Shropshire Partners in Care
The Care Workforce Development Partnership

Safeguarding Adults Forum

July 2018

NHS Telford and Wrekin Clinical Commissioning Group
a co-operative council
Telford & Wrekin Council
NHS Shropshire Clinical Commissioning Group
Shropshire Council

Agenda

Introduction from safeguarding adults forum organisers *(Karen Littleford)*

Medication – Common Themes concerning Medication Management and Adult Safeguarding
(Amy Potts)

Mental Capacity Act - DNACPR Forms
(Marion Kelly)

BREAK

The ReSPECT Initiative
(Marion Kelly and Paul Cooper)

Prevent - Awareness Level Training (40 minutes session with CPD certificate)
(Paul Cooper)

Forum Meeting Evaluation

The **purpose of the Safeguarding Adults Forum** is to promote awareness of good practice concerning safeguarding adults, including the application of the Mental Capacity Act, the Deprivation of Liberty Safeguards and the Prevent agenda

(SA Forum ToR, 2018)

Ground Rules for Forum Meetings and Engagement with the Forum

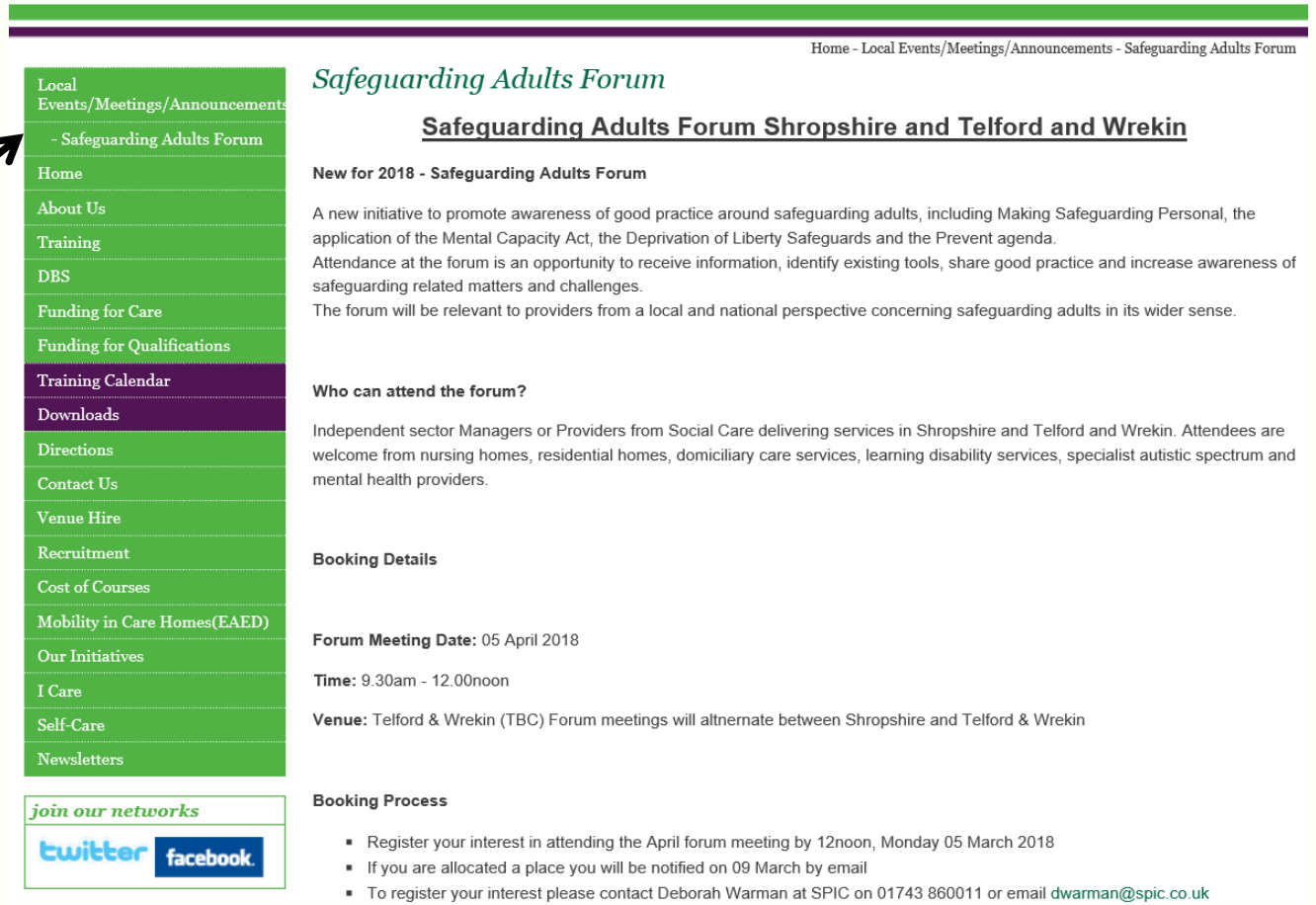
Applicable during forum meetings and in any subsequent communication, including electronic:

- Language (appropriate)
- Maintain individuals confidentiality
- Respect other forum members right to voice their opinions
- Acknowledge differences in opinions
- Contribute to requests for future agendas
- Work to the forum Confidentiality Agreement
- Commit to partnership working in order to improve the experience of adults with care and support needs
- Commit to engage, share good practice and take appropriate action
- Be open to suggestions ‘open, engaged and involved’
- Evaluate individual forum meetings in order to contribute to overall project evaluation
- Cascade information within your organisation

Ground Rules for Forum Meetings and Engagement with the Forum

Communication outside of forum meetings:

Visit the SPiC website to access signposting materials



Forum Questions

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Medication – Common Themes concerning Medication Management and Adult Safeguarding

(Amy Potts, Care Home Pharmacy Technician, Telford and Wrekin CCG)

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COMMON THEMES CONCERNING MEDICINES MANAGEMENT AND ADULT SAFEGUARDING

Telford and Wrekin Medicines Management Care Home Team

The Care Home Team is part of the Telford and Wrekin Medicines Management Team.

Amy Potts – Care Home Pharmacy Technician

- Roles and Responsibilities - To carry out Medicines Management audits including the annual Medicines Management checklist, provide Medicines Management advice and support to Care homes including support with medicines related processes for example medication ordering and to carry out level 1 medicines reviews for care home residents involved in the Prescription Ordering Direct (POD) pilot scheme.

Hitesh Patel - Pharmaceutical Adviser

- Roles and Responsibilities – Medicines Management Care Homes Safeguarding Lead and Pharmaceutical Adviser supporting medicines optimisation in care homes

Care Home Multi-Disciplinary Team (MDT)

- We also work alongside the Shropshire Community Trust Care Home MDT. This team includes

- Julie Roper – Enhanced Nurse & Clinical Lead
- Jo Dorling – Specialist Nurse with interest in end of life care
- Steph Wedmore – Physiotherapist
- Specialist Nurse with background in urgent care
- Lucinda Seabury - Assistant practitioner

Contact information – (01952)580428

Care Home MDT - Aims

- To reduce hospital admissions from care homes by 40%
- To improve the continuity of care provided throughout Telford & Wrekin
- Forging links with local providers
- Improve prevalence of pressure ulcers, urinary tract infection and falls (Harms)
- Subsequently, we may reduce GP call-outs

The team are currently rolling out

- emergency passports
- developing advanced care plans with patients and carers
- planning to roll out the use of red bags
- delivering training workshops
- supporting/developing previous learning to embed knowledge
- offering general advice and support to nursing/care homes
- helping to support discharge from secondary care.

