Adult Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safeguarding

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people’s individual needs.

Assessing needs

We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, well-being and communication needs with them.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Independence, choice and control

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and well-being.

Responding to people's immediate needs

We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Planning for the future

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Scope

Some residents will have in place advance planning, requiring no action to be taken on the event of them requiring Cardiopulmonary Resuscitation (CPR) and/or medical intervention in a medical emergency.

This policy provides guidance for staff on supporting residents who may experience a sudden collapse or medical emergency and/or residents receiving palliative care who have one of these orders in place.

Examples include:

- Do Not Attempt Cardiopulmonary Resuscitation
- Recommended Summary Plan for Emergency Care
- Treatment Escalation Plan

This policy and procedure are provided for the regulated activity of accommodation for people with personal care and nursing.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

- Residents have the right to make decisions about their treatment and this includes their wishes and choices on resuscitation. EFH will respect our residents' wishes should this situation arise.
- If a resident with capacity refuses CPR, or a resident lacking capacity has a valid and applicable advance decision to refuse treatment, specifically refusing CPR, this must be respected.
- DNACPR decisions should only be made by a senior clinician responsible for the resident's clinical care. This could be a consultant, general practitioner (GP) or suitably experienced and competent nurse.
- If a high risk of cardiac arrest has been identified, it is important clinicians make decisions about CPR in advance of clinical deterioration. This is so medical, nursing and care staff can provide appropriate care in the event of clinical deterioration, when the responsible senior clinician person may not be present.
- The ReSPECT process is an approach to encourage people to have an individual plan to try to ensure that they get the right care and treatment in an anticipated future emergency in which they no longer have the capacity to make or express choices.
- DNACPR decisions are solely based on medical factors (i.e. CPR would not be successful), or on the balance of benefits and burdens, which involves a broader "best interests" judgement. Decisions must not be made based on assumptions such as persons' ages, disabilities, or on a professional's personal view of a person's quality of life.
- There is a standardised DNACPR form which must be signed off by the relevant medical practitioner.
- There is specific guidance on the review requirements of DNACPR's and reviews are undertaken by the senior clinician. EFH is not responsible for completing DNACPR's or arranging reviews. However, we do have a duty to make the clinician aware of any changes to the person's circumstances that are relevant to the DNACPR.
- The DNACPR record must be kept in the the resident's file. This is so it is easily accessible to staff, and other health or social care partners such as paramedics in the event of a medical emergency.
- Effective communication between EFH and multi-agency partners is critical and two-way to ensure the residents wishes are conveyed and respected.
- Both Registered Managers and staff have responsibilities within this policy and need to be aware of these and implement them.

The primary goal of care is to restore or maintain residents health and well-being as far as possible, thereby maximising benefit and minimising harm.

If treatment fails or ceases to benefit the resident, and/or a resident with mental capacity can/has refused treatment then that treatment is no longer justified.

Decisions about DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) must be made by the responsible clinician based on an individual assessment of each case. These decisions should never be dictated by 'blanket policies.'

Decisions about DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) are made by a clinician responsible for the resident's care. Conversations can be sensitive and complex, and our staff may be asked to participate in a best interests discussion where a resident we support lacks capacity to consent to a DNACPR.

We will ensure that all senior staff have suitable skills and knowledge to participate in discussions about DNACPR when needed. Training on 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders will be delivered in line with the training needs analysis.

The Mental Capacity Act 2005 (MCA) protects residents rights to make capacitated decisions and ensures that where a resident lacks capacity to make a specific decision, decisions are made in their best interests. The MCA informs this policy and staff must be aware key aspects including, protection from liability, applicable and valid advance decisions and emergency treatment. Our organisation will respect a resident's known CPR decisions and act on any best interests decisions that have been made.

