Taking resuscitation decisions in the nursing home setting

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The way decisions about resuscitation are made in A&E departments is not the same as in nursing homes for older people. This article discusses prompt appropriate decision-making regarding resuscitation in the nursing home setting.

Decisions about whether or not to undertake resuscitation relate only to action following a sudden collapse. This should not be confused with deterioration at the natural end of life. Existing protocols on resuscitation decisions almost invariably focus on an anticipated collapse that can be discussed with the patient, clinicians, next of kin or significant others. However, these protocols do not provide sufficient guidance for the care home environment.

Protocols for treatment

There are many protocols for initiating or withholding resuscitation. However, none of these seems adequate for the care home setting. Care homes would benefit from a system that:

- All parties can turn to for guidance;
- Is robust enough to prevent inappropriate interventions from a panicky locum or paramedic team at 3am;
- Can distinguish between appropriate action in a chest infection or end-stage pulmonary disease;
- Is sensitive enough to be discussed with patients and can respond to their changing wishes and health;
- Gives value to the feelings of family without overruling those of the patient, even in cases of mental impairment.

The decision to resuscitate or not is, at root, an ethical rather than a medical one, and ethical issues do not have right answers, only right questions.

Guidance from the joint statement by the British Medical Association, RCN and Resuscitation Council (2001) notes that the way decisions are made in A&E departments is not the same as in nursing homes for older people. Without the protective framework of the hospital or other medical supervision it can be difficult for nurses, who are often the only clinicians on duty, to decide whether to intervene. Most nursing home policies involve ringing 999 if in doubt, and are unsatisfactory for patients, families and staff as they do not address their needs or wishes.

Resuscitation decisions are not entirely the same as decisions to treat or to withhold or withdraw treatment, although a decision to treat a chest infection and a decision to undertake cardiopulmonary resuscitation (CPR) may be on the same ethical continuum. Somewhere across that continuum a line must be drawn. The question is where do we draw that line?

Regnard and Hockley (2004) list what is and what is not resuscitation. Most interventions are regarded as comfort measures – only cardiac massage and CPR as true resuscitation. They point out that advanced decisions can only be made if the circumstances of the arrest can be anticipated.

This point may affect or be affected by the provisions of the Mental Capacity Act (2005) (Box 1). The act gives greater weight to advance directives that have been carried out in the prescribed manner. However, these directives can still be overruled by a subsequent appointment of lasting power of attorney. Importantly, advance directives may also not apply if the circumstances may not have been foreseen by the patient when making the directive.

Advanced decisions

Resuscitation policies generally focus on the issue of anticipation. If a cardiac arrest or its probability can be anticipated and discussed with a patient, advance decisions not to resuscitate may be valid.

However, this reduces the number of patients who, by their own decision, should not be resuscitated to patients with known and unstable heart disease. Using these policies it therefore follows that resuscitation should be attempted for all other...
patients who collapse – in whatever circumstances. However, Regnard and Hockley (2004) point out that at the end of irreversible terminal disease CPR will not succeed and is therefore an unrealistic and potentially cruel intervention. They also make the point that CPR is generally offered ‘by default’, in the absence of any alternative directive. This is not ethically sound as no other treatments are offered on this basis.

It could be reasonable to include all typical diseases of older age in this argument, although this is not sustainable for a resuscitation decision as old age and frailty are not terminal diseases in themselves. Therefore decisions on resuscitation should be based on other factors. One consideration could be whether it should be based on a subjective assessment of ‘quality of life’.

The surprise question
In continually focusing on whether a catastrophic event can be anticipated, protocols imply an exclusivity. The counter argument is what has come to be known as the ‘surprise question’ which, although usually expressed as guidance for clinicians, could also be turned around to act as guidance for patients.

The surprise question emerged from quality of life improvement teams in the US, who found that the best time to provide end-of-life services is at the point when it is recognised that a patient is sick enough that it would not be a surprise if they were to die this year. Murray et al (2002) believe that if programmes for end-of-life care targeted such patients, rather than focusing on a prognosis of less than six months, many more patients and carers would benefit from proactive care.

In order to trigger this care it is possible to ask the question: ‘Would it be a surprise if this person died in the next 12 months? (through an illness that is not susceptible to curative treatment).’ If it would not be a surprise, it is reasonable to offer the same kind of service as is offered to people who are certain to die within that time frame.

This can be used to identify patients who might reasonably expect or anticipate ‘not to be here this time next year’ and to plan accordingly, with the help of professionals and/or family members, so their wishes could be met in a crisis. Formal systems such as the Gold Standard Framework, which improves planning at the last stages of life (Royal College of General Practitioners, 2005), include a specific question on resuscitation wishes, which patients almost invariably welcome.

Parameters
Nurses are confronted by several issues (Box 2, p30). It is not suggested that likelihood of success or quality of life should be deciding factors when considering resuscitation, as they are the most subjective of the criteria. However, when making resuscitation decisions these issues will need to be taken into consideration.

