DNA CPR Decisions – The Why, When and How

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A DNACPR decision, a decision not to attempt cardio-pulmonary resuscitation is intended to prevent inappropriate attempts at CPR where it clearly will not work or would not be wanted by a patient.
Outline of the session

• Background to DNA CPR decisions including recent “light review”

• Decision Making Framework

• DNA CPR within ACP context

• Having the conversations
Defibrillation (attempting to re-set the heart rhythm with a DC electrical shock) was first used to re-start a human heart in 1947 (open chest).

Initially patients were selected to have this new treatment.
Default position is to attempt CPR unless there is a decision made not to.
Bob was a 78 year old gentleman with metastatic bowel cancer. His wish had been to die at home and the GP, district nurses and community palliative care nurses knew of this. He was becoming increasingly frail and bed bound and his family were told that time was short (days-weeks). One morning whilst his daughter was taking the children round the corner to school, Bob stopped breathing. His wife had been very anxious all the way through Bob’s illness and panicked. She called 999 as she could not remember the advice given by the GP. Paramedics commenced CPR – insisted on taking him to hospital. CPR stopped soon after arrival in Emergency Department. Bob’s wife and daughter got to the hospital after it was all over but had to wait for someone to come and speak with them and also for the police to come.
The Policy:

Original policy implemented in 2010

Light-touch review in 2015/16

In line with revised guidance from BMA/RCN/RC(UK) 2016 and GMC guidance (2010)

Fully integrated between Primary and secondary care services

Supported By Scottish Ambulance Service

Supported by Police Scotland and Crown Office & Procurator Fiscal Service
Why does it have to be integrated?

Inappropriate resus attempts
Nursing staff putting out 2222 call when they know patient was expected to die
Inconsistent and varied documentation causing confusion
DNACPR decisions delayed in futile clinical situations because it hasn’t been discussed
Doctors offering CPR as a choice to dying patients (or their relatives) where it would clearly be unsuccessful
Medical staff asking relatives to make DNACPR decisions
Hospital issues:

Increased movement of staff and patients between hospitals

Patients being looked after by increased numbers of different staff (shifts, teams, agency, hospital at night etc.)

DNACPR documentation deferred due to misunderstandings about the communication of DNACPR decisions
Community issues:

Existence of advance DNACPR decision needs to be communicated to GP, DN, care home staff and OOH on discharge and added to Key Information Summary (KIS)

Existence of advance DNACPR decision at home needs to be communicated to hospital/hospice team on admission

For DNs, Marie Curie nurses and other experienced community nurses a default of attempting CPR in the absence of a DNACPR form is impractical.
Ambulance issues:

Existence of DNACPR form needs to be communicated to ambulance personnel

Clear instructions are needed about what to do in the event of death in transit
Who to contact
Where to take the patient

DNACPR information may be accessible by ambulance crews via KIS
NHS Scotland DNACPR policy:

Single, high visibility, widely recognisable, self-explanatory DNACPR form designed to follow the patient and contain all info needed by community, acute and ambulance services

Decision making framework to assist medical and nursing staff in all settings

Patient information booklet to improve patient and relative awareness, and assist discussions
NHS Scotland DNACPR Policy 2016
Decision-making framework

Is cardiac or respiratory arrest a clear possibility for the patient?
NO

YES
Is there a realistic chance that CPR could be successful?
NO
YES

If a DNACPR decision is made on clear clinical grounds that CPR would not be successful there should be a presumption in favour of informing the patient of the decision and explaining the reason for it. Subject to appropriate respect for confidentiality those close to the patient should also be informed and offered an explanation. A decision can be made not to inform the patient at that time only if it is judged that the conversation would cause them physical or psychological harm. This must be clearly documented along with a plan to review the patient’s ability to engage with that conversation.

Where the patient lacks capacity and has a welfare attorney or appointed welfare guardian, this representative should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussion about the patient’s care.

Where a patient lacks capacity the decision should be explained to those close to the patient without delay. If this cannot be done immediately the reasons why it was not practicable or appropriate must be documented.

If the decision is not accepted by the patient, their representative or those close to them, a second opinion should be offered.

Does the patient lack capacity AND have an advance decision specifically refusing CPR OR have a welfare attorney or guardian?

YES

If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, this must be respected.

If a welfare attorney or guardian has been appointed they must be consulted.

NO

Discussion with those close to the patient must be used to guide a decision in the patient’s overall benefit. The question is what the patient would have wanted rather than what the family would want but account must also be taken of their views regarding what they feel would be of benefit for the patient. Those close to the patient must not be burdened with feeling that they are responsible for the decision as this responsibility rests with the senior clinician.