The Policy

Key Definitions

CPR stands for Cardiopulmonary Resuscitation. It's a lifesaving medical procedure which is given to someone who is in cardiac arrest. It helps to pump blood around the person's body when their heart can't.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) means that if a resident's heart or breathing stops, EFH staff will not try to restart it. A medical practitioner is required to complete the DNACPR documentation and sign it, and should discuss it with the resident where they have capacity, or their representative e.g. Power of Attorney for Health and Welfare, if they not.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. The ReSPECT process provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

A Treatment Escalation Plan (TEP) is a plan of care that healthcare professionals complete with residents. It relates to the medical care a resident wants to receive in the event that they become more unwell. Different residents may choose different levels of care and their decisions may change over time. The TEP is not a legal document but discusses the level of care residents may want. Decisions could include whether a resident wants to be admitted to hospital or prefers to stay at home, what type of medicine they may want, whether they would want sips of fluid or a needle put in their arm to provide fluids (IV), whether they would want to be admitted to intensive care and whether they want to be resuscitated (CPR).

EFH aims to provide a safe, effective, caring, responsive and well-led service to all its residents.

This is achieved through training, competency assessment, policies and procedures, staff supervision and oversight from management which includes quality assurance and audit.

EFH will ensure that staff are trained in basic life support and provided with guidance to support residents including acting effectively and safely on their decisions in relation to CPR.

EFH will work with resident, their families and healthcare representatives to respect their wishes in advance planning to ensure their dignity, respect and human rights are upheld.

National Guidance

Guidance on making decisions about CPR and DNACPR is provided in a document collectively written by the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. The document is called 'Decisions relating to CPR (cardiopulmonary resuscitation).'

CQC and DNACPR

The Care Quality Commission was asked to review 'do not attempt cardiopulmonary resuscitation' decisions during the coronavirus (COVID-19) pandemic. The report identified that the COVID-19 pandemic resulted in unlawful, prejudicial blanket DNACPR decisions being made about people. They produced a report with a series of recommendations, two of which are directly relevant for EFH. These are:

1. People must always be at the centre of their care, including advance care planning and DNACPR decisions.

   To achieve this EFH will ensure that residents and/or their representatives are included in compassionate, caring conversations about DNACPR decisions as part of advance planning conversations.

2. There must be comprehensive records of conversations with, and decisions agreed with, people, their families and representatives that support them to move around the system well.

   To achieve this, we ensure record keeping is of good quality and information is shared with key partners as required.

Making Resuscitation (CPR) Decisions

For many residents receiving care the likelihood of cardiorespiratory arrest is small, and no clinical decision is made in advance of such an event.

If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussions about CPR with the person.

However, even if the risk of cardiorespiratory arrest is low, care staff and general practitioners (GPs) should be prepared and trained to discuss resuscitation (CPR) in an honest and transparent fashion with residents who request it.

It is important the responsible clinician makes decisions about CPR in advance of clinical deterioration in cases where there is an identifiable high risk of cardiac or respiratory arrest, either because of:

- An underlying incurable condition (such as cancer or advanced heart failure),
- The resident's medical history (such as myocardial infarction or stroke), or
- Current clinical condition (such as overwhelming sepsis).

Please see 'Universal Principles for Advance Care Planning (ACP).'

This is so medical and care staff can provide care appropriate to the person's needs in the event of clinical deterioration.

CPR decisions should only be made by a senior clinician responsible for the clinical care of the person.

However, the views of the wider care team involved in the resident's care, are valuable in forming a decision about the likely clinical effectiveness of attempting CPR and about best interests where the resident lacks capacity to discuss this.

The Court of Appeal Tracey Judgement in 2014 highlighted people's right to be consulted and be made aware if a DNACPR is in place. This is to make sure the individual can request a second opinion. Consequently, our assessment of need will establish whether a DNACPR is in place. The resident's care plan will provide guidance for care workers on what action to take in the event of a medical emergency.

Refusal of CPR by Adults with Capacity

Adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where health professionals believe that CPR may be successful in restarting a person's heart and breathing, discussion should take place with the person to determine their views and wishes regarding CPR.

If a person decides that they do not wish to have CPR attempted, the healthcare professional should document this and ensure it is communicated appropriately to those who need to know, including our organisation.

When we know a DNACPR is in place this will be clearly recorded in the resident's care plan and the DNACPR form will be prominently positioned within resident's care file. This will be indicated on the banner of Access and Clinical digital care plans.

Care workers and other staff will not attempt CPR when there is a valid DNACPR in place.

