2011
1 - Medical staff invoked a DNAR and withdrawal of all treatment explaining their reasons to the patients family that the patient was not going to survive.

2 – Family member of patient overheard discussions taking place about the decision regarding a DNAR order. Family member of patient was very distressed to hear this being discussed in a telephone conversation whilst she was waiting on the ward.

3 - Alleged that Doctor who was part of team at that time should record DNAR on the patient's records.

2012
1 -Patient's family unhappy with how a doctor discussed DNAR with their mum.

2 - The complainant feels that the doctor who examined the patient could have asked questions re DNAR with greater sensitivity and kindness, not taking place late at night when the patient had just been admitted to the ward.

2013
1 - Concerns relate to the DNAR placed on his notes and the lack of fluids and nutrients.

2014
1 -Relative has accessed patient notes and found that a DNAR was placed on the patient when the patient only came to RAEI to be assessed for a hoist prior to discharge.

2015
1 - Complainant unhappy that patient was approached when family had just left to discuss DNAR.

2016
1 -MP enquiry on behalf of late patient's neighbour who is querying DNAR placed on patient before he died

2017

None

2018
1 -Patient admitted to department suffering worsening shortness of breath - DNAR mentioned but patient states was too ill to understand meaning. Discharged and DNAR was still in place. Suffers mental health issues and feels this is being affected. Would like to challenge DNAR decision.

2- Patients relative unhappy with the DNAR process whilst in hospital. Questions when why and who is involved in the process. Feels that patient should not be subject to resuscitation.