Does the patient lack capacity?
NO
YES

Respect and document their refusal. Discussion with those close to the patient may be used to guide a decision in the patient’s overall benefit, unless confidentiality restrictions prevent this.

Is the patient willing to discuss his/her wishes regarding CPR?
NO
YES

The patient must be involved in deciding whether or not CPR will be attempted in the event of cardiorespiratory arrest.

Adapted from Decisions Relating to Cardiopulmonary Resuscitation - guidance from the BMA, RCGP(UK) and the RCN 2016
What factors help you make a decision?
- Understanding the terminology

1. **Aim of CPR** – achieve sustainable life

2. **CPR** = total opposite of traditional idea of a “good death” (peaceful, dignified, comfortable, family presence etc)

3. **What is a DNACPR decision?**
   - CPR is not to be attempted when patient dies
     - CPR won’t achieve sustainable life (Clinical not quality of life decision)
     - The burden of CPR Rx and likely outcome is such that the patient doesn’t want CPR attempted (overall benefit)
   - Protection for patients from aggressive, undignified, unnatural death – not a possible Rx being withheld

4. **What is a DNACPR form?**
   - Communication tool for that decision
What the patient/relative might be thinking?

Common misunderstandings
- “Not for CPR” means not for anything
- “being left to die”
- “being written off”
- CPR is nearly always successful
  - TV/media survival = 64%!
- Successful CPR has no harmful effects
  - Wake up smiling and have a cup of tea
What other factors help you make a decision? – consideration of outcome

- What % of cardiac arrests occur outside hospital?
  = 80%

- Of these what % result in death?
  = 90% (Young et al 2009)

- Survival to 1 month in those who present in non shockable rhythm?
  = 2.3% (Hollenberg et al 2008)

- What % of in hospital cardiac arrests survive until discharge
  = 13-17% (Ferguson et al 2008) – lower (0%) in frail elderly, advanced irreversible illness

- What is % of successful cardiac arrests in Nursing Home?
  = 1-2%
When do you need to make a decision about resuscitation?

*Is cardiac or respiratory arrest a clear possibility for this patient?*

**NO:**

- No further thinking about DNACPR is required
- Do not burden the patient with having to make a decision about CPR unless they express a wish to discuss it
- In the unlikely event they have a cardiac arrest attempt resuscitation unless it clearly would not work
When do you need to make a decision about resuscitation?

Is cardiac or respiratory arrest a clear possibility for this patient?

YES:

Is there a realistic chance that CPR could be successful ie achieve sustainable life for the patient?

YES:

- decision to have DNACPR order rests with competent patient
- Sensitive exploration of patients wishes if appropriate
- Discuss in context of patient’s illness; goals of care, realistic treatment choices, and end of life care wishes; and likely benefits and burdens of “successful” CPR
When do you need to make a decision about resuscitation?

Is cardiac or respiratory arrest a clear possibility for this patient?  

**YES:**
- Is there a realistic chance that CPR *could be successful* ie achieve sustainable life for the patient?

**NO:**
- The DNACPR decision (CPR would not work) rests with senior clinician (Dr / Nurse) responsible for the patient
- the presumption is that *this information will be shared with the patient sensitively* as part of discussions about their clinical situation, goals of care and end of life care wishes
- DNACPR form can be completed and process and discussions must be clearly documented
Do I need patients consent for DNACPR when CPR will not work?

Making a decision not to attempt CPR that has no realistic prospect of success does not require the consent of the patient or of those close to the patient.”
Do I need to discuss?

• SG Health and Sport Committee Enquiry into Palliative Care

• Strategic Framework For Palliative Care (SG/2015)

• Montgomery vs Lanarkshire Health Board - Judgement (2015)

• Winspear vs Sunderland NHS Foundation Trust - Judgement (2015)

Patients must be made aware of a DNACPR decision when CPR won’t work

If that conversation cannot take place document:

• the clinical DNACPR decision without delay,
• the plan to review an opportunity to have the conversation,
• the reasons why the conversation can’t take place.

The only acceptable reasons for not having that conversation are:

• high risk of causing *psychological or physical harm*
• the Patient has capacity but refuses to discuss it
• the Patient does not have capacity and reasonable efforts to contact welfare attorney / guardian, or those close to the patient, have failed
Those close to a patient who lacks capacity must be made aware of a DNACPR decision without delay when CPR won’t work

If that conversation cannot take place document;
- the clinical DNACPR decision without delay,
- the plan to review an opportunity to have the conversation,
- the reasons why the conversation can’t take place.