Refusal of CPR by Adults without Capacity

In England and Wales advance decisions are covered by the Mental Capacity Act 2005. An applicable and valid advance decision can be made by a person aged 18 or over, whilst still able to make a capacitated decision to refuse medical treatment (including CPR).

It is made for a time in the future when the person may lack capacity to consent or refuse the treatment. The MCA confirms that an advanced directive for care and treatment (ADRT) refusing CPR will be valid, and therefore legally binding on the care team, if:

- The person was 18 years old or over and had capacity when the decision was made;
- The decision is in writing, signed and witnessed;
- It includes a statement that the advance decision is to apply even if the person's life is at risk;
- The advance decision has not been withdrawn;
- The person has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
- The person has not done anything clearly inconsistent with its terms; and
- The circumstances that have a risen match those envisaged in the advance decision.

If an ADRT does not meet these criteria but appears to set out a clear indication of the person's wishes, it will not be legally binding but should be taken into consideration in determining the person's best interests.

A tattoo with the words 'Do not resuscitate' or similar does not legally constitute a binding ADRT but should be taken into consideration when assessing a person's previously expressed views and wishes, in order to make a decision in their best interests.

Although an ADRT is not relevant until a person has lost capacity and may not come to light until a person has lost capacity, there should be a presumption that the individual had capacity when an advance decision was made unless there are grounds to suspect otherwise.

Where a resident lacks capacity to make a decision about DNACPR and does not have a valid advance decision, a best interests decision will be made by the senior clinician. This decision must take account of the residents known wishes and preferences and involve consulting with those (including our staff) who are involved with the resident to gain their views on what may be in the person's best interests e.g. Power of Attorney for Health and Welfare.

Duration and Review of DNACPR Decisions

Decisions about reviews and duration are the responsibility of the senior clinician. Each decision about DNACPR should be subject to review based on the person's individual circumstances. The only time a DNACPR would not be reviewed is when the responsible clinician has assessed and documented that the DNACPR decision will be appropriate until the death of the person.

EFH will ensure staff are suitably trained to understand when a request for review may be needed and know how to raise a concern about the appropriateness or validity of a DNACPR.

Procedures

EFH will ensure residents and their representatives are made aware of what care workers should do in the event of a medical emergency where a resident stops breathing. This will be recorded in the care plan.

The Registered Manager

- Establish whether a resident has made an advance decision regarding their treatment and, if so, whether this decision has been lodged with their medical practitioner.
- Establish whether there is a DNACPR in place and make sure this information is documented.
- Check the validity of the DNACPR. Has it been signed by the responsible clinician? Has it been discussed with the resident?
- If there are concerns about the validity of the DNACPR form, the Registered Manager must raise these with the responsible clinician and/or the resident's GP.
- Establish whether there is a ReSPECT or TEP plan in place and if so, ensure information about this is provided in the care plan.
- Share information about an advance decision, a DNACPR, or a known wish not to be resuscitated with the resident's medical team.
- Ensure DNACPR, and or other advance planning documents/forms are stored at the front of resident care files to ensure they are easily accessible for care workers and healthcare practitioners who may need to respond in the event of a medical emergency.
- Provide staff with guidance and learning opportunities to clarify their attitudes and feelings over such issues and to understand their respective roles and responsibilities in such situations.

Care Staff

Read this policy.

- Participate in basic life support training, which will include discussions/training on DNACPR, TEP and ReSPECT.
- Read and follow the resident's care plan to ensure they understand and follow any emergency instructions. If staff are unsure of the actions they should take, they do not feel competent, require further training and/or have concerns regarding the documentation they must raise this with their Line Manager and/or the Registered Manager.
- Summon immediate medical help including the emergency services in incidents of sudden collapse.
- If there is a valid DNACPR in place, do not attempt CPR.
- If there is not a DNACPR in place commence basic life support until emergency assistance arrives in line with the EFH policy.

References

https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation

https://www.resus.org.uk/library/2021-resuscitation-guidelines

https://www.resus.org.uk/public-resource/cpr-decisions-and-dnacpr

https://www.resus.org.uk/respect

https://www.resus.org.uk/sites/default/files/2020-06/2016_07_25_CPRdecisions_patientinfo_FINAL.pdf

https://www.nhs.uk/conditions/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/

Review date	Next Review Date
May 2024	May 2027