

Trust Board in Public: Wednesday 12 May 2021**TB2021.35**

Title: Response to CQC report: Protect, respect, connect - decisions about living and dying well during COVID-19

Status: For Information

History: Clinical Governance Committee – 21 April 2021

Trust Management Executive – 22 April 2021

Board Lead: Chief Medical Officer

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Confidential: No

Key Purpose: Policy

Executive Summary

1. The CQC published an interim report: [Do not attempt cardiopulmonary resuscitation \(DNACPR\)¹](#) in November 2020 in response to national concerns that DNACPR orders were not appropriately established during the pandemic.
2. In October 2020 the DNACPR lead presented a report to CGC and CQC detailing an in-depth review of DNACPR documentation focusing on decision making and patient consultation during March-June 2020. This identified that DNACPR decisions are documented electronically on standardised templates. In each individual patient record there was a reason and discussion of the conversation for that person. There were many excellent examples of compassionate conversations. In some cases the rationale and discussion was brief and this was any area for improvement. There is no evidence that decisions were made inappropriately during COVID 19 within OUH. [Do Not Attempt Cardiopulmonary Resuscitation \(DNACPR\) & Treatment Escalation Plans \(TEPs\) \(oxnet.nhs.uk\)](#)
3. The CQC final report was published: [Protect, respect, connect - decisions about living and dying well during COVID-19](#) in March 2021. This emphasises the need for people and/or their representative to be included in their advance care planning, including DNACPR. That this must always be undertaken on an individual basis, and must be reviewed sufficiently frequently to ensure it reflects current medical and best interest decisions. There needs to be education to ensure healthcare professionals are prepared for this role. A national model standardising and governing the process will ensure documentation is portable and recognised by all health and social care organisations. There needs to be improved oversight and assurance in making sound clinical decisions that are person centred and protect people's human rights, and the quality and effectiveness of ACP² training provided.
4. Recommendations from the CQC report to be considered within the OUH;
 - a. Information, training and support;
 - i. To ensure adequate time and support structures are in place to enable a meaningful conversation between the person, their significant other and the clinician.
 - ii. To engage in activities to understand the patient, significant other and clinicians experience of ACP in OUH.
 - iii. To ensure all patient/staff complaints, comments and letters are available to a committee that manages ACP/ TEP and DNACPR decisions so lessons can be learned and appropriate 'learning from action' is implemented within the Trust.

¹ DNACPR Do not attempt cardiopulmonary resuscitation- CPR is a medical procedure initiated when a person's breathing and heart stops functioning, involving repeated cycles of compression of the chest and artificial respiration, performed to maintain blood circulation and oxygenation.

² ACP Advanced Care Planning – Process to think about what matters to person and plan what level of care and treatment they wish to receive.

- iv. Education resources for healthcare professionals, appropriate to role, to focus on knowledge and skills in patient/relevant other/clinician ACP conversations. Emphasis to be placed on gaining practice skills.
 - v. Healthcare professionals must read and review these decisions as frequently as is required for each person. To acknowledge that they are dynamic documents that may need further actions throughout the admission. Patients must be informed that these conversations are documented in the electronic record and then sent to GP.
- b. A consistent national approach to advance care planning;
- i. Implement ReSPECT in order to align to national standardised model. This ensures DNACPR is part of holistic advance care planning. This was supported pre COVID by EoLC, Resuscitation Committee and at CGC. Resources will need to be allocated for this change in policy.
 - ii. To work in collaboration with OCCG to ensure our systems work in partnership with community organisations.
- c. Improved oversight and assurance;
- i. Resuscitation Practitioners to monitor a proportion of current DNACPR/TEP documentation in EPR and act on decisions which cause concern on a weekly basis. To collect data for reports to CEC and CGC at least on an annual basis.
 - ii. To recognise the newly formed committee and request this committee works with / as part of the EoLC Committee.
 - iii. To continue to develop a suite of ACP documentation in the EPR system to allow all clinicians immediate access to this information, to have data sets available for investigation and audit.
 - iv. To evaluate the effectiveness of education resources used for ACP development.
5. Trust Board is asked to note the CQC Protect, Respect and Connect report and the recommendations with planned actions.

