

Ten things that all care home managers should know

Please use this within the care home and pass it on to staff, residents and relatives – it's been composed in order to promote good decision-making and protect against misinformation during the Covid-19 crisis.

1. DNAR and ReSPECT forms

A DNR/DNAR/DNACPR form is something that a **capacitated** person can choose to fill out as an indication that they do not want to be resuscitated, should they cease breathing independently.

Making and recording a decision about CPR in advance and communicating it to those who need to know about it, can help to ensure that as far as is humanly possible, **inappropriate** CPR is avoided.

It is a person's personal **choice** whether they fill out a DNAR form and to do so they must have capacity to understand what they're signing. They should be given the time required and proper, well-informed information, against which to consider the consequences and implications of their decision.

When a medical **professional** fills out such a form, it is an indication that their clinical opinion is that it would not **work**, so should not be attempted, usually because the patient is dying from an advanced and irreversible condition. A medical professional should never unilaterally impose that view as a ban on treatment.

In a case where this is the view, and the person lacks capacity to discuss the matter with a medical professional, the person's **family** should be consulted (unless before losing capacity the person stated that this should not happen). Family members should be made aware of the person's condition, their chances of survival and plans for treating them, or not, before such a record is added to the records of any incapacitated person.

So the fact that such forms may have been **issued for thinking about, in the Covid-19 crisis**, is not wrong in *itself* - nor should the mere receipt of such forms convey an expectation that a GP is requiring or expecting them to be completed and signed by or 'for' all residents by care home managers ...

Here is a link to the Resuscitation Council's guidance on DNAR/DNACPR processes:

<https://www.resus.org.uk/faqs/faqs-dnacpr/> and information about **DNARs** and what is known as the **ReSPECT** Process can be found here: <https://www.resus.org.uk/respect/?assetdeta3af2d45-c6ff-4793-84c9-61858f65b520=31444>

Two other forms on the RH side of that ReSPECT page are worth looking at: the **ambulance** guide and the **clinician's** guide.

A DNAR form is not a **formal Advance Decision**, which *can* be binding on medical professionals to prevent treatment from being administered. The only way to know if those words were included in an apparent Advance Decision is to look: the signed and witnessed document must contain words must make clear that the refusal of the specific treatment is to apply, **even if life is at risk** – which it obviously will be if the person has stopped breathing – but which would also be the case if they needed to be on a ventilator. See <https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf>

A DNAR form is not legally binding *unless* it is in the form of an advance decision signed by the person themselves, and with the special words required. See here for more guidance on Advance Decisions: <https://www.nhs.uk/conditions/end-of-life-care/advance-decision-to-refuse-treatment/>

2. Next of Kin's and relatives' rights - and limits to those rights

If the person **lacks** capacity through mental or physical infirmity (e.g. advanced dementia, delirium, a low BMI, hypoxia), their next of kin or wider group of relatives are not final **decision**-makers on the DNAR issue. Neither is the care home manager.

(NB A person with a **registered Lasting Power of Attorney** over a person's welfare, **may** have been given that power through opting IN to **special wording in section 7 of that document**, if the person being cared for wanted to give a power to refuse life sustaining treatment to the person granted the LPA, for a time in the future when the grantor lost capacity.)

If there is no LPA holder with that power, then people interested in the welfare of the individual, e.g. the family and the person in charge of their care should be consulted before a best interests conclusion is reached **and recorded in advance on a DNAR form** – which conclusion is **still** not binding. A person's closest supporters might well want to record their views about what they think the person would have wanted, regarding resuscitation, but that is information for the clinical team at the hospital, not a decision that a paramedic, or the care home manager or a GP **can properly regard as a decision about or justification for refusing treatment or hospitalisation of that person.**

A short profile of the person's condition, needs, capacity when not unwell, their dependency and other information that can be shown to a paramedic or read out to a GP for their input based on what they know of the patient is just as important for good triage, once a person gets to hospital. A photograph with a date stamp on it as to when the person was last enjoying some quality of life, would be helpful.

If a person in the home lacks capacity, and **no family members are available** to be consulted (even on the phone) about best interests balance sheet approach about hospitalisation or treatment that could well be invasive and disproportionate or intolerable to the person, **then an IMCA should be appointed by the council and may need to act quickly.** IMCAs should know about new guidance from the Court of Protection on when an application may need to be made to the Court of Protection for a decision about best interests.

