The implications of an NMC caution for nurse who did not perform CPR

When is it acceptable for a nurse to decide to withhold cardiopulmonary resuscitation (CPR)? This article presents a critical evaluation of an apparent ethical-legal paradox after the judgement of the Nursing and Midwifery Council (NMC) in Jane Kendall’s case. It also incorporates considerations on the futility of CPR, the promotion of dignity in ordinary dying, patient safety, clinical decision-making and the use of policies that may expose staff to vicarious professional regulation.

Fitness to practise hearing

In January 2017, Jane Kendall, a nurse of considerable experience, received a caution order for a period of 24 months. Her decision to withhold cardiopulmonary resuscitation (CPR) from a nursing home resident had led to a fitness to practise hearing by the NMC Conduct and Competence Committee. The committee, which heard the case in Ms Kendall’s absence, considered that her professional misconduct had impaired her fitness to practise and upheld both charges that had been levied against her. The first charge was that she had ‘failed to attempt cardiopulmonary resuscitation’ (CPR) on a nursing home resident and ‘failed to contact or ensure that the emergency services were contacted’. The ruling prompted serious concerns about the implications for nursing practice, exercising professional judgement and withholding CPR when it is considered futile and not in the best interests of patients. This article provides an analysis of the case, explaining why the ruling is debatable and why nurses should expect to be supported - not reprimanded - when making similar decisions.

Author

Ken Spearpoint is principal lecturer, University of Hertfordshire and formerly consultant nurse in resuscitation at Imperial College Healthcare Trust.

Abstract

In January 2017, the Nursing and Midwifery Council upheld charges that an experienced nurse had ‘failed to attempt cardiopulmonary resuscitation’ (CPR) on a nursing home resident and ‘failed to contact or ensure that the emergency services were contacted’. The ruling prompted serious concerns about the implications for nursing practice, exercising professional judgement and withholding CPR when it is considered futile and not in the best interests of patients. This article provides an analysis of the case, explaining why the ruling is debatable and why nurses should expect to be supported - not reprimanded - when making similar decisions.

Citation

Discussion

Serious concerns
We do not have the full facts, nor access to the patient’s medical records. The limitations of the documentation from the hearing mean it is not possible to know what time of day the event occurred or what the end-of-life care wishes of the resident were – if she had any.

This ruling has raised a number of concerns among the nursing and medical professions, to the extent that, in March 2017, the British Medical Association (BMA), Royal College of Nursing and Resuscitation Council UK issued a joint statement (BMA et al, 2017) in response. Many commented on social media, in professional journals and through professional bodies (Launer, 2017; McCartney, 2017; Moore, 2017). There were unanimous expressions of serious concern about the wider implications of the ruling for nursing practice, professional clinical judgement and the conduct of CPR that is not of benefit or in the best interests of people who may have already died.

Current guidance
The national guidance, Decisions Relating to Cardiopulmonary Resuscitation (BMA et al, 2016), unambiguously states that the default legal position on CPR is that, in the absence of any form of advance directive to withhold CPR or when the patient’s wishes about CPR are unknown, health professionals are expected to conduct CPR to the best of their abilities.

The guidance also contains important caveats pertinent to Ms Kendall’s case. For example, it includes a description of CPR conducted in a situation of unexpected death – where it is considered to be invasive and traumatic – asking readers to reflect on that intervention. The guidance also advises that CPR should not be attempted without giving due consideration to its potential outcomes for the patient’s quality of life and the burdens associated with it.

Furthermore, section 8 of the guidance specifically addresses one aspect of Ms Kendall’s case. It strongly supports health professionals who decide to withhold CPR if they discover a patient showing overt characteristics of non-reversible death, have not been breathing and have been without a heartbeat from some time. The guidance acknowledges that decisions in this context are always made quickly and often under considerable duress. It may be entirely appropriate for the health professional to make a considered decision, based on their knowledge, skills and experience, to withhold CPR in the ‘best interests’ of the patient.

An ethical-legal paradox
The guidance further underlines its support for health professionals who have had to make such difficult decisions through a critically important statement written in carefully chosen language: “In such circumstances, any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies” (BMA et al, 2016).

After closely reading the notes of the hearing (NMC, 2017), it would appear that this crucial guidance was not considered when determining the judgement and outcome for the experienced nurse, and it is reasonable to ask why. It is also reasonable to argue that, on this point alone, the judgement – which has practice implications for all registered nurses caring for adults – presents an ethical-legal paradox and a source of ambiguity and confusion.

A medical panacea against death
The medico-legal regulation of death has long been established (Foucault, 1973) and recently, many statements, guidelines, policies and memoranda have been published in response to a succession of legal cases. The question of decision-making, communication and application of DNACPR orders has become the subject of considerable medico-legal scrutiny in contemporary medicine (Page, 2006).