Shropshire Medicines Management Care Home Team



- The Care Home Team is part of the Shropshire Medicines Management Team.
- Their role is to work in conjunction with care homes and GP practices by providing support and best practice guidance around medicines management:
  - Holistic clinical medication reviews
  - Training and education
  - Improving the systems around the prescription cycle
  - Reducing waste medicines
- The Team consists of Care Home Lead, Clinical Pharmacist & Pharmacy Technician and a Dietitian who all specialise in care homes medicines management best practice.

Shropshire Care Home Team Roles

- Care Home Lead (Pharmacy Technician)
  - The main point of contact, provides overall advice, training and support to care homes & home care organisations and co-ordinates the team projects.
- Clinical Pharmacist
  - Focuses on the clinical aspects of medication reviews; looking at the most frail residents, ensuring that no resident is offered a medication that is not beneficial and checking that appropriate medicines and monitoring are in place.
- Care Home and Dietetic Support Technician
  - Provides support across the team. Carries out audits in care homes, looks at storage of medicines, makes sure correct quantities of medicines are on GP systems and provides non-clinical reviews of medicines. (We are currently recruiting an additional technician).
- Dietitian
  - Offers training on the Think Food in Care Homes Pathway and takes referrals for Care Home residents who are at risk of malnutrition, but for whom the pathway has not been adequate to meet their nutritional needs.

CARE HOMES – SAFEGUADING AND MEDICINES

What is considered a safeguarding incident in relation to medicines?

- The deliberate withholding of a medicine(s) without a valid reason
- The incorrect use of medicine(s) for reasons other than the benefit of a resident
- Deliberate attempt to harm through use of a medicine(s)
- Accidental harm caused by incorrect administration or a medication error

National Institute for Clinical Excellence (NICE) guidance – Managing Medicines in Care Homes

safeguard my meds

What do we mean by a ‘near miss’? And the importance of reporting

- A ‘near miss’ is defined as an event where significant harm could have happened, but was prevented from happening. For example Wrong dose prescribed, supplied or administered and omitted or delayed dose(s)e.g. Delayed administration of antibiotics leading to a hospital admission

- An appropriate process should be in place that allows all staff to raise and report near misses within the home

- Care homes are required to have ‘policies and procedures in place to support a culture of openness and transparency, and all staff follow these. They include encouraging open and transparent reporting of errors and incidents’.

What do the regulations say?

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 outlines that:

- In order to prevent people from unsafe care and treatment and prevent avoidable harm or risk of harm, providers must assess the risks to peoples health and safety during any care or treatment and make sure that staff have qualifications, competence, skills and experience to keep people safe. Providers must make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities. Medicines must be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe (Regulation 12).

Medication Errors

There is an 8 -10% chance of an error happening during each act of prescribing, dispensing or administering a medicine*

Errors are more common in the morning, why do you think this is??????

Common Causes of medication errors include –

- Interruptions during the preparation and administration of medicines are common and can contribute to an error occurring
- Selection of the wrong drug or incorrect dosage
- Inadequate, inaccurate, incomplete or illegible records (MAR Chart)
- Misreading directions (MAR chart, medicines label, medicines container)
- Incorrect transcribing or abbreviations e.g. 10iu transcribed for insulin dose and misread as 100 units and administered

*Care Homes use of medicines study Alldred et al 2009; Barber et al 2009

Minimising Medicines Errors/Risks

- Keeping your knowledge and practice up to date and acknowledging your own limitations
- Having clear medication policies and procedures
- Double checking by a second person in high risk situations and with high risk drugs e.g. administration of Controlled Drugs, Warfarin, insulin, Methotrexate, measuring quantities of solutions/syrups
- Taking time and not rushing, avoiding interruptions
- Accepting that when you are administering medications you are responsible for your actions
- Communicating, documenting & recording, ensuring thorough handovers take place and any PRN medication administered has been recorded and communicated accurately.

All care homes should be registered to receive patient safety alerts, public health messages and critical safety information as it is released

Central Alerting System (CAS) – web based cascading system – helpdesk 020 3080 6747 – email safetyalerts@dh.gsi.gov.uk to register

Process for reporting medicines errors

Care home providers should have a clear process for reporting medicines related safeguarding incidents under local safeguarding process and to the Care Quality Commission (CQC). This process should be recorded in the care home medicine policy and should clearly state:

1. When CQC or another regulator should be notified
2. Which medicines related safeguarding incidents should be reported under local safeguarding processes and when
3. The accurate details of any medicines related safeguarding incidents are recorded as soon as possible so that the information is available for any investigation and reporting.

Do I have to notify CQC about medicines errors?

There is no requirement to notify CQC about medicines errors, but a notification would be required if the cause or effect of a medicine error met the criteria to notify one of the following:

- A death
- An injury
- Abuse, or an allegation of abuse
- An incident reported to or investigated by the police

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To report safeguarding concerns to Telford and Wrekin Local Authority

TELEPHONE:

- **Family Connect/Adult safeguarding on 01952 385385 (Monday to Friday from 9am - 5pm)**
- **Emergency Duty Team on 01952 676500 (Monday to Sunday after 5pm)**

A Telford and Wrekin Council, 'Safeguarding Adults Concern Form' needs to be completed and emailed to:

EMAIL:
familyconnect@telford.gcsx.gov.uk

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To report safeguarding concerns to Shropshire Local Authority -Keeping Adults Safe in Shropshire

- **First Point of Contact team on 03456 789044 Monday to Thursday, 9am to 5pm, and Friday 9am to 4pm.**

- **If you have urgent adult safeguarding concerns outside of these hours, please phone the Emergency Social Work Duty Team on 0345 678 9040.**

https://shropshire.gov.uk/adult-social-care/where-can-i-get-help/concerned-about-someone/

All medicines related safety incidents, including all 'near misses' and incidents that do not cause any harm, should be raised as a resident safety incident.

An RCA (Root Cause Analysis) investigation should then be carried out by the provider, ensuring that any training needs that are identified are recorded and actioned.

All care homes in the Telford and Wrekin area should also complete a Significant Event and NHS to NHS Concerns '**PURPLE CARD**' report form. This then needs to be sent electronically to amy.potts@nhs.net. Any significant events reported in this way will then be logged on to the Datix system, NHS Incident Reporting software. Each anonymised incident will be used for education, learning and patient safety purposes for all Care Homes across Telford & Wrekin. Through SHARED learning this can then help to mitigate further risk.

Datix®
Software for Patient Safety

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Significant Event and NHS to NHS Concerns 'Purple Card' Report Form

Significant Event or NHS to NHS Concern:	
If it is an NHS to NHS Concern, where did the event occur? (organisation and ward/service):	
Date and time of the event:	
Who was affected by the event? **Name:** **DOB:** **NHS number:**	
If it was a medication event, what medication(s) were involved?	
If the event involved equipment, what was the equipment?	
Have you attached any supporting documents? (please list):	
Description of the event, please provide fact rather than conjecture:	
Action taken by you:	
Severity of actual harm or potential harm for a near miss: VERY LOW / LOW / MODERATE / SEVERE / DEATH:	
Your full names, job title and contact details (telephone and/or e-mail address):	

IMPORTANCE OF AN ACCURATE MEDICATION ADMINISTRATION RECORD (MAR)

There is a statutory requirement that medicines records be kept for all medicines in care homes.