The fact that certain medical treatments (including, where relevant, withholding or withdrawing treatment on best interests grounds) are defined as 'serious' does not require that they should be subject to an application to the Court of Protection. Rather they indicate the need for special care and attention to the decision-making process surrounding them, **including the appointment of an Independent Mental Capacity Advocate in appropriate circumstances.** It may not be necessary to apply to the Court of Protection if everyone agrees about a person's best interests regarding resuscitation or life-saving treatment, but only if decision makers can demonstrate:

- the provisions of the Mental Capacity Act 2005 and relevant guidance in the Code of Practice have been followed; and
- relevant professional guidance has been observed; and
- there is agreement at the end of the decision-making process as to the decision-making capacity of the person and the best interests of the person in question.

In those circumstances, in principle, medical treatment may be provided to, withdrawn from, or withheld in accordance with the agreement, without application to the court, in reliance upon the defence in section 5 Mental Capacity Act 2005. If, however, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:

- (a) finely balanced, or
- (b) there is a difference of medical opinion (e.g. as to the risks or prospects of success), or
- (c) a lack of agreement as to a proposed course of action being in the best interests of the person from those with an interest in the person's welfare, or

(d) there is a potential conflict of interest on the part of those involved in the decision-making process

then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration must always be given as to whether an application to the Court of Protection is required and that should be all that one needs to say to the Hospital, Ambulance Trust or Safeguarding team, if **rationing** scarce resources seems to be what is driving the views of those discussing hospitalisation or treatment: there will be a conflict of interest and a serious one in that situation - unless those opposing hospitalisation or treatment are able to point to the source of their legal authority and a rationale that is not **blanket, or arbitrary**, in its approach to care home residents, their condition or their age.

Where any of the above matters arise and the decision relates to the best interests aspect – to the pros and cons of specific life-sustaining treatment – **as opposed to its scarcity, availability or non-availability, an application to the Court of Protection must be made.** This is an inalienable facet of the individual's rights, guaranteed by the European Convention on Human Rights ('ECHR') and this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration. **If scarcity or rationing seems to be the issue, judicial review is the right route for challenge.**

The most recent case in which this approach has been used is *Sherwood Forest Hospitals NHS Foundation Trust v H* (<https://www.bailii.org/ew/cases/EWCOP/2020/5.html>)

The link to the practice guidance from the Court of Protection is found here:

<https://www.bailii.org/ew/cases/EWCOP/2020/2.html>

3. Being clear about hospital visiting during the virus crisis

Relatives can only hope to indicate their view of what would be in the person's best interests if they are acting on a well-informed basis. Nobody in a caring profession would ever want to mislead people's family members as to their legal rights, but care home managers are not likely to be experts in human rights or NHS law, regarding the allocation of scarce resources, even if they are strong on the Mental Capacity Act.

- a) When someone's heart and breathing stop because they are dying from an advanced and irreversible condition, CPR will subject them to a vigorous physical intervention. **It may deprive them of a dignified death or prolong the process of dying and, in doing so, prolong or increase suffering.**
- b) In the Covid-19 period, people's families need to understand (and may well depend on care home managers for discussion of best interests) that
 - i. Hospitals accommodating patients in the UK **are not allowed to impose blanket bans on visiting those patients.** Hospitals are public places and hospital managers can and do have policies, not rules - for visiting - and exceptions must be made before the hospital can be said to be respecting everyone's human rights.
 - ii. Some hospitals' policies will set **out** the exceptions in advance, such as for 'end of life' patients, and impose infection control conditions - but even if they do **not**, they are obliged to permit people to make the assertion that one's loved one is an exceptional case and needs to be visited.

<https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/visiting-someone-in-hospital/> is a link to the NHS information on hospital visiting.

<https://www.bbc.co.uk/news/uk-northern-ireland-52055447> is a link to the position in N. Ireland and is a typical policy described by the media as a ban, which turns out **not** to be a ban, so be warned and be astute! Visiting a relative in hospital is not against the Coronavirus Staying at Home regulations. Those regulations **allow** for providing care or assistance to a vulnerable person. It is inconceivable that someone visiting a seriously ill patient in hospital would be given a fixed penalty notice.

4. Admission to hospital and access to specialist treatment

It is the law in this country that doctors are not allowed to ration treatment, and hospitals are not allowed to refuse **admission**, on the basis of age, disability or the concept of clinical frailty, or the person's likely dependency on hospital care or resources.