Response to CQC report: Protect, respect, connect - decisions about living and dying well during COVID-19

1. Purpose

- 1.1. This paper provides a summary of the recently published CQC report: [Protect, respect, connect – decisions about living and dying well during COVID-19](#) and the OUH response to the recommendations.

2. Background

- 2.1. The CQC published an interim report: [Do not attempt cardiopulmonary resuscitation \(DNACPR\)](#) (November 2020) in response to national concerns that DNACPR orders were not appropriately established during the pandemic.
- 2.2. The CQC (July 2020) requested a Trust response relating to DNACPR complaints from external sources. [Do Not Attempt Cardiopulmonary Resuscitation \(DNACPR\) & Treatment Escalation Plans \(TEPs\) \(oxnet.nhs.uk\)](#) The Trust provided a retrospective report, focusing on March to June 2020. This report presented to CGC and CQC October 2020 studied adult electronic patient records (EPR), specifically investigating the rationale for DNACPR decisions and the documented discussion between the clinician and the patient in order to identify if there was any suggestion that decisions were made due to rationing of services or initiating blanket decisions for groups of patients.
- 2.3. At the time of OUH report the OUH adopts the Unified South Central Adult DNACPR Policy which is a stand- alone DNACPR policy. [Introduction \(oxfordshire.gov.uk\)](#)
- 2.4. 178 electronic DNACPR records initiated during March-June 2020 were analysed in-depth and they identify that decisions and discussions were held on an individualised basis and documentation of both rationale and discussion was evident with some excellent examples of practice, however some were brief and would not have been able to reflect the detail of conversations.
- 2.5. Recommendations from the Trust report concentrate on documentation of DNACPR decisions and include;
 - 2.5.1. Developing educational tools to improve the documentation of rationale and discussion with patient. Improving understanding and documentation of reviews at key points in the patients' journey.
 - 2.5.2. Consider methods to support consultants to endorse decisions in a more efficient manner.
 - 2.5.3. The e-DNACPR should be integrated with a 2 way electronic communication between partner organisations.
 - 2.5.4. Building warning messages in the e-DNACPR workflow highlighting when tasks are not done within specified time period.

3. Key recommendations taken directly from the CQC report: ‘Protect, respect, connect’ [Protect, respect, connect – decisions about living and dying well during COVID-19](#)

Three key focus areas:

- Information, training and support
- A consistent national approach to advance care planning
- Improved oversight and assurance.

CQC Recommendations;

3.1. “DNACPR decisions need to be recognised as part of wider conversations about advance care planning and end of life care, and these decisions need to be made in a safe way that protects people's human rights. To do this, a new Ministerial Oversight Group must be set up to look in depth at the issues raised in our report. The group, which should include partners in health, social care, local government and voluntary and community services, should be responsible for overseeing the delivery and required changes of the recommendations of this report. Lead responsible body: Department of Health and Social Care”

3.2. **People must always be at the centre of their care, including advance care planning and DNACPR decisions.** To do this, providers must ensure that people and/or their representatives are included in compassionate, caring conversations about DNACPR decisions as part of advance planning conversations. This includes making reasonable adjustments for disabled people to remove any information or communication barriers. Providers must also ensure that clinicians, professionals and workers have the necessary time to engage with people well.

Lead responsible body: **Providers**

OUH Position	Recommendation	Action to be taken	Responsible Lead/Committee	Action complete
Conversations often take place at bedside making privacy challenging.	Conversations planned ahead of time and consideration given to environment	<ol style="list-style-type: none"> 1. Acute medical/surgical wards to identify areas for ACP conversations 2. Roll out ReSPECT which enables decision making in clinics 	Directorate Leads	September 2021
Lack of time for ACP conversations during initial assessment and treatment of acute life threatening events in emergency environments	Prioritisation of ACP <u>planning</u> on post take ward rounds.	<ol style="list-style-type: none"> 1. ACP conversations to include DNACPR/TEP/ACP incorporated into one conversation 2. Conversations to occur outside of ward round with relevant others included 3. Insert checklist within admission process 4. Safety message and discussion at Safety Huddles 	All OUH consultants	September 2021