An audit trail should be maintained for each medication:

- entering the premises
- Administered
- disposed/leaving the premises

MAR charts/eMAR are the formal record of administration of medicine within the care setting and may be required to be used as evidence in clinical investigations and court cases. It is therefore important that they are clear, accurate and up to date.

All residents MAR charts should be supported by an individualised, accurate and up to date care plan.

Ensuring that records are accurate and up to date

Health and social care practitioners should ensure that records about medicines are accurate and up-to-date by following the process set out in the care home medicines policy The process should cover:

- recording information in the resident's care plan
- recording information in the resident's medicines administration record
- recording information from correspondence and messages about medicines, such as emails, letters, text messages and transcribed phone messages
- recording information in transfer of care letters and summaries about medicines when a resident is away from the home for a short time
- what to do with copies of prescriptions and any records of medicines ordered for residents.

Care home providers must follow the relevant legislation to ensure that appropriate records about medicines are kept secure, for an appropriate period of time, and destroyed securely when appropriate to do so.

https://www.nice.org.uk/guidance/sc1/chapter/recommendations#developing-and-reviewing-policies-for-safe-and-effective-use-of-medicines

CARE PLANS

A care plan is an agreement between an individual and those who are delivering care and support to them and is designed to help clarify what support is needed and how it should be provided.

http://www.careuk.com/care-homes/choosing-funding-care/glossary-of-terms

The three main purposes of a care plan is:

- to ensure that the patient/client gets the same care regardless of which members of staff are on duty
- to ensure that the care given is recorded
- to support the patient/client to identify, manage and, hopefully, solve his or her problems, ensuring that all care plans are outcome focused

A CARE PLAN NEEDS TO BE INDIVIDUALISED AND REGUARLY REVIEWED

Covert Administration

- Covert administration of medication occurs when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. Covert administration of medication can only be necessary and justified in exceptional circumstances when certain legal requirements have been satisfied. **Medicines should never be administered covertly to patients who have capacity to make their own decisions**.

- Covert medication can refer to medication given to treat either mental or physical health problems. Covert medication should not be confused with enforced medication, where it is given with the person's full knowledge, but not their consent.

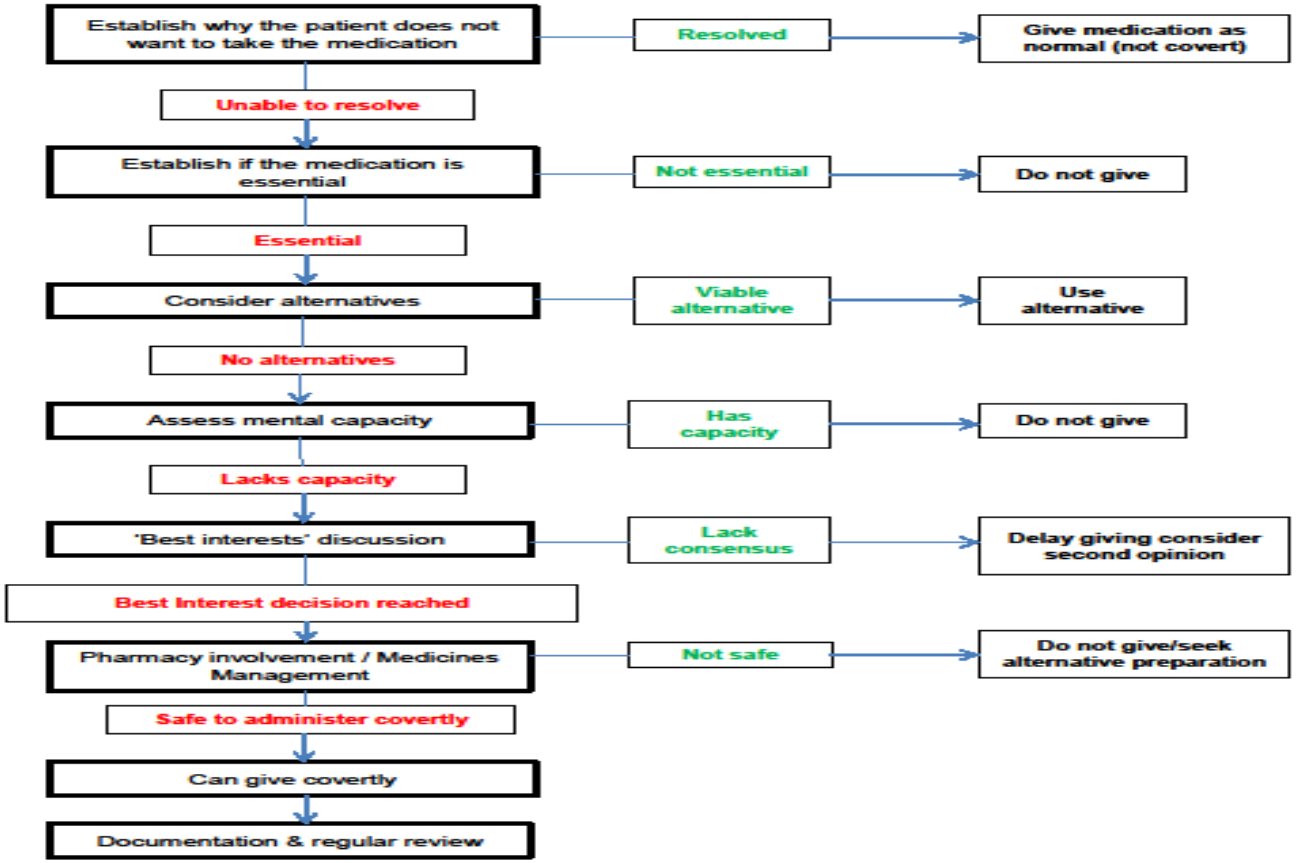
ALL care home providers must have procedures for arranging for covert administration of medicines.

Where covert medication is used the following principles should be seen as good practice:

Last resort; covert medication should only be used when all other options have been tried
Medication specific; each medicine must be considered individually for covert administration
Time limited; it should be used for as short a time as possible
Regularly reviewed; the necessity of a covert medication plan should be regularly reviewed as should the person's capacity to consent as this can differ on a daily basis in particular for residents with fluctuating dementia
Transparent; the decision making process should be easy to follow and clearly documented
Inclusive; the decision process should involve discussion and consultation with the team of people responsible for caring for the person and the person's relatives where appropriate.
Best interests; all decisions should be made in the person's best interests, having undertaken a holistic assessment of the impact of covert medication on the person

Appendix 2

Flowchart for the use of covert medication



COVERT ADMINISTRATION OF MEDICINES POLICY
Shropshire and Telford and Wrekin CCG's

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

Click here to access

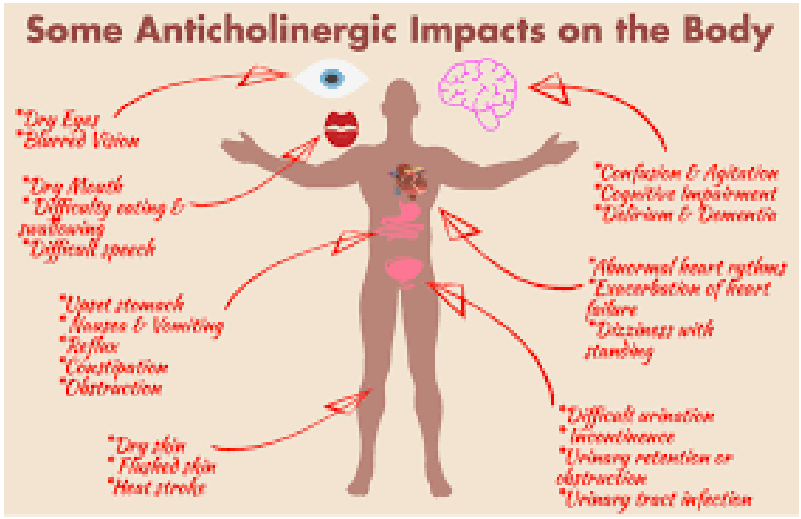
LOCAL PRESCRIBING INITIATIVES

- Stopping the over medication of people with a learning disability, autism or both (STOMP)

STOMP

Stopping over medication of people with a learning disability, autism or both

- Reducing Antipsychotic Prescribing in Dementia
- Reducing anticholinergic burden (ACB)
- Review Polypharmacy



BRANDED/GENERIC MEDICINES

GENERIC NAME - **This is based on the drug's main ingredient**

BRAND NAME - **This is the name given to the medicine by the company who make it**

Sometimes the same medicines may be supplied under different names so it is **essential** to check this out prior to administration.