Clinicians may, in **extreme circumstances, not yet current**, have no option but to allocate access to critical care or specialist equipment, taking into consideration a range of factors informed by their ethical code, such as

a) the **current capacity of the hospital** – capacity in terms of empty beds, sufficient PPE, the date of patients' admission to hospital, the number of staff available to work to support patients if allocated to those beds

b) the person's **individual clinical presentation**, the prospects of benefiting from what could be provided, the likely period over which the person would need to occupy a hospital bed if provided with the treatment, the risks and drawbacks of the treatment in question, the person's wishes and feelings, and if the person lacks capacity, the views of people interested in that person's health and wellbeing.

See links here for the NICE guidance on access to critical care, including the clinical frailty algorithm it recommends doctors could use. <https://www.nice.org.uk/guidance/ng159/chapter/1-Admission-to-hospital>. Note that the very first page makes it clear that this document is regarded as good guidance for allocation **to critical care only**, NOT for admission to hospital in the first place.

Furthermore, it is considered by the British Medical Association to be ethically not inappropriate if **the NHS were to become stretched beyond its capacity to treat everyone according to need**, for clinicians to pursue agreed policies for rationing treatment – for instance, withholding or only providing treatment for a limited period, from those not expected to benefit significantly from it or those who have not benefited from it within a certain time, or ordering people in terms of the date of their admission to hospital in the first place. The BMA does not have the authority to do anything more than suggest what those policies might be.

See here for that BMA thinking: <https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf>

See here too for the Royal College of Physicians' ethical guidance for the Covid-19 period:

https://mcusercontent.com/feeed3bba7c179fd3a7ef554/files/f5cf180e-c1bf-4e63-8199-4171f30b5026/Ethical_dimensions_of_COVID_19_for_front_line_staff_1.pdf

It should be noted that in a very recent case, since the virus began, the courts have said this about Human Rights and the rationing of resources:

"In some circumstances, a hospital may have to decide which of two patients, A or B, has a better claim to a bed, or a better claim to a bed in a particular unit, even if ceasing to provide in-patient care to one of them will certainly cause extreme distress or will give rise to significant risks to that patient's health or even life. A hospital which in those circumstances determines rationally, and in accordance with a lawful policy, that A's clinical need is greater than B's, or that A would derive greater clinical benefit from the bed than B, is not precluded by Article 3 ECHR from declining to offer in-patient care to B. This is because in-patient care is a scarce resource and, as Auld LJ put it in R v

North West Lancashire Health Authority ex p. A [2000] 1 WLR 977, at 996, “[i]t is plain... that article 3 was not designed for circumstances... where the challenge is as to a health authority’s allocation of finite funds between competing demands”. Decisions taken by a health authority on the basis of finite funds are, in my judgment, no different in principle from those taken by a hospital on the basis of finite resources of other kinds. In each case a choice has to be made and, in making it, it is necessary to consider the needs of more than one person.

Analytically, the reason why a decision to require a patient to leave a hospital is unlikely to infringe Article 3 ECHR is because it is based on a prior decision **not to provide [further] in-patient care**. Such a decision engages the state’s positive (and limited) obligation **to take steps to avoid suffering reaching a level that engages Article 3**, rather than its negative (and absolute) obligation not itself to inflict such suffering. Where the decision to discontinue in-patient care involves the allocation of scarce public resources, **the positive duty can only be to take reasonable steps to avoid such suffering**: cf *R (Pretty) v Director of Public Prosecutions [2002] 1 AC 800, [13]-[15]* (Lord Bingham). **It is difficult to conceive of a case in which it could be appropriate for a court to hold a hospital in breach of that duty by deciding, on the basis of an informed clinical assessment and against the background of a desperate need for beds, to discontinue in-patient care in an individual case and, accordingly, to require the patient to leave the hospital. The present is certainly not one.**

Even though the decisions to cease to provide in-patient care to MB and to require her to leave, plainly interfere with MB’s right to respect for private and family life, the evidence adduced by the Claimant amply **demonstrates that the interference was justified in order to protect the rights of others**, namely those who, unlike MB, **need** in-patient treatment. Bearing in mind the broad discretionary area of judgment applicable to decisions of this kind, there is **no prospect that MB will establish the contrary.**”

The link to this case (*University College Hospitals Foundation Trust v MB*) is here:

<https://www.bailii.org/ew/cases/EWHC/QB/2020/882.html>

The judge accepted that a decision by an NHS hospital not to provide in-patient care in an individual case might, in principle, be **challengeable on public law grounds, by judicial review** (NOT the Court of Protection, please note) if the decision were tainted by **improper purpose or had been made in breach of statutory duty or otherwise contrary to law**. So that position preserves public law challenges for anyone to raise in the Covid-19 period, for instance on the basis of a blanket policy of non-admission or non-selection of anyone aged over 90, or just based on being disabled intellectually or physically, assuming the property owner is a public body amenable to judicial review, such as hospitals.