It can be challenging for patients/relevant others and clinicians to have ACP conversations	To make reasonable adjustments for patients to empower them to have more informed conversations	<p>To ensure lead champions for learning disability/safeguarding/mental capacity act/PALS are involved in ACP developments and added to the group membership of ACP committee.</p> <p>To ensure patients have relevant others/advocate available for the conversation</p> <p>To identify/ make available an advocate system for clinicians</p> <p>To undertake MCA assessment for ACP conversations</p> <p>To ensure patients have access to necessary tools to participate actively in conversations. Glasses, hearing aids, pain relief, written documentation, process to seek redress.</p> <p>Review DNACPR patient leaflets with aim to make them accessible and 'easy to read'.</p> <p>Create mandatory field in EPR to identify if patient does not want 'significant other' included in the conversation. The default is to include relevant others in ACP conversations.</p> <p>Undertake annual survey of patients/relevant others and clinicians to understand difficulties in ACP</p>	<p>ACP Committee membership to include Lead for safeguarding, disability liaison lead, PALS.</p> <p>ACP committee</p>	<p>July 2021</p> <p>Annual</p>
Clinicians do not have effective access to previous ACP records outside the organisation. They do not know what has been previously discussed.	OUH and OCCG to work in partnership to share more depth of electronic records	ACP/TEP/DNACPR are considered in OUH and OH Trust level electronic record documentation	OUH Chief Clinical Information Officer OCCG Transformation Programme Manager	September 2021
No Trust process to advise patients on how to make their own advance decisions to refuse treatment (ADRT) ³	To inform patients how to legally refuse medical treatments if they wish to do this.	To liaise with the charity Compassion in Dying who specialise in supporting people to document their ADRT within a recognised legal method. Produce communications to inform healthcare professionals.	ACP committee	April 2022

3.3. Everyone needs to have access to equal and non-discriminatory personalised support around DNACPR decisions that supports their human rights. To do this, health and social care systems must consider diversity, inequality and mental capacity factors when planning care for the local population, in partnership with local communities, including voluntary and community services.

Lead responsible body: Integrated care systems

3.4. Clinicians, professionals and workers must have the knowledge, skills and confidence to speak with people about, and support them in, making DNACPR decisions. To do this, there needs to be clear and consistent training, standards, guidance and tools for the current and future workforce. This needs to be in line with a national, unified approach to DNACPR decision making. [ReSPECT | Resuscitation Council UK](#)

³ ADRT Advance decisions to refuse treatment – Is legal framework under the requirement of the MCA 2005 to ensure people can make their own decisions to refuse stated medical treatments and that if they lose mental capacity their advance decision is valid and protected by law.

Providers also need to ensure that there is training and development available for all health and care professionals. - Lead responsible body: Health Education England, Skills for Care and **Providers**

OUH Position	Recommendation	Action to be taken	Responsible Lead/Committee	Action complete
<p>This Trust has adopted the South Central Unified DNACPR Policy (2012). The form paper/electronic are aligned. This policy refers only to DNACPR, practice has moved on, valuing holistic discussions encompassing ACP/TEP/CPR where the outcome is not predetermined and can change (e.g. ReSPECT).</p> <p>Clinical staff receive training on completing the documentation in relation to their role through mandatory resuscitation training. Clinical staff at level 3 and specialist level (4) receive broader knowledge on DNACPR in nationally accredited Resuscitation Courses. They do not receive practice skills on conversations.</p>	<p>To prepare proposal and timeline to adopt ReSPECT, to present to CGC and TME.</p> <p>Implementing ReSPECT will ensure we benefit from national best practice policy, procedures and education resources for people, their families and healthcare professionals.</p> <p>Using national standardised model will improve efficiency and protect resources</p> <p>To support newly created TEP/DNACPR committee – This group will work with the EoLC committee.</p>	<p>ACP committee to present timeline and implementation plan identifying necessary resources for ReSPECT to Trust CGC and TME</p> <p>The ACP committee will report to CGC as part of the EoLC Committee report</p> <p>To promote a DNACPR lead/champion within the Trust</p>	<p>ACP committee</p>	<p>ReSPECT TBC</p> <p>September 2021</p>
<p>There is very limited access to skills practice in holding advance care planning conversations.</p>	<p>To prepare and pilot face to face ACP conversation study sessions</p>	<p>DNACPR lead to draft elearning package and lesson plans for course.</p> <p>ACP committee to support and evaluate effectiveness of study sessions.</p>	<p>DNACPR lead and ACP committee</p>	<p>April 2022</p>

