DNACPR

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14th January 2015
Objectives

• NHS Scotland DNACPR policy
• Decision making framework and the forms

• DNACPR within ACP context
• Communication with patients, relatives and colleagues
Background

- Confusion and uncertainty about CPR
- Variation in local policies and practice
- Increased movement in patients between different care settings made an integrated and consistent approach a necessity
- 2007 Joint Statement on Resuscitation (BMA, RCN and Resuscitation Council)
- Treatment and Care towards End of Life -Good Practice in Decision Making (GMC)
- NHS Lothian/SAS/Review of Palliative Care services Scotland drivers
Why?

- Inappropriate resuscitation attempts in community, ambulance’s, hospitals
- Arrest Team calls –default position
- CPR being offered in futile situations
- Medical staff asking relatives to make decisions
- Want to identify patients who competently make the decision that don’t want CPR
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

NHS Scotland Policy
DNAPCR, not DNAR

• Policy solely refers to CPR in the event of a cardio pulmonary arrest
• “It does not refer to other aspects of care e.g. analgesia, antibiotics, suction, treatment of choking, treatment of anaphylaxis etc which are sometimes loosely referred to as “resuscitation”.

'Do not resuscitate' does not mean 'do not treat'
Consideration of outcome of CPR

• Unrealistic expectations of CPR
• 80% Cardiac arrests occur outside hospital
• 90% of these result in death (Young et al 2009)
• Survival to 1 month 2.3% in those who present in non shockable rhythm (Hollenberg et al 2008)
• 13-17% of cardiac arrest in hospitals survive to hospital discharge (Johnson et al 2008)
In context of a progressive illness

- Even lower likelihood of success
- Best that could be hoped for is return to usual state or worse
- Rib fractures and hypoxic brain injury risks
- Some patients where it must be considered, e.g. longer trajectory, life prolonging treatments available, relatively “fitter”
- Balance of potential benefits and burdens
- **Aim of CPR – achieve sustainable life**
- **CPR = total opposite of traditional idea of a “good death” (peaceful, dignified, comfortable, family presence etc)**
Framework for Cardiopulmonary Resuscitation (CPR) Decisions

**Can a cardiac or respiratory arrest be anticipated?**

- Progressive cardiac or respiratory compromise.
- Previous life-threatening event or condition in which cardiac arrest is likely.
- Patient dying from irreversible condition e.g. advanced cancer.
- Patient whose death would not be unexpected.

**Do not burden the patient or relevant others with a CPR decision**

- Continue to communicate and assess any concerns of the patient and relevant others. This may involve discussion about CPR and its outcome.
- Review only when circumstances change.
- In the event of cardiopulmonary arrest, carry out CPR unless it would clearly be unsuccessful.
- For patients with strong views about CPR, advice may be given about creating an advance healthcare directive.

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**Advance Decision on CPR is possible**

- Sensitive exploration of the patient’s wishes regarding resuscitation should be undertaken by the most experienced staff available.
- If the patient has capacity for this decision, discuss options of CPR and DNACPR with patient, involve relevant others* if appropriate (with patient’s permission).
- If the patient does not have capacity to understand the implications of this decision, the medical team should make this decision based on available information regarding patient’s previous wishes (from relevant others*, advance healthcare directive, other healthcare professionals or members of the multidisciplinary team). Relevant others* should never be asked to make the decision unless they are the legally appointed welfare attorney/welfare guardian/person appointed under an intervention order. Healthcare staff must be aware of the principles of assessing capacity and the patient must be cared for in line with the terms of the Adults with Incapacity (Scotland) Act 2000 (see policy).
- Document the decision and any discussion around that process.
- Continue to communicate and assess concerns of the patient and relevant others*.
- Review at individualised clinically appropriate intervals to assess any change in circumstances.
- In the event of a cardiopulmonary arrest, act in accordance with the documented decision.

**CPR inappropriate**

- As CPR would fail it cannot be offered as a treatment option. A DNACPR form should be completed and used to communicate this information to those involved in the patient’s care.
- Document the reasons for the decision and any discussion around that process.
- Do not burden the patient or relevant others* with a CPR decision.
- Continue to communicate and assess any concerns of the patient and relevant others (which may include discussion about why CPR is inappropriate).
- Patients at home or going home should be offered the DNACPR form if appropriate through sensitive discussion by experienced healthcare staff.
- Review when clinical responsibility for the patient changes.
- Review at individualised clinically appropriate intervals to assess any change in circumstances.
- Where the patient is clearly dying in days allow natural death with good palliative care and support for patient and relevant others.

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*Relevant others refer to the patient's partner, relatives, carers, guardian etc.

• Don’t need to burden patient with CPR discussion where arrest not anticipated
• Patients who want to refuse CPR in certain future circumstances should be advised to do this through formal advance directive, not this form
• Decision needs to be recorded by most senior clinician
Specific Medical decisions

- Role of medical team is to decide if CPR realistically likely to have a medically successful outcome
- Consider if patient would be appropriate for ICU
- Overall responsibility lies with most senior clinician caring for patient at that time but good practice to reach consensus with other staff involved
Medical decisions

• Don’t have to burden patient with resuscitation decisions if medically clear that it will fail, but can be part of communication about illness and prognosis with patients and relatives – Change in emphasis with Tracy Judgement followed by SG guidance

• Exception is where patient is being transferred home from hospital/hospice
Tracy Judgement

• “Judgement emphasises and enforces the duty of clinicians to engage in timely, honest and sensitive communication that is truly individualised to meet the patients need and situation”

• “Clinician has a duty to consult the patient in relation to DNACPR unless he/she thinks that the patient will be distressed by being consulted and that the distress will cause the patient harm”
Patient Decisions

• Where CPR is likely to be medically successful but is judged to have doubtful overall benefit for the patient, the patient’s wishes must be given priority.

