



# Care Home Practitioners Guidance to Cardiopulmonary Resuscitation (CPR)



## **Care Home Practitioners Guidance to Cardiopulmonary resuscitation (CPR)**

This guidance has been written for care home practitioners as a quick reference guide. Full guidance can be found via: <https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr>

All organisations that face decisions about attempting cardiopulmonary resuscitation (CPR), including hospitals, general practices, care homes, hospices and ambulance services, should have a policy about CPR decisions. These policies must be readily available and understood by all relevant staff and should also be available to the public.

### **1. Advanced care planning**

When a decision about CPR is discussed, made and recorded, clinicians should be clear about the basis for the decision. Health care professionals have an important role in helping people to participate in making appropriate plans for their future care in a sensitive but realistic manner, making clear whether or not attempted CPR in their situation, when appropriate and to clarify their wishes in respect of CPR. If an LPA is given after an advanced decision is made, the LPA can over rule it.

### **2. Non –discrimination**

It must not be assumed that the same decision will be appropriate for all people with the same condition. Decisions must not be made on the basis of assumptions based solely on factors such as a person's age, disability, or a professional's subjective view of a person's quality of life.

### **3. Human Rights Act**

Policies and individual decisions about CPR must comply with Human Rights Act 1998. Provisions particularly relevant to decisions about attempting CPR include the right to life (Article 2), the right to be free from inhuman or degrading treatment (Article 3), the right to respect for privacy and family life (Article 8), the right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and the right to be free from discriminatory practice in respect of these rights (Article 14). In considering decisions about treatment in relation to the Act, the courts have indicated that

the degree of patient involvement required by Article 8 depends on the particular circumstances of the case, and notably the nature of the decisions to be taken. An individual has to be involved in the decision-making process, seen as a whole, to a degree sufficient to provide her or him with the requisite protection of their interests.

#### 4. Decisions not to attempt CPR because it will not be successful

Adults with capacity may decide to refuse CPR, with or without giving a reason for their decision. Decisions about CPR may be made following consideration of a balance of benefits and burdens. In other cases, the decision not to attempt CPR is a clinical decision, if the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not re-start the heart and breathing for a sustained period. If there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. The patient and /or their representatives should be involved in the decision making process. If the clinician makes a conscientious decision not to inform a patient of a DNACPR decision, as they believe that informing the patient is likely to cause them harm, they should document clearly their reasons for reaching this decision. When a person lacks capacity and a decision is made that CPR will not be attempted because it will not be successful, those close to that person must be informed of this decision and of the reasons for it, and unless this is contrary to confidentiality restrictions expressed by the patient when they had capacity. Sensitive and careful explanation is needed to help people to understand that the intention is to spare the patient traumatic and undignified treatment that will be of no benefit, as they are dying, not to withhold life-saving treatment, and not to withhold any other care or treatment that they need.

Clinicians should:

- record fully their reasons for not explaining a DNACPR decision to those close to the patient at that time, documenting clearly why to do so would not be practicable or appropriate
- ensure that a plan for on-going active review of the decision is recorded and implemented
- ensure that a plan for informing those close to the patient of the decision at the earliest practicable and appropriate opportunity is recorded and implemented
- Be conscious that simply because it may be inconvenient or undesirable to inform those close to the patient of a decision at a particular time does

not, in itself; meet the threshold for it being not practicable and appropriate. Failure to document reasons in this way may leave clinicians at risk of legal challenge.

Healthcare professionals discussing and communicating CPR decisions to patients, and those close to them, should:

- offer as much information as is wanted (with due regard for the patient's wishes concerning confidentiality)
- be open and honest
- use clear, unambiguous language
- use a combination of verbal discussion and information in printed or other formats
- provide information in formats which people can understand; this may include the need for an interpreter or easy-to-read formats
- provide information that is accurate and consistent
- check understanding
- Where possible, have conversations about decisions in an appropriate environment and allow adequate time for discussion and reflection.

#### 5. People with a welfare attorney or court- appointed deputy or guardian

If a patient lacks capacity and has a personal welfare attorney (also described as an attorney for health and welfare) or a deputy, it will be necessary to discuss matters relating to CPR with them. The nature of the discussion will depend upon the basis on which the person is acting. It is important to understand that a personal welfare attorney is not empowered to make decisions on behalf of a patient regarding whether or not CPR will be attempted, unless their power of attorney document states specifically that the personal welfare attorney has the power to consent to or refuse life-sustaining treatment (which would include CPR). Where there is disagreement between the healthcare team and an appointed health and welfare attorney or court-appointed deputy about whether CPR should be attempted in the event of cardiorespiratory arrest, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration.