<p>A new DNACPR/TEP group has emerged during COVID as a result of the successful development of TEP's. This group, in its infancy, has met on several occasions and published its draft terms of reference. This group asks for guidance on its reporting structure and recommends aligning under patient safety and risk.</p>	<p>To agree the DNACPR/TEP membership and reporting route for this group. To formally change the name of this group to ACP committee (Advance Care Planning)</p>	<p>This group will adopt ReSPECT title in the Trust</p>	<p>ACP committee</p>	<p>TBC ReSPECT September 2021</p>
<p>ACP/TEP/DNACPR Feedback, complaints, incidents and concerns comes into the Trust through various mechanisms. Difficult to understand the scale and type of the issues</p>	<p>That ACP committee review/audit all ACP/TEP/DNACPR feedback, complaints and incidents to undertake learning from feedback</p>	<p>To present quarterly reports on all complaints/incident reports/feedback</p>	<p>ACP and CEC</p>	<p>Quarterly</p>

A consistent national approach to advance care planning

3.5. People, their families and representatives need to be supported, as partners in personalised care, to understand what good practice looks like for DNACPR decisions. This should include what their rights are and how to challenge and navigate experiences well. In addition, there needs to be positive promotion of advance care planning and DNACPR decisions, as well as a more general focus on living and dying well. To do this, there needs to be more widely publicised and accessible information available via a national campaign and in partnership with the voluntary sector and advocacy services.

Lead responsible body: Department of Health and Social Care and NHS England and NHS Improvement

3.6. People, their families and/or representatives, clinicians, professionals and workers need to be supported so that they all share the same understanding and expectations for DNACPR decisions. To do this, system partners across health and care need to work with voluntary sector organisations, advocacy services and people to establish and assure a national unified approach to policy, guidance and tools that supports a positive experience of DNACPR decisions for people.

Lead responsible body: Department of Health and Social Care

3.7. People need to have more positive and seamless experiences of care, including DNACPR decisions, when moving around the health and care system. This requires the system to ensure digital compatibility between providers, enabling them to share real-time updates and information between professionals, services and sectors.

Lead responsible body: NHSX and integrated care systems

Improved oversight and assurance:

3.8. 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. This requires providers to ensure standards of documentation and record keeping and sharing of information around the system.

Lead responsible body: **Providers**

OUH Position	Recommendation	Action to be taken	Responsible Lead/Committee	Action complete
<p>DNACPR records created within the Trust have significantly improved with use of electronic standardised form. TEP electronic form introduced this year.</p> <p>DNACPR and TEP included in discharge summary.</p> <p>No e-ACP form. This results in non-standardised power notes that are difficult to find and then do not travel with patient to ongoing care areas.</p>	<p>To have standardised e-forms for ACP/TEP and DNACPR so that when we align to ReSPECT we have both a summary national document populated by each element of advance care planning.</p> <p>To continue to update electronic forms based on audit cycles, creating flags/alerts to help clinicians meet required quality in documentation.</p>	<p>To develop standardised e-ACP form. To merge ACP, TEP and DNACPR documentation into one form. All ACP documents to be stored in one Resus/ACP folder which will become the ReSPECT folder. Utilising digital technology to only print or send relevant areas to other healthcare providers.</p>	<p>ACP Committee to CAG committee</p>	<p>September 2021</p>