Opinions differ on clinical responsibility. Positively withdrawing life support – an act to end life – is normally unlawful but initiating procedures to save life is a different matter. The NMC Code of Professional Conduct states that nurses are accountable for their practice and answerable for their actions and omissions, regardless of advice or directions from another professional.

The NMC also says nurses should obtain consent to treat patients – which is impossible following collapse. In such situations nurses may be the only people who can decide what is in the patient’s best interest.

Foster (2003), a barrister, argues that doctors can choose not to treat and that while such choices may get them into trouble with their employers or the GMC, they would not get into trouble with the law of tort – which relates to civil wrongs. There is nothing intrinsically illegal about deciding not to initiate resuscitation but whether or not a nurse would feel comfortable with that decision is another matter.

Consent to treatment
The best defence for giving or withholding treatment is the patient’s known and documented wishes. If a patient has been asked about preferences, and it is documented that they do not want resuscitation, it is reasonable to withhold treatment – any other course of action could be construed as assault.

Consent to treatment does not mean a patient merely complies with or does not refuse treatment – they must give voluntary and informed consent. Is it then reasonable to initiate the ‘default treatment’ of resuscitation without having checked first?

It can be argued that the circumstances of an arrest or collapse do not dictate the response – this is done by patients themselves while they are competent to do so. Although there is no judicial authority for an advance directive, it ‘may be binding on the practitioner when it expresses a refusal of treatment that the patient has anticipated’. Nurses should not therefore initiate treatment to which they know their patients would have objected had they had the opportunity to do so.

REFERENCES


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net
Mental capacity and best interest

The Mental Capacity Act laid out a set of principles that protect health professionals making decisions in the patient’s best interests – providing they have taken reasonable steps to establish capacity or lack of capacity and decide what the best interest of the patient would be.

The act also established lasting power of attorney – where decisions about patients who lack the capacity are taken by someone appointed to act in their interests. They can make decisions on health care-related issues – in theory they can refuse life-sustaining treatment for the patient.

However, this has yet to be tested against nurses’ duty to act ‘regardless of advice or directions from another professional’.

The questions the act requires to be asked include whether or not the person will regain mental capacity, what their past wishes may have been, and the views of any appropriate person such as close family.

The patient’s best interest is at the heart of resuscitation decisions, but defining it is a subjective task. It includes medical, emotional and welfare issues, all of which must be considered. The BMA, RCN and Resuscitation Council (2001) refer repeatedly to ‘best interest’ but do not define it.

The guidance also points out that no benefit is gained if only a very brief extension of life can be achieved and that the burdens of the treatment may outweigh the benefits. But how brief is brief, and what is the benefit of that short extension to the patient and the family? The answer to these questions depends on the individual. An apparently comfortable and symptom-free life may be purgatory for an individual who has lost all that makes life meaningful, while another might be happy in a life that seems intolerable to observers.

This is a particular problem when the patient is cognitively impaired. While relatives might suggest their mother’s dementia means she is no longer herself and would be horrified if she knew the state she has reached, the mother may be happy in her confusion, enjoy activities and appreciate affection.

However, some families insist on every effort being made to revive a patient whose quality of life health professionals believe is dreadful. Could an advance directive compel practitioners to act against their judgement? Munby (2004) has indicated in the Court of Appeal that intolerability is too narrow a test on which to make decisions, and that decision-making should be by consensus. Views can differ as to what is the patient’s best interest but grief on the part of families who cannot bear to see their mother in her current state may also play a part in forming their attitudes.

Conclusion

Until the Mental Capacity Act has been tested and examined, nursing home nurses making resuscitation decisions remain in limbo. Default positions, such as calling 999 if in doubt, are not sufficient although legally probably safe. It is still uncertain whether a nurse attempting resuscitation with the best of intentions in defiance or ignorance of an advance directive would be entirely culpable. On the one hand, assault, on the other best interest.

The concepts of best interest and benefit seem to be the core of the decision-making process. When these decisions fall to nurses they have little but opinion to guide them – it will be impossible to prove that they got it right.

Asking the individual, and witnessing and recording the decision in writing, is an important first step. Involving all ‘stakeholders’ – the attending physician, next of kin, close family and friends – is an important second step, although the autonomy of (and confidentiality for) the individual must still be the guiding principles.

The overarching principle would be that such decisions are not taken ‘on the hoof’ but thought out and thoroughly explored beforehand. Nurses working in nursing homes are in a unique position in that they usually have the time to build up open and trusting relationships with both patients and families on which these decisions are based.

Guided reflection

Use the following points to write a reflection for your PREP portfolio:

- List where you work and why you read this article;
- Write about how resuscitation decisions are made in your workplace;
- Identify the ideas in this article that are relevant;
- Describe how you can apply these issues to improve practice;
- Discuss how you will follow up this learning.
The overarching principle would be that such decisions are not taken “on the hoof” but thought out and thoroughly explored beforehand. The nursing home nurse is in a unique position in relation to the patient having time (usually) to build the relationship of trust and openness with both patient and family on which these decisions are based.

Guided reflection

Use the following points to write a reflection for your PREP portfolio:

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