#### 6. Adults who lack capacity and have no family, friends or other advocate who it is appropriate to consult.

The Mental Capacity Act 2005 requires consultation with an independent mental capacity advocate (IMCA) regarding all decisions made by an NHS body or Local Authority about 'serious medical treatment', where people lack capacity and have nobody to speak on their behalf.

## 7. Responsibility for decision making

The overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician responsible for the person's care as defined explicitly by local policy. This could be a consultant, general practitioner (GP) or suitably experienced and competent nurse. Where care is shared, for example between hospital and general practice, or between general practice and a care home, the healthcare professionals involved should discuss a decision about CPR with each other and with other members of the healthcare team. There should be shared responsibility for deciding about the likelihood of a successful outcome from CPR, and discussing the subject with the patient or with those close to patients who lack capacity where appropriate.

Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. An initial presumption in favour of CPR does not mean indiscriminate application of CPR that is of no benefit and not in a person's best interests.

[Section 8 of the Resuscitation Council, BMA and RCN guidance](#) states that: "...there will be cases where healthcare professionals discover patients with features of irreversible death – for example, rigor mortis. In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies."

## 8. Recording decisions

Any decision about whether or not to attempt CPR must be recorded clearly in the patient's current health record, and should be available immediately and easily to all healthcare professionals who may need to know it, including staff of hospitals, hospices and nursing homes, GPs and other community healthcare professionals, out-of-hours medical services, and ambulance clinicians.

The CPR decision form itself should contain sufficient detail to allow a healthcare professional facing an emergency situation to assess quickly and easily the basis on which the decision was made, the people involved in making the decision (including the patient and if not, reasons why not), and others who have been informed of the decision.

In many circumstances it is necessary to record additional information in the text of the patient's health record. When a CPR decision form is transferred with a patient, this fact should be documented in the health record.

When applying section 8 guidance, it is imperative that both the decision and the rationale for the decision is recorded clearly in the patients records.

## Patient transfer

Transfer of patients from one setting to another presents particular challenges in relation to decisions relating to CPR and their documentation. This has been highlighted by examples of inappropriate CPR being applied to people being transferred between healthcare organisations, because a DNACPR decision was not communicated effectively or because the healthcare organisation transferring or receiving the patient did not accept a decision by another healthcare organisation. In some instances this has been compounded by unnecessary involvement of police or the coroner following an expected death during transfer. This emphasises the importance of effective communication between healthcare professionals involved in all aspects of a person's care and the importance of policies that allow clinical decisions, and the documents used to record them, to cross geographical and organisational boundaries.

You should check the handover arrangements where you work, and use the available systems and arrangements for information storage and exchange, to ensure that the agreed care plan is shared within the healthcare team, with both paid and unpaid carers outside the team and with other healthcare professionals involved in providing the patient's care. This is particularly important when patients move across different care settings (hospital, ambulance, care home) and during any out-of-hours period. Failure to communicate some or all relevant information can lead to inappropriate treatment being given (for example, DNACPR decisions not being known about) and failure to meet the patient's needs (for example, their wish to remain at home not being taken into account).

## 9. Review

Decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person's condition or in their expressed wishes. This applies to a decision that CPR is appropriate as well as to a DNACPR decision. The frequency of review should be determined by the healthcare professional responsible for their care and will be influenced by the clinical circumstances of the patient.

The required frequency of review of CPR decisions may differ greatly between different types of care setting. It may also differ greatly between individual patients within any one care setting, so the frequency must be based on the needs of the individual patient and not on any 'blanket' policy. For example, in a palliative care environment frequent review of DNACPR decisions will not be necessary for many patients, but the healthcare staff should be competent to recognise those whose situation warrants more frequent review of the decision.