Ethical and legal challenges have informed practice, with the welcome intention of providing clarity for all parties – patients, carers and health professionals (Wood and Wainwright, 2007). Health professionals have benefitted from regulated standardised training programmes in CPR and have been increasingly supported by well-developed and organised resuscitation services, a succession of technological improvements and progressive evidence-based treatment guidelines (Robertson, 2001).

It can be argued that CPR, in its attempt to reverse or delay unexpected death, has become a medical panacea (Bains, 1998). In modern Western healthcare, the application of CPR at the point of dying has become compulsory, except when DNACPR orders or similar advance decisions – if they are known to exist – have been made before expected or irreversible death (Page, 2006).

Despite this well-intentioned progress, the outcomes of CPR remain dismal: this is evident in the data from both in-hospital and pre-hospital settings (Resuscitation Council UK, 2015; Nolan et al, 2014). The prospects of a successful outcome from cardiac arrest in older people and the likelihood of a full and meaningful recovery, at under 6%, are limited (Levinson and Mills, 2014).
The reality of resuscitation work
Ms Kendall’s case raises a number of questions. Had a DNACPR order – or other forms of advance care planning towards the end of life – been considered and/or discussed with the resident? If not, why? What was the nursing home’s policy on CPR? If there was such a policy in place, did it adhere to national guidance? Were residents and staff aware of its existence and implications? These important considerations were conspicuous by their absence in the notes of the NMC hearing (NMC, 2017).

In any case, it is important to provide clarity for nurses and other health professionals. We need to look beyond the theory of policy and examine the reality of what actually goes on in our care facilities. In 2012, a stark picture of in-hospital resuscitation emerged from a report, *Time to Intervene?*, published by the National Confidential Enquiry into Patient Outcome and Death (Findlay et al, 2012). It provided an insightful analysis of the many complexities of DNACPR orders. It also presented a reality that challenged much of what we imagined the work of resuscitation to be – particularly around end-of-life care and decision-making.

The report analysed cases where CPR had been conducted on hospital inpatients after cardiorespiratory arrest and revealed that, in 87% of cases, no DNACPR order had been considered when clinical teams had reviewed patients. Furthermore, experts believed that 85% of patients should have had a DNACPR order in place and should not have received CPR.

Withholding CPR
There is a further important aspect of the NMC ruling that is debatable – Ms Kendall’s lack of competence to pronounce death. While this is cited in the hearing proceedings (NMC, 2017), it actually bears no relevance to the case. Withholding CPR is not a pronouncement of death, it is an explicit decision to withhold a treatment considered to be futile – and is, in that sense, compliant with national guidance (BMA et al, 2016).

The decision was a professional judgement that included a risk-benefit analysis. It led the nurse to conclude that attempting CPR would be unlikely to reverse death or result in a good quality of life after survival. It is important to differentiate between the ability to make a decision that upholds dignity and compassionate care in ordinary dying – by sparing a patient futile chest compressions – from the competence to pronounce death in these circumstances.

Legal and professional advice
Another relevant question is what legal and professional advice Ms Kendall accessed to support her in her defence. She was not represented at the hearing nor, it would seem, in the preparations for the hearing. With the very best of intentions of the committee, the lack of representation was duly recorded (NMC, 2017), but this still left the nurse in a vulnerable position. An appropriately appointed representative may have given her the support and confidence she needed to assert her professional judgement, and may have enabled her to use the national guidance to mitigate her decision and subsequent actions.

As previously stated, the current guidance has enough scope to support a decision to withhold CPR in these circumstances. However, some nursing staff may find it challenging to assert their clinical decision-making in similar situations. This underpins the absolute necessity for nurses to have access to appropriate professional and legal support and representation through trade union and/or professional organisations.

Emergency care plans
A situation where a patient found in a state of collapse has had no advance care planning of any sort is avoidable. Such situations have been subject to increasing awareness and subsequent criticism (Fritz et al, 2017). The recently launched ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process seeks to avoid them and offers comprehensive guidance to help health professionals devise patient-centred emergency care and resuscitation plans (Pitcher et al, 2017; www.respectprocess.org.uk). The ReSPECT process supports the view that, where possible, patients – particularly older people and those at risk of cardiac arrest – should be offered the opportunity to be involved in decision-making around their ongoing treatment and care towards the end of life.

Conclusion
Jane Kendall’s fitness to practise hearing has led to professional dissonance between guidance, law and clinical practice, but has also highlighted a serious and avoidable patient safety issue at the end of life – a time-critical point of clinical decision-making where the best interests of patients should be foremost. The case highlights the need for better, more timely and more appropriate decision-making that is in the best interests of patients and in support of a dignified death.

Appropriately skilled, knowledgeable and experienced nurses should not fear litigation or regulatory investigation when withholding CPR if they consider death to be irreversible. They should expect the exact contrary – to be listened to, understood and supported.