The only acceptable reasons for not having that conversation are:
- judged to be not practicable
- judged to be not appropriate
It is inappropriate to involve the patient personally in the process if the clinician considers that to do so is likely to cause the patient to suffer physical or psychological harm but the mere fact that the subject matter is likely to distress the patient will generally not be sufficient to justify excluding the patient from the decision-making process ([54]).

The fact that a physician considers that the treatment is futile is not a sufficient reason not to communicate the decision.

“I would reject this submission for two reasons. First, a decision to deprive the patient of potentially life-saving treatment is of a different order of significance for the patient from a decision to deprive him or her of other kinds of treatment. It calls for particularly convincing justification. Prima facie, the patient is entitled to know that such an important clinical decision has been taken. The fact that the clinician considers that CPR will not work means that the patient cannot require him to provide it. It does not, however, mean that the patient is not entitled to know that the clinical decision has been taken. Secondly, if the patient is not told that the clinician has made a DNACPR decision, he will be deprived of the opportunity of seeking a second opinion.”
If CPR might be successful but patient lacks capacity to make a decision

A decision about what will be of overall benefit for the patient must be made by the clinical team with legal welfare attorney/guardian.

A “benefit vs burden” judgement must be made about CPR and its likely outcome for that patient.

Those close to the patient must not be made to feel that they are responsible for the decision but must be involved in any overall benefit decision and enabled to offer opinions about what the patient would have wanted.

The discussions and decision-making process must be documented.
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Name: ..........................................................................................................................
C1VD08: ....................................................................................................................
Address: ....................................................................................................................
Postcode: ...................................................................................................................

Communication tool not legal document (Decision-making process and discussions must be clearly documented in notes)

- File in front of notes (immediate visibility & access in emergency)
- No form does not automatically mean CPR must be attempted

Select reasons for DNACPR decision (please choose only A or B. Within Section A or B select therelevant communication or decision-making strategy by ticking the appropriate option

A. CPR will not be successful and is not in the patient's best interest

- The patient is aware of the decision
- Yes [ ] or was made at a date and time documented [ ]
- No [ ]
- Reason: [ ]

- The ward staff and key family and/or those close to the patient are aware of the decision
- Yes [ ]
- Date: [ ]
- No [ ]
- Reason: [ ]

The presumption is that the parents and those close to the patient who lacks capacity will be aware of the DNACPR decision – see Definitions section for valid exceptions. Where the presumption has not yet happened, the full explanation and a plan to revisit this must be documented in the clinical notes.

- CPR could be successful but the likely outcome would not be of overall benefit to the patient (The patient informed others and others are of paramount importance). One of the following boxes must be ticked

  - The patient has given specific instructions to the doctor
  - and does not wish CPR to be attempted
  - The patient has given specific instructions to the doctor and does not wish CPR to be attempted
  - The patient has given specific instructions to the doctor
  - The patient has given specific instructions to the doctor
  - The patient has given specific instructions to the doctor

  E.g: [ ]
  (A clear plan must be documented in clinical notes)

- Document clearly any assessment and all discussions clearly in clinical notes

Names of multidisciplinary team members involved in the decision

<table>
<thead>
<tr>
<th>Name of Healthcare Professional reporting the DNACPR decision</th>
<th>Responsible Senior Clinician (Doctor/Nurse)</th>
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<tbody>
<tr>
<td>Name: .............................................................................................................</td>
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The original DNACPR Form should follow the patient or move to their electronic record if requested.
Complete “Communication with Ambulance Crew” before transfer

If the form is going home with the patient it must be the original

Review when clinical responsibility changes and at individualised clinically appropriate intervals

Prompt GP to update KIS on patient’s discharge. Where the discussion has not happened to allow the form to go home with the patient the GP must be made aware of the reason so this can be put on the KIS
Key Information Summary (KIS) -

An extension to Emergency Care Summary (ECS) & electronic Palliative Care Summary
For use both in Hours & OOH - ECS / KIS replaces faxed communications
Info available to NHS24, paramedics, A&E, Hospitals via Portal or TRAKcare
Useful / helpful for:
Patients with long term conditions, in particular if they take multiple medications and attend multiple specialist clinics
Patients who are likely to present to unscheduled care at the weekend or out of hours
Patients who may find it difficult to communicate in an emergency (for example, people who have communication or memory problems, mental health issues or learning disabilities)
Patients with palliative care needs
Where no DNACPR decision made and patient arrests?