## 10. Standards, audit and training

CPR decisions and conversations about them are often sensitive and complex. They should be undertaken by appropriately trained, competent and experienced members of the healthcare team. Organisations providing healthcare must ensure that their clinical staff have up-to-date knowledge and adequate training to:

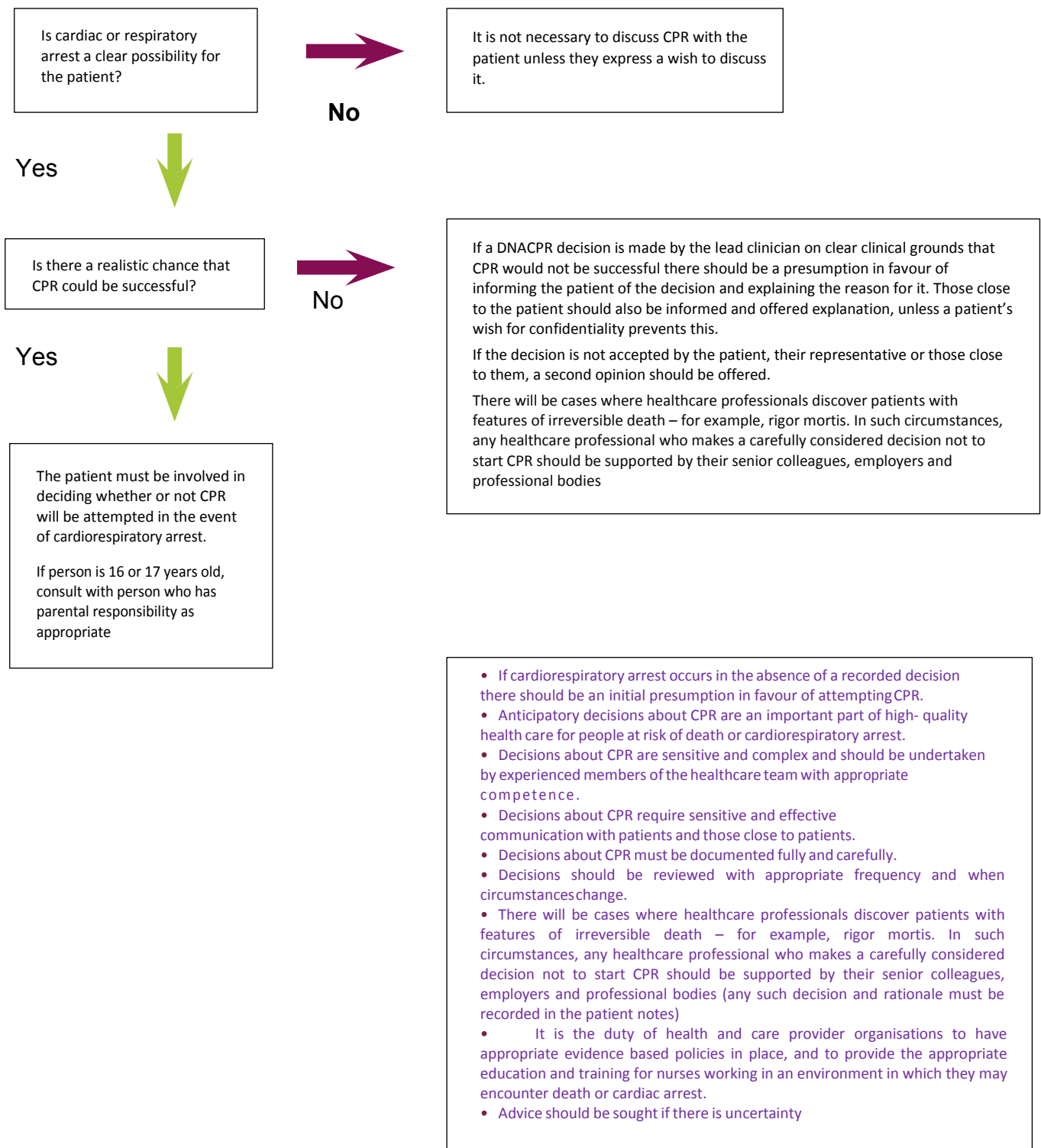
- make appropriate decisions about CPR
- provide relevant information to patients and those close to them
- communicate effectively with patients and those close to them
- support involvement of patients and those close to them through sensitive discussions
- Undertake appropriate review of decisions about CPR.

CPR should be performed competently and in accordance with current national and international guidelines. Local policies should be subject to scrutiny.