An important difference between this and any other case that might arise in the context of accessing a ventilator or an ICU bed, is that here, the view was very firmly reached that this woman MB did not **NEED any other treatment the hospital could possibly give her**, whereas in a Covid-19 related competition for a ventilator, it could well be different.

So although this case points to the difficulty of challenging a rationing decision of the nature that may be driving all sorts of people not to seek or push for hospitalisation of care home residents, **it must be made clear to patients and their loved ones that it is always going to be possible to use law against blanket, discriminatory or irrational policies** that are contrary to ethical and professional values (“outrageous in their defiance of logic or accepted moral standards” – Lord Diplock in a seminal case on *irrationality*.)

5. The Home’s duty of care, regarding standing up for an incapacitated person’s rights to be considered for hospital admission - AT the hospital

A care home manager, a paramedic, an ambulance trust or the NHS should not therefore refuse to convey a patient (or acquiesce in someone else’s refusal) who otherwise needs to go to hospital, on the grounds of the setting where a person lives, or their age or condition, or diagnosis. Just as anyone living

in their own home with any friend of neighbour or the means to call a cab will take themselves to hospital, people in a care home are entitled to an equal chance to be treated.

It is part of a duty of care in the law of negligence, owed to all in the care home, to call the emergency services and be able to assert a person's basic rights – such as making sure that any advance decision that they have made or any other statement of wishes, or the views of an LPA welfare holder with the special authority over life sustaining treatment - and a profile of that person's recent health and well-being - is passed on to the authorities.

A person who is struggling to breathe and for whom human or nursing or mechanical assistance is beyond the capability of the person's residential or nursing home staff or registration level, **has a right to be considered for NHS treatment of all levels**; it must be part of the duty of care owed to all residents that those looking after them will take reasonably practicable steps to ensure that this occurs, including asking anyone who refuses, to tell them what the source of their authority for that stance *is thought to be*.

6. Hospital Discharge arrangements during the Covid-19 crisis

In the Covid-19 crisis period, anyone who goes to hospital (with Covid-19 symptoms or for something else unrelated) will be discharged as soon as it is possible to discharge them safely **even if they have not been tested to negative status**. See here for the hospital discharge policy which explains the current vision for Discharge to Assess within 2 hours of a person's fitness for safe discharge.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf

That document makes clear that the NHS is obliged to fund their follow-on care, unless and until it decides that the person does not qualify for NHS continuing health care.

It is suggested in the document that the local authority will continue to contract for the care of that person if they are already so doing, but that the NHS will fund the care. The person's status as a self-funder, or a person whose assets are above or below the capital threshold, will not be relevant and should not delay discharge. Care homes might therefore wish to consider applying a scale of fees (whether banded or not) that makes no distinction between those who have been publicly funded, or privately funded, up to admission to hospital.

The Adult Social Care Plan issued 15 April 2020 has a section on funding which is the government's commitment to ensuring that sufficient funds are available to support rapid hospital discharge:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/879639/covid-19-adult-social-care-action-plan.pdf

"4.3 We expect local authorities to get the funding they have received quickly to the front line. Local authorities should take steps to:

- Protect providers' cashflow, including making payments on plan in advance;
- Monitor the ongoing costs of delivering care, such as higher workforce absence rates caused by self-isolation, sickness and family caring responsibilities; and
- Adjust fees to meet new costs."

On the 18th April, the government doubled the amount of money it had already committed to supporting local authorities through the crisis.

7. Admission and re-admission arrangements

Privately funded care home clients cannot be evicted without regard to the Protection from Eviction legislation because they are residential occupiers, even though they are not **tenants**.

Service users who are publicly funded are also protected as residential licensees, through permission for their occupation having been procured by the public body's contract for their benefit, together with the necessary care.

Any care home contract that provides for less than 28 days' notice may not be **lawful** given that it cannot abide by that overriding legal right to protection under the above Act. The Act requires 28 days' notice and due process through the **courts** (ie a possession action) if the person will not leave voluntarily. Some people will lack mental capacity and need a litigation friend, even to defend proceedings.

We think that most care home contracts (whether for privately or publicly funded clients) contain a term providing for shorter notice to be given if the home's management has reason to believe that it cannot meet the person's needs any longer – and that in general the Protection from Eviction legislation is not considered because the council or CCG will still owe a duty to meet a person's needs – and urgently - in any event, whether or not the local authority has adopted the Care Act easements described in section 10 below.