It is presumed staff would initiate CPR

However, it is unlikely to be considered reasonable to initiate CPR when a patient dies who was clearly in the advanced stages of a terminal illness where death was imminent and unavoidable. Where signs of irreversible death are present e.g. rigor mortis,

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.
Ambulance Service

• Fill in ambulance section of form
• Inform Ambulance crew at time of booking ambulance re DNACPR order
• Ambulance crew must know whether patient and relatives are aware of form. If not, then ambulance crew should be shown original DNACPR form prior to transfer
• Ambulance staff can now use their judgement if no DNACPR form (usually consult with a senior)
• How do Ambulance staff cope with End of Life situations and DNACPR forms?
Communicating DNA CPR decisions

- When
- How
- Always?
Why do we shy away from discussion?

- Time and competing demands
- How well do we know this patient and family?
- Fear of taking away hope
- Inadequate training and support
- Clinicians – unresolved feelings about death and dying – feel sense of personal failure if patient dying
- Concerns about patient autonomy

(Chittendon et al J Hosp Med 2006)
Only approach discussions about DNACPR in the context of wider discussions about future care
How to discuss?

1. “How much do you know about your illness?”

2. “How much do you want to discuss the future? How much do you want to know what is happening/likely to happen? Are you the kind of person likes to know a little/everything about what's happening?

3. “As you look to the future, what do you hope for?” “What matters to you?”

4. “When the time comes, we want to allow you to die peacefully… this also means that we would not try and restart your heart…

5. Need to emphasize what the decision means: treatment for potential reversible things but if it doesn’t work and the heart stops then there isn’t anything we could do to restart it
Person Centred Care...

1. What matters to you?
2. Who matters to you?
3. What information do you need?
4. Personalised contact
5. Nothing about me without me
Treatment Escalation Plans

Ceilings of Treatment

Goals of Care
More cases - Patient 1

76 yo old woman with Pulmonary Fibrosis
First seen as outpatient
Progressive decline, on oxygen 24/7, but still quite active
Had conversation about future care, management of complications such as infection, would she consider hospice admission, preferred place of death and all led easily to CPR discussion – she laughed, expressed relief at discussion and wanted to take form home to “stick on fridge”
Patient 2

78 yo man with Myelodysplasia which had progressed to AML
Admitted to hospice from Haematology ward, no DNACPR in place
Advised coming to hospice for “convalescence”, expecting
treatment with blood/platelets etc but condition very frail and
obviously progressing
Discussion about level of intervention and CPR discussion had to
happen on admission
Wife extremely angry, refused to let admitting doctor look after
husband again
Patient 3

65 yo woman with breast cancer and liver metastases, recently had chemo
Admitted to hospice for symptom control
Arrest could be anticipated (chemo)
CPR discussed, for resuscitation and transfer
Patient 4

58 yo old woman with Head and Neck Cancer
Asked to see in hospital clinic
Progressive illness, moderate stridor
Did not want hospital/hospice admission under any circumstances although risk of sudden deterioration
DNACPR discussed and completed form, along with just in case meds, GP and DN discussions
Acute deterioration, 999 call by relative but daughter showed them DNACPR form, stayed in house and paramedics cared for her until she died within an hour
Patient 5

68 yo man with Advanced Floor of Mouth Cancer
Declined treatment 1 year ago and went abroad
Returned recently as illness worsening
Seen as outpatient
Significant risk of terminal haemorrhage or Respiratory Obstruction
Discussed goals of Care and DNACPR included
Gave patient form and he wrote “Let me die in Peace form” on outside envelope
Final Thoughts

*Remember:*
DNACPR Forms only refer to cardiopulmonary resuscitation, not to any other treatments

DNACPR forms completed prior to the launch of the new NHS Scotland DNACPR Policy (2016) will remain valid and a completed 2010 form does not need to be replaced with a new form

Documented evidence of communication is *essential*
If conversation does not take place: *document rationale*
DNACPR Education Resources

ACP toolkit and DNACPR information

www.palliativecareinpractice.nes.scot.nhs.uk

Communication aspects of DNACPR discussions - videos available via palliative care in practice website

DNACPR Document links

Living and Dying Well (SG 2008, 2011)

Are we Living and Dying Well
https://www.mariecurie.org.uk/globalassets/media/images/blog/2014/05/are-we-living-and-dying-well-yet-final-report.pdf

DNACPR Policy 2016  www.scotland.gov.uk/dnacpr


BMA/RC(UK)/RCN (June 2016)
https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

Caring for people in the last days and hours (SG 2014)

Person Centred Care Strategy


A National Clinical Strategy for Scotland