perform CPR. As a result, the panel determined, on the balance of probabilities, that Mrs Nasiri had not made a "*carefully considered decision based on her clinical judgment*". The outcome may have been different if Mrs Nasiri had been able to explain how she reached her decision not to perform CPR. It would have been even better if she had made a contemporaneous record of her decision in the resident's notes.

Concerns have been raised that this decision may lead to nurses feeling obliged to attempt CPR even if it is inappropriate, for fear of being referred to the NMC. The NMC has tried to reassure its registrants by stating that this decision does not conflict with the current best practice guidance.

The guidance, which is jointly authored by the BMA, Resuscitation Council (UK) and RCN states *"Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR". The NMC's response published on 27 January 2020 emphasises the key part of the guidance, which states professionals can depart from this on the basis of "careful, considered clinical decision making."*

## Learning and reflection

Despite the NMC's quick response to the concerns raised about this case, it is clear that a more detailed response is needed from the NMC. Nurses need to feel confident that the decision in this case has not departed from the best practice guidance. The NMC should advise nurses how to exercise and demonstrate carefully considered clinical judgment when making decisions about attempting CPR.

## Key learning points



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- This case highlights the importance of having difficult conversations as early as possible. Not everybody wants to talk about death and it can be difficult. However, it is important to have advanced plans in place, where possible. If a DNAR notice is in place, this removes any uncertainty.

- All healthcare professionals must ensure they keep clear and accurate records. If a nurse makes a clinical decision not to perform CPR, the reasons for this should be clearly documented.

- If you are unsure about what to so in a particular situation – seek advice and assistance from appropriate colleagues. Remember to document any discussions that take place.

- Health and social care providers need to have clear policies and procedures regarding CPR and they must ensure that all staff members fully understand and adopt the policy.

- Nurses should ensure they are familiar and keep up to date with relevant best practice and policies. It is often helpful to be aware of recent decisions and reflect on them. The NMC has stated that it encourages nurses "*to learn lessons from specific cases to inform their own future practice and prevent similar issues occurring.*"

This case emphasises the importance of obtaining early legal advice and engaging with the process following referral to the NMC. There are real risks to your registration if you do not. It is also important to be open and seek advice and support from colleagues, friends and family. Facing any type of investigation can be stressful and it is important to have the right support network around you.

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