During the Covid-19 crisis, however, **NO possession actions are being heard by the courts**, and all will be 'stayed' (put on ice). This measure will cover all private and social renters, as well as those with mere licenses covered by the Protection from Eviction Act 1977.

An **injunction** can, however, be sought, and the *MB* case referred to above, brought by a hospital, is an example of the use of that solution, and is not dependent on notice having expired, if notice has at least been given.

Apart from the possibility of such notice terms being triggered, by genuine concerns about how to isolate people who have not got a negative testing status, nor completed 14 days' isolation from first symptoms, publicly funded residents ought only to arrive or return from hospital **with their needs documented to at least a level that enables preparation of a detailed care plan by the home**.

Care home managers are not automatically obliged to accept, or to accept BACK, people to their homes, for care, where their needs have not been sufficiently documented or recorded as to enable the manager to make a professional decision whether the Home can deliver safe, appropriate care, whilst managing the duty of care to other residents and their own staff. The home is providing care together WITH accommodation, as one integrated and inter-dependent package.

Their registrations with CQC depend on them remaining financially viable and not taking on responsibilities that they cannot deliver upon, for the price that has been agreed, whether in a framework or on the spot at the time the bed is needed. Care home managers are professional people and not public servants – contracting with the council does not make them formal partners of councils and CCGs.

Any Guidance directed to them from government only constitutes advice and requests unless a piece of legislation provides specific authority for a **direction**.

8. Human Rights obligations owed directly by care homes

Care homes **owe human rights**, as a matter of law, to all publicly funded clients, directly, and must in particular discharge the function of providing care together with accommodation in a way that recognises and delivers upon what is required by the **right to life, freedom from inhuman or degrading treatment, the freedom from unjustified deprivation of liberty and the right to respect for private and family life and the person's home.**

The home's **owners** must fund compliance with these obligations in order for the service to be a fit service for purpose, and therefore must be able to justify their decisions regarding the resourcing of managers' day to day functions, so far as staffing, PPE and all other strategic decision-making are concerned.

Section 73 of the Care Act 2014 is where this legal status stems from, and it has not been suspended or modified. It was the position for care homes anyway, under the Human Rights Act 1998, giving them the status of a public body, for legal claims about any breach of human rights.

9. Accessing Personal Protective Equipment, beyond what homes' management have been able to source

All Homes are being assisted to cover PPE shortages by the parallel supply chain that the government has set up, the details of which can be found below.

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe> is the link to government guidance on PPE.

Local authorities have been given funding to meet the likely increased costs of meeting needs properly, in the Covid-19 crisis. They are obliged to tell government how they are ensuring that providers get that funding so that the care home market remains viable.

10. Care Act functions

Since April 1st, Councils have been given the option to regard the Care Act duties of assessment, eligibility and review as suspended, but whether they have chosen to do so, is a matter for them.

If they so decide, then they must notify this intention to the DHSC, and put it on their websites. The implications will be for assessment functions and care planning. A care home faced with a decision to reduce an existing client's publicly funded budget is not obliged to meet **ONLY** the needs that the council might wish that home to meet. They can decline to keep the client/patient if the commissioner will not contract for care that the home can demonstrate is required in order to meet need safely, in professional terms.

Despite the Covid-19 crisis, a care home is still its own-decision maker as to whether it accepts variations of public sector contracts, and if it does not, it is not a criminal or civil law wrong to reject unilateral variation of a contract. The extent of responsibility and risk that care homes choose to agree to accept under the law of contract, is a separate matter to the rights of the member of the public who is owed a duty by a public body, in respect of the meeting of their needs, or who is being provided with services through a public body's commissioning, under a statutory power such as s19 of the Care Act, or under the auspices of **safeguarding.**

Unless or until councils decide to adopt the easements, the Care Act duties and all the principles that underpin a **rational, transparent and sufficient personal budget** continue to apply and amount to a set of rights for the client, upheld through public law.

When a council decides to adopt the Care Act easements it must explain how it is doing that, and there may be a role for providers to play, to help councils through this period – such as Trusted Assessor Status for assessments and reviews.

Here is the guidance for councils as to what they must consider before adopting the easements:

<https://www.gov.uk/government/publications/coronavirus-covid-19-changes-to-the-care-act-2014/care-act-easements-guidance-for-local-authorities>

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We aim to offer clear, legally literate guidance to support service users, carers, practitioners and strategic leaders during the outbreak. We aim to survive as a charity so that we can continue to stand up for legally literate social work once the Care Act is brought back into full force!