Performance of CPR and the appropriateness and effectiveness of decisions about CPR should be the subject of continuous clinical audit.

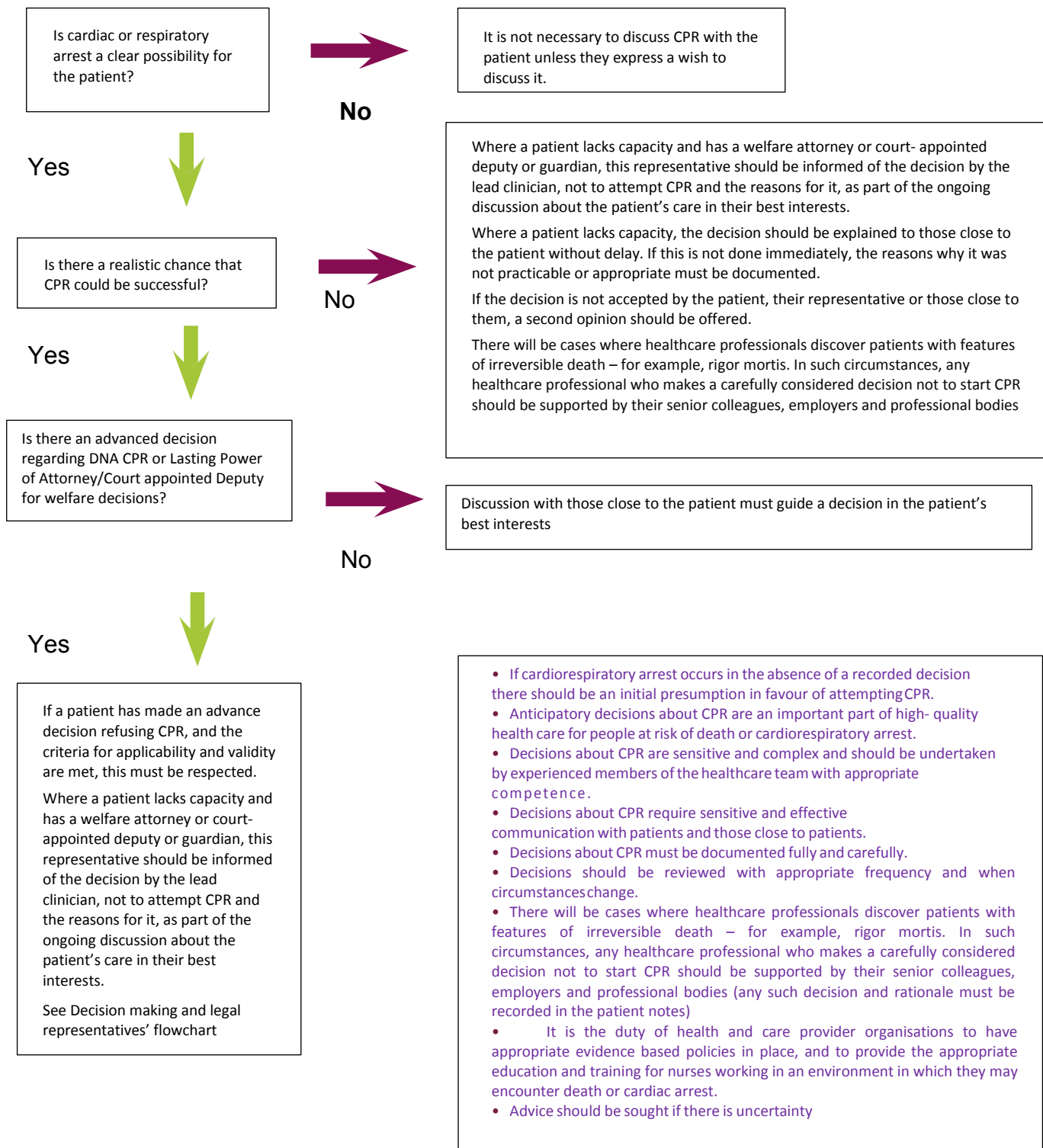
It is the duty of health and care provider organisations to have appropriate evidence based policies in place, and to provide the appropriate education and training for nurses working in an environment in which they may encounter death or cardiac arrest.