An example of an actual error in a care home in Telford and Wrekin, both in stock due to a supply issue, care home staff unaware that these two brands where the same drug and administered to the resident one dose of each.

SAFEGUARDING INCIDENTS – PREPERATION AND ADMINISTRATION

- Medicines being given covertly without following correct procedure i.e. no best interest meeting held, no MCA in place, no agreed covert care plan
- Essential medicines not being administered and no valid reason as to why e.g. Parkinson's medication not being administered at specific times as prescribed (outside of set drug rounds)
- Medicines not being reviewed resulting in medicine being continued unnecessarily with risk of adverse effects e.g. Chlorphenamine initially prescribed for a rash, resident no longer required, continued to be prescribed and administered increased risk of Anticholinergic Burden (ACB)
- Resident administered the wrong medication, dose, route e.g. Incorrect insulin pen selected from the refrigerator and administered to the resident by District Nurse
- Resident administered an out of date medicine e.g. Expired Zopiclone dispensed and administered for several doses
- Medication administered to the wrong resident e.g. identified during medicines round that a resident is missing a Citalopram in their dossette box, career left meds round to contact community pharmacy regarding the error, upon returning to the meds round incorrect dossette selected and administered

MONITORING ERRORS

- A Prescription Ordering Direct (POD) Care Home Pilot Scheme has been introduced over the last 6 months by the CCG, this scheme has allowed the Medicines Management team to monitor errors and identify safety interventions.

- Patient known to be allergic to medication, but medication prescribed/dispensed/administered e.g. Penicillin prescribed, dispensed and administered for a chest infection when resident Penicillin allergic

- Failure to monitor therapeutic levels e.g. resident prescribed Levothyroxine, no recent TSH levels monitored or recorded resulting in resident being over compensated.

- Failure to monitor resident who is self-administering medicines e.g. incorrect dose of Bisoprolol taken following medicines review and dose decrease by GP

- Failure to react appropriately to signs of ill health, pain or requests for help due to being unwell associated with medication administration e.g. a resident had refused Gliclazide for 3 days and no intervention was made by the home to communicate these refusals to the residents GP

MONITORING ERRORS

- Continual administration of a ‘when required’ Benzodiazepine and/or sedative medication

- Delayed antibiotic treatment for an acute condition due to this being prescribed on a Friday, resulting in an avoidable hospital admission – What are your thoughts of how this error would be prevented within the care home environment?????

OTHER ERRORS

- Poor communication e.g. Alendronic Acid reviewed and stopped by GP, communicated to care home, but communication not recorded on MAR chart, home continue to administer

- Poor, inadequate or incorrect recording/documentation e.g. Omitted signatures on MAR following medicine administration or transdermal patch application records incomplete

- Inappropriate or incorrect process for the disposal of medicines e.g. controlled drug doom kits utilised, but not fully denatured or stored correctly until fully denatured i.e. stored in the CD cupboard until destroyed

- Inappropriate administration of behaviour controlling medication e.g. Lorazepam prescribed ‘when required’ for anxiety, being administered daily to enable care staff to administer personal care

- Deviation from local policy and guidelines relating to medicines management e.g. Homely remedies administered to a resident for 72 hours as opposed to 48 hours as per care home policy with no GP review

POTENTIAL AREAS OF HIGH RISK

- Processes which involve the use of appliances which require special administration techniques e.g. Catheters, Oxygen, PEGs and PR anticonvulsants.
- Administration of controlled drug preparations, in particular combinations of immediate release and slow release
- Transdermal patch application
- Insulin dosing
- Anticoagulant dosing
- Handling of medicines with similar names e.g. promethazine and promazine, Maxidex and Maxitrol, Tramadol and Trazodone, Hydroxyzine and Hydralazine

Assigning levels of risk - HIGH

HIGH RISK TO THE RESIDENT

- Medicine given to the wrong resident
- Wrong dose administered
- Hospital discharge changes not acted upon
- Discontinued medicines still being administered
- Medicines not in stock – level of risk depends on the medicine
- Medicines signed for administration, but not given e.g. if not in stock
- Controlled drug procedures not followed
- Covert administration undertaken without following correct procedure or lack of recording/documentation to support
- Unlabelled medication or medication kept that is no longer prescribed
- Recognised drug error not acted upon as per care home policy
- No recorded allergy status
- Crushing Medicines

MEDIUM RISK

MEDIUM RISK TO THE RESIDENT

- Medicines routinely signed for following medication round
- Omissions on MAR charts for internal preparations
- No PRN protocols for ‘when required’ medicines in particular pain management and psychotropic drugs
- Medicine keys not kept safely by the responsible member of staff
- Medicines left out for residents to take later on (no witness for administration)
- Best practice not followed when administering specialised drugs e.g. PEG residents, PR rescue medicines, IV drugs
- Lack of a regular medicines review
- Medicines stored incorrectly e.g. fridge out of range (2c – 8c) and treatment room below 24c
- Medicines labelled ‘As Directed’
- Medicines incorrectly ‘booked in’ to the home
- No accurate MAR records for the administration of Oral Nutritional Supplements (ONS)

LOW RISK

LOW RISK TO THE RESIDENT

- Variable dose administered not recorded (possibly medium risk depending on medicine administered e.g. Paracetamol given more regularly than 4 – 6 hourly.

- Administration of external preparations not recorded accurately on the MAR

- Externals administered by staff who have not been adequately trained

- Homely remedies not accounted for

MALADMINISTRATION PREVENTION CHECKLIST

- Where possible support residents to manage their own medicines if risk assessed as suitable to do so
- Robust systems need to be in place for medication administration (protected time) and record keeping as per the care home medicines policy
- Adherence/audit checks carried out regularly by management team
- Medication training is provided for all staff involved in medication administration and this is kept up to date with regular competency checks carried out
- Staff aware of error reporting and safeguard reporting procedure
- The home have an open, transparent and ‘no blame’ culture in order to encourage staff to report medicines errors
- Adequate staffing levels
- Regular medication reviews are carried out for all residents
- Effective communication

THANK YOU

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Clinical Commissioning Group

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SY3 8XL

Telephone: 01743 277557
Email: ceri.wright@nhs.net

Website:
http://www.shropshireccg.nhs.uk/professional-resources/medicines-management/

Do Not Attempt Cardio Pulmonary Resuscitation

(Marion Kelly, Trainer and Development Officer, Shropshire Partners in Care)

Shropshire Partners In Care

Do Not Attempt Cardio Pulmonary Resuscitation

Marion Kelly
Trainer and Development Officer

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

Name

Address

Date of birth

NHS number

Date of DNACPR decision:

/ /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO
If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? YES / NO
If "YES" go to box 6

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? YES / NO
If "YES" they must be consulted.