<p>Ongoing weekly monitoring of in-patients DNACPR decisions.</p> <p>Resuscitation practitioners identify all DNACPR records on one day for every week. Each DNACPR is filtered to ensure it is acknowledged (read) on this admission, consultants have endorsed the decisions and a smaller number are looked at in detail for reasoning and discussion. Action is taken if required and urgent.</p> <p>Audit continues to identify clinicians are not acknowledging/reading these decisions on every admission in order to consider if they need review. Documentation stating unable to contact relatives with no evidence of trying to contact relatives during the reminder of the admission</p>	<p>DNACPR lead to attend OCCG Oxfordshire wide DNACPR working group OUH to share patient information with partner organisations.</p> <p>Ensure ACP is undertaken on each new admission. ACP is a dynamic process.</p> <p>All documentation for advance care planning to be located in centralised area in EPR</p>	<p>To work with OCCG to establishing ReSPECT in Oxfordshire</p> <p>To ensure documentation travels with patient across care boundaries</p> <p>Need to build tasks/flags into e-ACP system to remind clinicians to consider need for ongoing discussions and updates and ensure this is documented.</p>	<p>RP's to continue to monitor/audit records</p> <p>ACP committee chair and DNACPR lead to attend OCCG DNACPR meetings</p> <p>OUH consultants to educate medical teams to place all ACP documentation in resus and ACP folder in EPR not in date related powernotes</p> <p>ACP committee to work with CAG/EPR team to identify documentation needs in EPR for ACP.</p>	<p>Ongoing</p> <p>September 2021</p>
<p>Community ACP documentation predominantly arrives via paper, with electronic documentation limited to headline tags, no depth in narrative. People outside region present with mix of models and forms, usually on paper.</p>	<p>This is identified in recommendations at a national, NHSX and integrated care systems level</p>	<p>For OUH staff to assess ACP documents coming from outside the Trust and move it to our current documentation. Until this is done other organisations ACP documentation should be used to base decisions for care.</p>	<p>Outside organisations</p>	
<p>Audit concentrates on DNACPR during in patient admission.</p>	<p>The patient and/or their relevant other is aware of the existence of the ACP/DNACPR on discharge. Has a paper copy and understands how this document informs other healthcare professionals and carers of what to do in an emergency.</p>	<p>Audit DNACPR on discharge</p> <p>Place knowledge and skills on incorporating ACP documentation when preparing for discharge</p>	<p>DNACPR lead and resuscitation practitioners</p> <p>Ward managers and nurses.</p> <p>Report to CEC and ACP committee</p>	<p>Ongoing</p>

3.9. **Integrated care systems need to be able to monitor and assure themselves of the quality and safety of DNACPR decisions.** To do this, there needs to be a consistent dataset and insight metrics across local areas.

Lead responsible body: Integrated care systems

3.10. **Health and social care providers must ensure that all workers understand how to speak up, feel confident to speak up and are supported and listened to when they speak up.** To do this, providers must follow national guidance to foster positive learning cultures and ensure consistency and clarity of speaking up arrangements across the patient pathway.

Lead responsible body: National Guardian's Office

3.11. **CQC must continue to seek assurance that people are at the centre of personalised, high-quality and safe experiences of DNACPR decisions, in a way that protects their human rights.** To do this, we will ensure a continued focus on DNACPR decisions through our monitoring, assessment and inspection of all health and adult social care providers.

Lead responsible body: CQC

4. Conclusion

4.1. This paper has provided an overview of the CQC report, whilst also identifying ongoing Trust audit on DNACPR documentation during COVID within the OUH Trust.

4.2. At the heart of the CQC report is the right of the person to be front and centre of their care, the need to ensure 'reasonable measures' are taken to enable people to participate in these conversations, with an expectation that documentation is comprehensive enough to assure that the patient/significant other was involved in the conversation (and if not, why not), and it allows other clinicians to base their actions on in an emergency.

4.3. The CQC report highlights the need for a national process and education to prepare clinicians adequately for these conversations.

4.4. Emphasis is now needed on gathering assurance of the quality of the patient/representative/clinician conversation itself.

4.5. Education needs to focus and develop in ACP conversation knowledge and skills. There needs to be assurance systems monitoring the effectiveness of education methods used.

4.6. The CQC will continue to monitor Trusts in relation to the recommendations in this report.

4.7. There are recommendations for organisations at government, national and regional levels.

5. Recommendations

5.1. In line with the Trust's 2020-2025 strategy framework which aims to *"Improve the access, quality and experience of care for all Our Patients. Work with partners to improve the health and wellbeing of Our Populations, working collaboratively to deliver integrated and sustainable services."* Trust Board is asked to note the CQC Protect, Respect and Connect report and the recommendations with planned actions.

References

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