# Decision-making framework for a person (16+) with mental capacity re DNA CPR decision

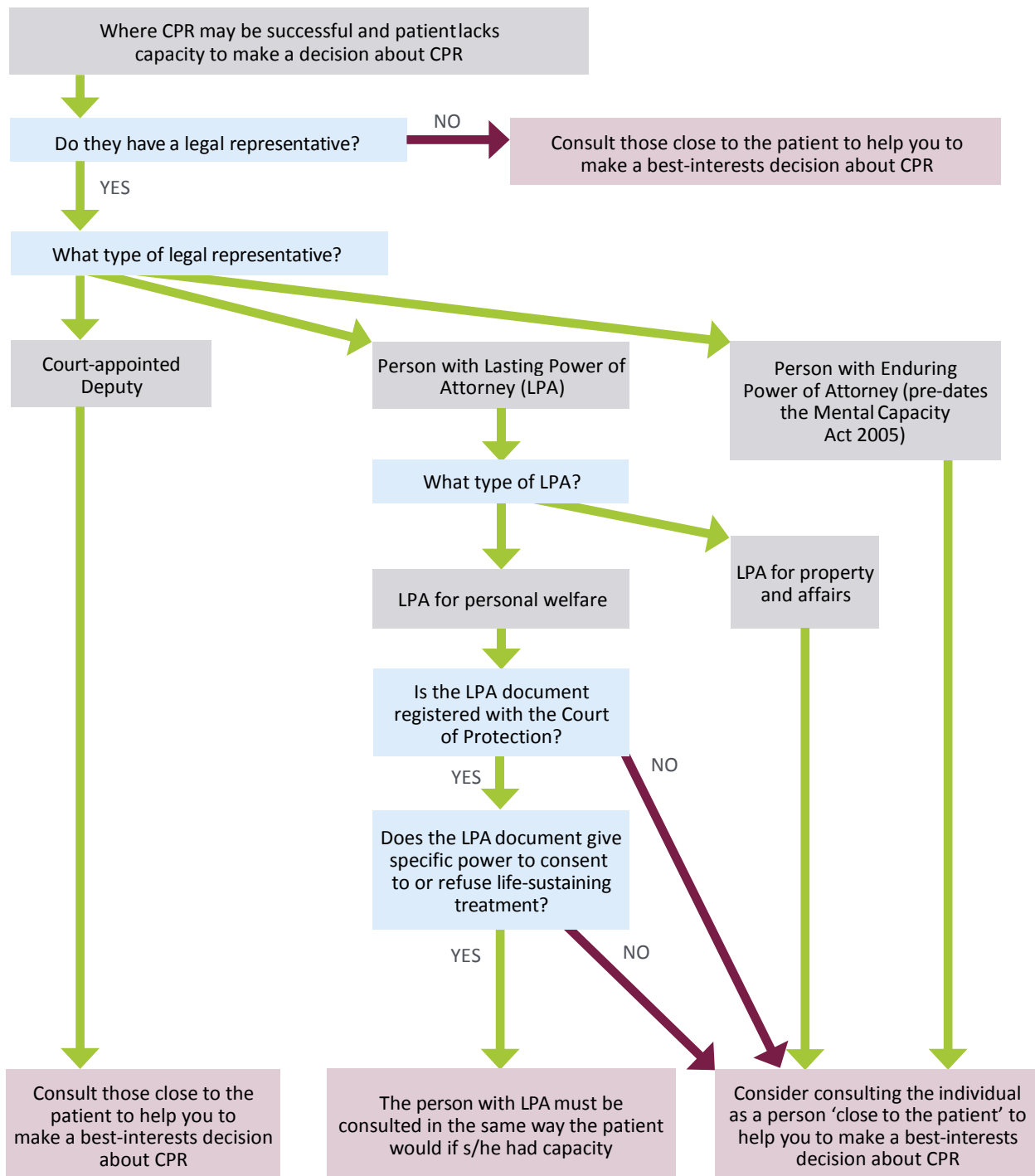




# Decision-making framework for a person (16+) lacking mental capacity re DNA CPR decision



# Decision-making and legal representatives



In all situations, where CPR will not work it should not be offered. This decision and the reasons for it should be explained carefully to those representing and those close to the patient. Where there is objection to or disagreement with this decision, a second opinion should be offered. The court may be asked to make a declaration if it is not possible to resolve the disagreement.