All other decisions must be made in the patient's best interests and comply with current law.
Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multidisciplinary team contributing to this decision:

6 Healthcare professional recording this DNACPR decision:

Name Position

Signature Date Time

7 Review and endorsement by most senior health professional:

Signature Name Date

Review date (if appropriate):

Signature Name Date

Signature Name Date

What is Cardiopulmonary Resuscitation (CPR)?

Cardiopulmonary arrest means that an individual's heart and breathing have stopped. It is sometimes possible to restart their heart and breathing with an emergency treatment called Cardiopulmonary Resuscitation (CPR).

- CPR can include some or all of the following;
- Repeatedly pushing down very firmly onto the chest
- Using high voltage electric shocks across the chest to try to restart the heart
- Mouth to mouth breathing, placing a mask over the nose and mouth or a tube into the windpipe to start the breathing
- Injection of drugs

Advance Care Planning	Advance Decisions to Refuse Treatment	DNACPR
This is a process of discussion between an individual and their care providers irrespective of discipline. The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.	These must relate to a refusal of specific medical treatment and can specify circumstances. It will come into effect when the individual has lost capacity to give or refuse consent to treatment. Careful assessment of the validity and applicability of an advance decision is essential before it is used in clinical practice. Valid advance decisions, which are refusals of treatment, are legally binding.	A DNACPR decision applies to CPR only, other ceilings of treatment need to be discussed. A DNACPR is a method of communicating a medical instruction, a clinical decision made on best interests relevant to the disease of the person.

https://heeoe.hee.nhs.uk/sites/default/files/2011-03-23_dnacpr_and_how_it_relates_to_mental_capacity_act_mca_leaflet.pdf

Issues identified

People in care homes were the care home staff have been consulted with by the doctor and have been filing completed forms were there have been omissions in the process around consultation and large gaps in the form i.e.

- **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:**

  A condition stated rather than explanation i.e.: learning difficulties/dementia Non-discrimination

- **Summary of communication with patient and relatives (Q3-4)**
  - Forms with no evidence of consultation. Hospital violated patient's rights with 'do not resuscitate...

Non-discrimination

- Any CPR decision must be tailored to the individual circumstances of the patient.
- It must not be assumed that the same decision will be appropriate for all people with a particular condition.
- Decisions must not be made on the basis of assumptions based solely on factors such as the person's age, disability,16 or on a professional's subjective view of a person's quality of life.
- Blanket policies that deny CPR or apply CPR to groups of people, for example to all patients in a hospice, nursing home or particular hospital ward, or to people above or below a certain age, are
  - unethical and probably unlawful.

Decisions or policies that discriminate in favour of, or against, people with defined disabilities would be unlawful under the Equality Act 2010 (in England, Wales and Scotland) or the Disability Discrimination Act 1995 (in Northern Ireland). Issues identified

Hospital violated patient's rights with 'do not resuscitate' order, court rules

Family of woman who died after order was put on her records without consultation win case against Addenbrooke's hospital

Meikle, J (2014) Janet Tracey Family Handout/PA Hospital violated patient's rights with 'do not resuscitate' order, court rules Family of woman who died after order was put on her records without consultation win case against Addenbrooke's hospital. The Guardian Online https://www.theguardian.com/society/2014/jun/17/hospital-patient-rights-do-not-resuscitate-addenbrookes

Judgement - https://www.judiciary.uk/wp-content/uploads/2014/06/tracey-approved.pdf

Tracey Ruling (DNAR)

Court case between Tracey and Cambridge University Hospital NHS Foundation trust:

The judgment *stated that when it came to a decision "which will potentially deprive the patient of life-saving treatment, there should be a presumption in favour of patient involvement" and convincing reasons would be needed not to involve them*.

You must :

- Discuss with patient
- Make a decision that is in the patients best interests
- Discuss with Relatives (if the person lacks capacity)
- If no relatives appoint an IMCA
- Record the discussion- including efforts that have been made to discuss that have been declined
- Consider offering the patient the option to seek a second opinion about their condition if the patient or family disagree

Issues identified

- **Names of members of multidisciplinary team contributing to this decision:**
  - Nurse in the care home has then had her/his details included in Q5 as being a member of the MDT who has been consulted with.
- **Mental Capacity Assessments not being completed**
- **Best interest assessments not being completed**

Mental Capacity and DNACPR

If the individual 'lacks capacity' consider;

- The views regarding DNACPR from the individual / representatives / IMCA
- The views regarding DNACPR from the care staff who support the individual
- The level of awareness that the individual has of their existence and surroundings.

Recording Mental Capacity Assessments

- It is essential practice for **professionals to carry out a proper assessment of an individual's capacity** to make particular decisions and to **record the findings in the relevant professional records.**

- A doctor or healthcare professional proposing consideration of a DNACPR decision should lead/take overall responsibility for an assessment of the individual's capacity to consent (with a multi-disciplinary team, if appropriate). They must ensure a record of the process and final decision regarding capacity for this decision is in the individual's notes and care plan.

Best Interests of the Person

Recording Best Interest Decisions

- Any Health professional or Senior Responsible Clinician who leads on a DNACPR decision, for an individual who lacks capacity, is responsible for recording information on the process of working out the individual's best interests including;

  - The process followed in making the decision in the best interests of the individual
  - The identified reasons which led to the decision being made.
  - Who was consulted in the best interests' decision making process.
  - What particular factors were taken into account and considered during the best interests meeting.
  - This Best Interest Discussion Record should remain in the individual's file.

https://www.39essex.com/cop_cases/elaine-winspear-v-city-hospitals-sunderland-nhs-foundation-trust/

Questions to ask the Decision Maker

- Why has a DNAR order been put in place?
- Has the person been consulted
- Has the persons relatives/next of kin been consulted/informed
- Has the person expressed their preference, wishes, views or feelings either in the past or now about CPR?
- Does the person have any concept or understanding of death?
- What risk and/or burdens will the person face if CPR is performed?
- What is the chance of CPR revival for the person if they have a cardio respiratory arrest?
- Are there known illnesses or medical problems that will impact on the outcome of

  a decision to perform CPR?
- What is the overall condition of the person's health and what effect will performing CPR have on this i.e. is it likely the person will have more physical health or care needs?
- Has the person's faith, beliefs or culture been considered in terms of levels of medical intervention and to what level the person would want these to be considered?
- When will the DNAR order be reviewed?
- Is there an advanced decision to refuse treatment that is applicable to this decision or have attempts been made to find one?

Please note some of these questions are sourced from the BMA

- A DNACPR decision is made and recorded to guide the decisions and actions of those present should the person suffer cardiac arrest, but is not a legally binding document. Fitness to Practise Statement

- An ADRT (as defined in the Mental Capacity Act 2005 – England & Wales) is a legally binding document that the person has drawn up (when they had capacity to make decisions) and in which they have stipulated certain treatments that they would not wish to receive, and the circumstances in which those decisions would apply. Where a properly drawn-up ADRT refuses CPR (despite acknowledging that their life would be at risk) a healthcare professional who attempts CPR on that person in full knowledge of the valid ADRT would be at risk of a charge of battery

https://www.resus.org.uk/faqs/faqs-dnacpr/

Fitness to Practise Statement

- Ms Kendall admits the following charges: That you a Registered Nurse, whilst employed at Moorland Nursing Home: 1. On 26 November 2014, upon finding Resident A unresponsive:

  1.1. Failed to attempt Cardiopulmonary Resuscitation (CPR);

  1.2.Failed to contact or ensure that the emergency services were contacted.

  2. AND, in light of the above, your fitness to practise is impaired by reason of your misconduct. To Resuscitate or Not to Resuscitate

Decision Making Framework

Decisions relating to cardiopulmonary resuscitation – Guidance from the British Medical Association, the Resuscitation Council (UK)and the Royal College of Nursing

- The British Medical Association [BMA], Resuscitation Council (UK) [RC (UK)] and Royal College of Nursing [RCN] note the findings of the Nursing and Midwifery Council's Conduct and Competence Committee in January 2017, recorded at

- https://www.nmc.org.uk/globalassets/sitedocuments/ftpoutcomes/2017/january-2017/reasons-kendall-cccsh-048388-20170109.pdf

DNACPR

- **DNACPR model forms and recommended standards for recording decisions**
  - www.resus.org.uk/dnacpr/do-not-attempt-cpr-model-forms/
- **Decisions relating to cardiopulmonary resuscitation –Guidance from the British Medical Association, the Resuscitation Council (UK)and the Royal College of Nursing**(previously known as the 'Joint Statement')**3rd edition (1st revision) 2016**
  - https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/
- **Best Practice for IMCAs**
  - www.cheshire-epaige.nhs.uk/ePaige%20Documents/DNACPR%20and%20IMCA.pdf
- **DNACPR Good Practice Guidance**
  - www.suffolk.gov.uk/assets/Adult-social-care-and-health/mental-capacity-and-deprivation-of-liberty-safeguards/Suffolk-DNACPR-Good-Practice-Guidance.pdf

ReSPECT Briefing Recommended Summary Plan for Emergency Care & Treatment

(Paul Cooper, Head of Safeguarding Adults, Shropshire CCG)

ReSPECT Briefing
Recommended Summary Plan for Emergency Care & Treatment

SAFEGUARDING FORUM – JULY 2018

With acknowledgement to:

The ReSPECT Process – Resuscitation Council

https://www.respectprocess.org.uk/

The BMJ

DNACPR in Context

DNACPR decisions are considered in three situations *:

- when a patient with capacity refuses CPR or a patient without capacity has recorded their refusal of CPR in advance

- when CPR is judged very unlikely to be effective because the patient is dying from an irreversible condition

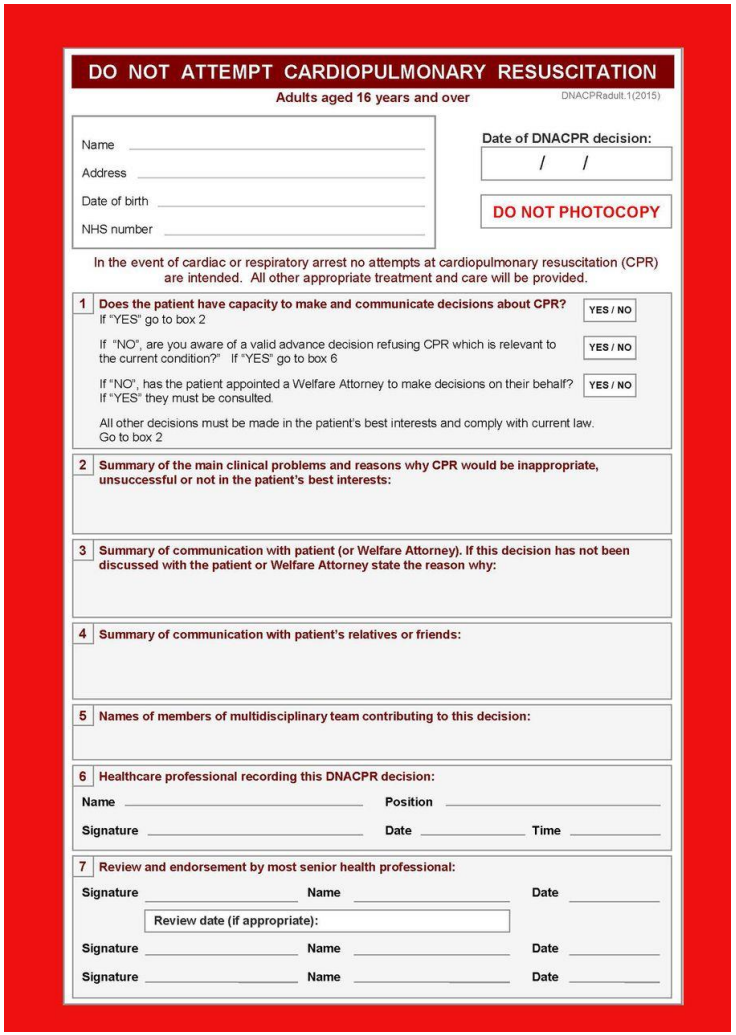
- when the potential burdens of CPR outweigh the potential benefits

*BMJ 2017; 356 doi: https://doi.org/10.1136/bmj.j813 (Published 28 February 2017)

BMJ Research Review Found:

- DNACPR policies are in widespread use. They exist in many countries,
- 80-90% of those who die in hospital have a DNACPR in place
- One in five CPR attempts made in hospital result in survival. Average survival rate in the community is one in 10
- DNACPR decisions are distinct from decisions around palliative/other care **BUT do they also trigger advanced care planning if required**
- Many patients with DNACPR decisions are discharged from hospital – issues regarding, review, how to manage in new facility & store **(in care home)**
- Primary focus on acute care settings and a lack of consistency in policies between care settings – would this include knowledge and training too?
- Standardised DNACPR forms are often used to provide immediate access to decisions in the event of a cardiorespiratory arrest

Fig 1 DNACPR decision form.



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNACPRadult.1(2015)

Name

Address

Date of birth

NHS number

Date of DNACPR decision: / /

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. All other appropriate treatment and care will be provided.

1 **Does the patient have capacity to make and communicate decisions about CPR?** If "YES" go to box 2 — YES / NO

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition?" If "YES" go to box 6 — YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? If "YES" they must be consulted. — YES / NO

All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

2 **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:**

3 **Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:**

4 **Summary of communication with patient's relatives or friends:**

5 **Names of members of multidisciplinary team contributing to this decision:**

6 **Healthcare professional recording this DNACPR decision:**

Name _____ **Position** _____

Signature _____ **Date** _____ **Time** _____

7 **Review and endorsement by most senior health professional:**

Signature _____ **Name** _____ **Date** _____

Review date (if appropriate):

Signature _____ **Name** _____ **Date** _____

Signature _____ **Name** _____ **Date** _____

Zoë Fritz et al. BMJ 2017;356:bmj.j813

BMJ Review of DNACPR Usage. They found:

- "Shortcomings" in considering, discussing and implementing (Perkins GD, Griffiths F, Slowther AM, 2016)
- Futile CPR owing to frailty and comorbidities a major concern for patients
- Some Doctors reluctant to initiate discussion of the topic
- Legal requirement to consult not always understood
- Erroneous conflation of DNACPR decisions with other end of life care practices (reduction in some treatments)

Evidence of Good practice

- Physician Order for Life Sustaining Treatment –POLST in Oregon

- Medical Orders for Scope of Treatment –MOST in Canada
  - "talk early talk often" campaign

- Treatment Escalation Plan –TEP in Devon & SW strong role out in care homes

- **All of these schemes involve the contextualisation of DNACPR decisions with the overall goals of care**

ReSPECT Rationale

- ***"An approach that focuses only on withholding CPR in people who are dying or for whom CPR would offer no overall benefit has resulted in misunderstandings, poor or absent communication and poor or absent documentation. ReSPECT aims to encourage patient and family involvement in decision-making, to consider recommendations about CPR in the context of broader plans for emergency care and treatment, and to record the resulting recommendations on a form that would be used and recognised by health and care professionals across the UK."***

Goals of ReSPECT Project

- Consider decisions about CPR within overall goals of **an advanced care plan**
- Individual plan to ensure overarching right care and treatment in an anticipated future emergency including DNACPR
- To engage patients and the public & those important to patients
- To engage Health professionals
- Be underpinned by a good decision-making process
- Be underpinned by dialogue between individuals and clinicians
- Be used across all care settings
- Be used for individuals of all ages
- Use evidence and experience from other successful initiatives

ReSPECT Process

- Develops a shared understanding of a person's condition, circumstances and future outlook

- Then explores that person's preferences for their care and realistic treatment in the event of a future emergency

- Then goes on to making and recording agreed clinical recommendations for their care and treatment in a future emergency in which they have lost the capacity to make or express decisions.

ReSPECT OUTCOMES

Succinct plan intended to provide rapidly accessible information for professionals faced with an emergency,

Help people to make immediate decisions that respect their wishes and their clinical needs.

Includes a recommendation as to whether CPR should be attempted or not.

ReSPECT provides more than a DNACPR form. It's a person-centred plan which records treatments that should be considered as well as those that are not recommended.

ReSPECT supports the wider advanced/anticipatory care planning process.

My future wishes Advance Care Planning (ACP) for people with dementia in all care settings

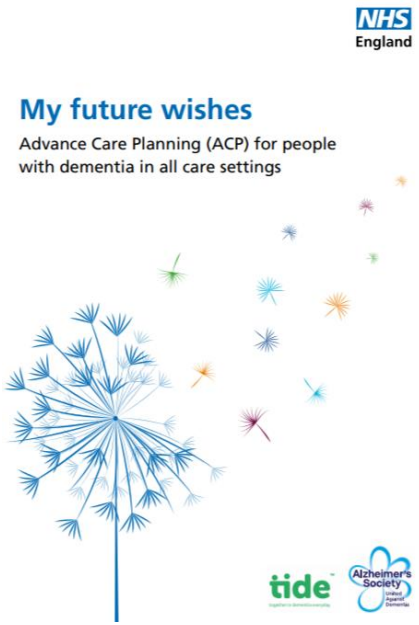
An ACP encompasses preferences and wishes for living and dying well.

Considerations around ACP / future wishes could be introduced from the point of diagnosis onwards

Ideas / choices might be expressed during everyday living. Consider how these should be captured.

Practical advice and guidance on how to Initiate – check - review

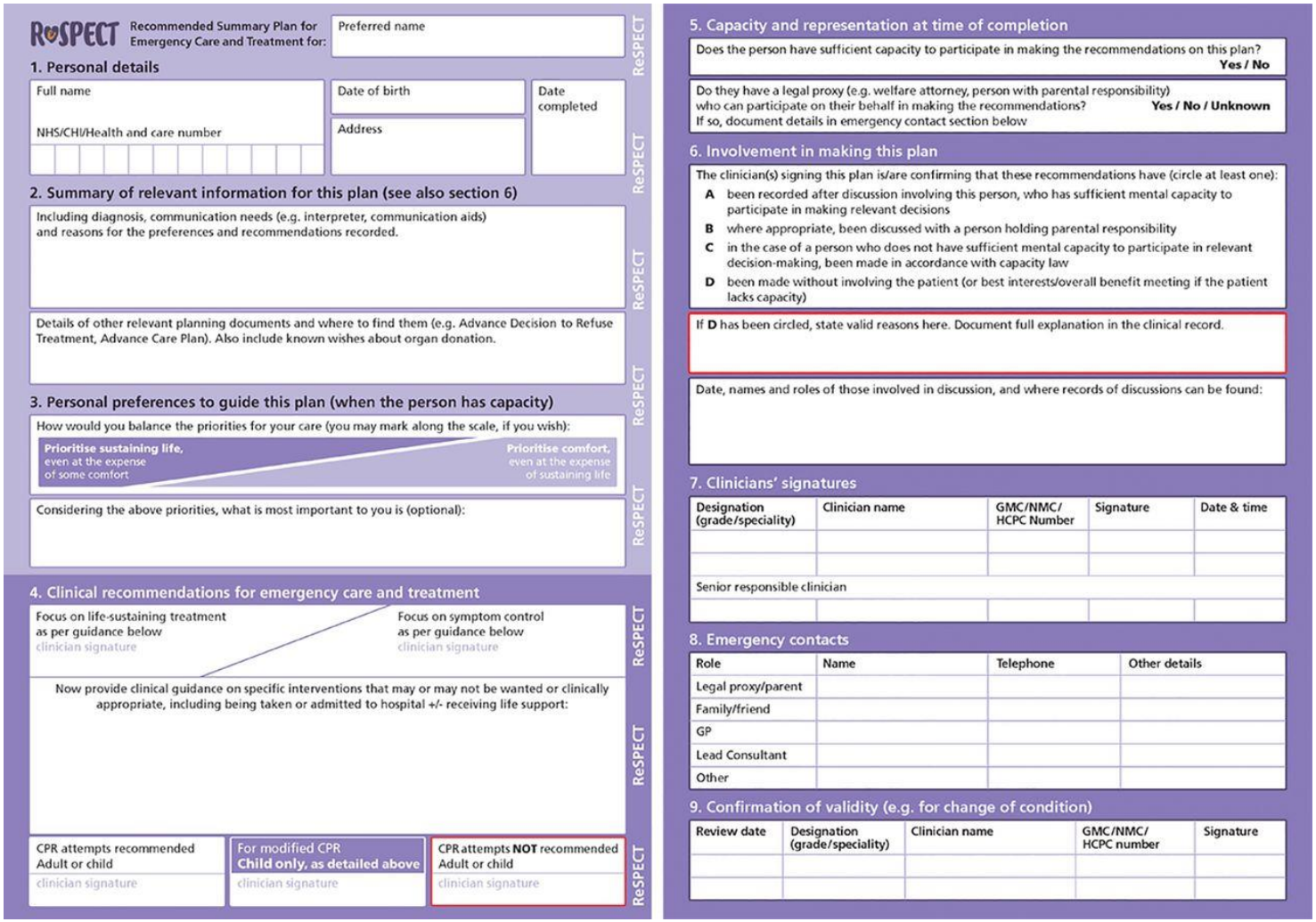
https://www.england.nhs.uk/wp-content/uploads/2018/04/my-future-wishes-advance-care-planning-for-people-with-dementia.pdf



ReSPECT Role Out

- 12 sites to launch 2018
- 32 areas working to adoption
- 30 more areas starting discussions
- Working on the creation of “full electronic portability”
- Early adopters have ensured Section 6 of the form has better reporting of Mental Capacity issues

Fig 2 ReSPECT form.



ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below clinician signature

Focus on symptom control as per guidance below clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend			
GP			
Lead Consultant			
Other			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

Zoë Fritz et al. BMJ 2017;356:bmj.j813

ReSPECT website

Respect Website -

https://www.respectprocess.org.uk/

Prevent - Awareness Level Training

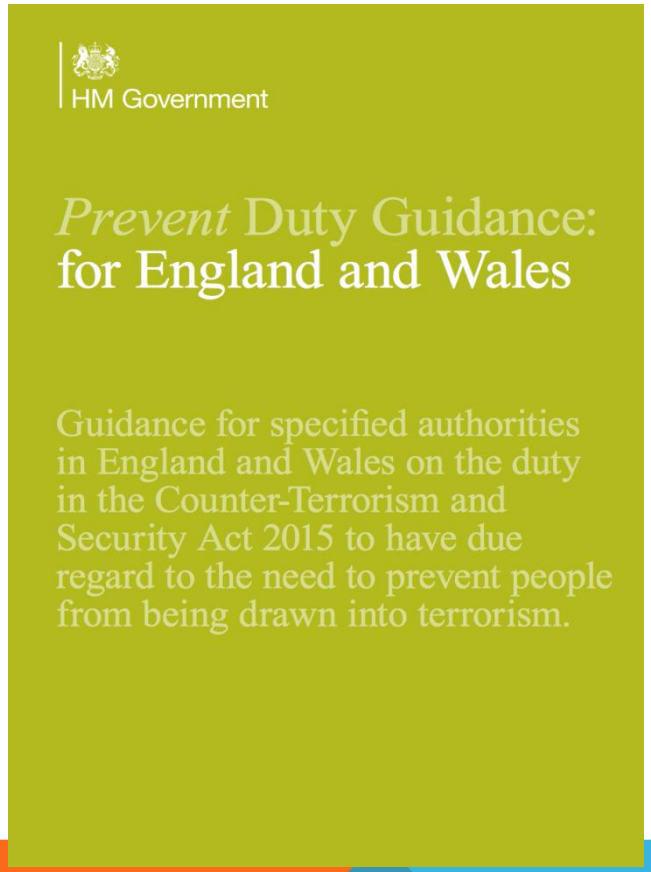
(40 minutes session with CPD certificate delivered during the session – unable to host that on line but please find links to resources)

(Paul Cooper, Head of Safeguarding Adults, Shropshire CCG)

PREVENT BASIC AWARENESS TRAINING LEVELS 1 & 2

SAFEGUARDING FORUM

PREVENT STATUTORY DUTY



Section 26 of the Counter-Terrorism and Security Act 2015 places a **duty** on certain bodies, in the exercise of their functions, to have **"due regard to the need to prevent people from being drawn into terrorism".**

The specified authorities in Schedule 6 to the Act are those judged to have a role in protecting vulnerable people and/or our national security and includes NHS organisations.

Prevent Duty Guidance
https://www.gov.uk/government/publications/prevent-duty-guidance

REFERRAL INTO CHANNEL

Discuss with Colleagues/Practice Safeguarding Lead

Consult Prevent lead : CCG Prevent Lead – see below

Referral into Channel via Concern Referral Form to be sent to:-

prevent@warwickshireandwestmercia.pnn.police.uk

Further information available from Shropshire CCG Prevent Duty Guidance Policy and Prevent lead

Channel General Awareness (eLearning)

http://course.ncalt.com/Channel_General_Awareness/01/index.html

Paul Cooper - paulcooper2@nhs.net 01743 277 500 X 2022

eLearning and other resources

Home Office eLearning package https://www.elearning.prevent.homeoffice.gov.uk/

There is more information if you need it on the NHS England website: https://www.england.nhs.uk/2017/11/nhs-england-prevent-mental-health-guidance-and-new-e-learning-package-now-available/

PREVENT FOR FURTHER EDUCATION AND TRAINING - Complying with the Prevent Duty
http://preventforfeandtraining.org.uk/

Channel General Awareness (eLearning)
http://course.ncalt.com/Channel_General_Awareness/01/index.html

Educate against hate https://educateagainsthate.com/

NHS training may have to register to access:

- Level 3 Training: E-Learning (e-learning for healthcare) Preventing Radicalisation Level 3: https://portal.e-lfh.org.uk/Component/Details/511790
- Level 1/2 Training E-Learning (e-learning for healthcare) Preventing Radicalisation Level 1 and 2: https://portal.e-lfh.org.uk/Component/Details/459770

Safeguarding Adults Forum

Future Dates:

19th December - 9:30-12noon (Telford & Wrekin venue)

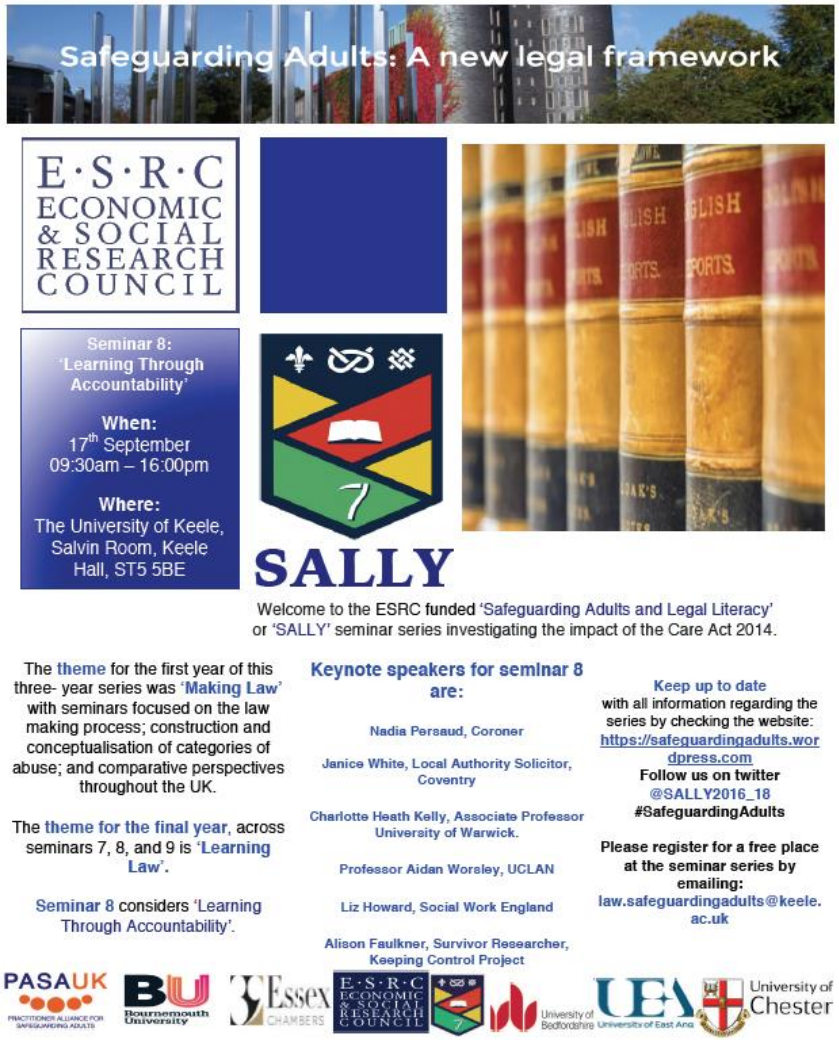
Other Diary Dates

3rd August – Newport Dementia Conference (Contact Deborah Warman, S.P.i.C., 01743 860011)

17th September 2018, Keele University.

Email: law.safeguardingadults@keele.ac.uk

8th November 2018, Joint Children and Adults Safeguarding Board event Shrewsbury – details to be announced.



Agenda December 2018

Next Meeting:

Pressure Ulcer Protocol

Tissue Viability

Local authority approach to safeguarding and pressure ulcers

MCA – IMCA's

Monitoring and Supporting Waking Night Staff