• But there is no obligation to give treatment that is futile or burdensome (GMC 2010).

• If CPR would not restart the heart and breathing it should not be attempted (BMA, RC UK, RCN OCT 2007).

• *not a possible Rx being withheld.*
Patient who lacks Capacity

• If CPR could be realistically successful, consult legally appointed welfare guardian or clinical team makes the decision based on judgement of overall benefit (check if advance directive)
• Legal Proxy can not demand CPR if it is clear that it would be unsuccessful. May need to seek second opinion if agreement not reached
Role of relatives/relevant others

• Where patient has capacity, their permission should be sought before discussion with relatives

• Relatives do not give or withhold permission but should if possible be part of discussions (unless they have welfare power of attorney..)
Where no DNACPR decision made and patient arrests

- It is presumed staff will attempt resuscitation
- However, likely to be considered unreasonable in terminal phase of illness
- Experienced medical or nursing staff not obliged to attempt resuscitation in this circumstance
Ambulance Staff

- 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)
This decision applies only to CPR treatment where the patient is in Cardiopulmonary arrest.

Patients must continue to be assessed and managed, with whatever treatments are appropriate for their health and comfort irrespective of their DNACPR status (this may include emergency assessment if appropriate in the event of unexpected deterioration).

A decision has been taken (please indicate below) that the above patient is not for attempted Cardiopulmonary Resuscitation (CPR). Any discussion around this decision (with patients, relatives, team members etc) must clearly be documented in patient's notes.

Please tick one of the three boxes below

☐ CPR is unlikely to be successful due to: ** (NB: It is essential that the patient/relevant other is made aware of this decision if this DNACPR form is to go home with the patient. Every effort should be made to do this in other situations but, where CPR will fail, the decision can be documented without discussion.)

○ This has been discussed with patient/relevant other:
  (name) ..................................................................................................................

  (Tick whenever discussion has occurred and record details of discussion in patient's notes).

☐ The likely outcome of successful CPR would not be of overall benefit to the patient.
  (The patient's informed views and wishes are of paramount importance for this decision).

  One of the following circles must be ticked:

  ○ Decided with the patient who has capacity for the decision.

  ○ Decided with the patient's legally appointed welfare guardian/welfare attorney/person appointed under an intervention order:
    (name) ..................................................................................................................

  ○ Patient lacks capacity for the decision and no legal welfare guardian/welfare attorney/person appointed under an intervention order can be identified. Decision made on basis of overall benefit to the patient in discussion with:
    (name) ..................................................................................................................

  (Tick whenever discussion has occurred and record details of discussion in patient's notes).

☐ CPR is not in accord with a valid advance health care directive/decision (living will) which is applicable to the current circumstances.

* See full policy guidelines. ** Record underlying condition(s) e.g. end stage heart failure; end stage Chronic Obstructive Pulmonary Disease; large intracerebral haemorrhage with coagulopathy etc.

For hospital inpatients Junior Doctors with full GMC licence to practise can sign but the decision must be fully discussed and agreed with the Responsible Senior Clinician who should then sign the next available opportunity.

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<tr>
<th>Responsible Senior Clinician’s Signature:</th>
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<td>Print full name:</td>
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<tr>
<th>Responsible Senior Clinician’s Signature: (Dr or Nurse)</th>
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The Responsible Senior Clinician is most senior clinician assuming clinical responsibility for the patient during that care period who has the appropriate capability and knowledge (e.g. GP, Consultant, Staff Grade doctor, Associate Specialist, Nurse, Out of Hours Clinician).

This original DNACPR Form should follow the patient (e.g. On admission to, discharge from or transfer between hospitals). Please note that if the DNACPR Form is to be at home with the patient this must be discussed with them and the relevant others to ensure they are aware of its positive role in ensuring the patient receives appropriate care at home.
Decision kept under review

Community Services and OoH Service informed

Where to take patient still area of uncertainty
Communication

• My experience – can be easy or very difficult
• I have to make judgement on the “right time” for discussion but sometimes time against us
• I always have discussion in context of discussing prognosis, illness trajectory, what we can do to manage symptoms etc – i.e. needs time
Why is it difficult?

Common Misunderstandings

• Not for CPR means not for anything – “being left to die”, “being written off”
• CPR nearly always successful in the media
• Successful CPR means no side effects

• But also...
• Death and Dying is difficult
• This policy does not make discussions or clinical decisions easier – that’s part of the job
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
To discuss or not to discuss

• Know patient and the context
• Be clear about the burden/benefit balance of CPR
• Consider the burden/benefit balance of the discussion
• Look for signs of willingness to engage in advance care planning discussions, checking for distress in discussing future
• For some patients, will never be the right thing and for others it is a relief
What do I say?

• “How much do you know about your illness?”
• “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?
• “As you look ahead, what worries you most?”
• “As you look to the future, what do you hope for”
What do I say?

• “Hope for the best, Prepare for the worst”
• Give a plan – managing pain and symptoms, what might be possible if there are complications (thinking of ceiling of care and wondering if patient will concur)
• “when the time comes, we will want to help you die peacefully... this also means that we would not try and restart your heart...
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
Advance Care Planning

Legal
- Welfare Power of Attorney
- Continuing Power of Attorney
- Guardianship

Personal
- Advance Statement
- My Thinking Ahead & Making Plans

Medical
- Lanarkshire Home Care Pack
- Potential Problems
- DNA CPR
  - SPAR
  - GSFS
  - Just in Case
    - Anticipatory Care Plan
      - preferred priorities of care
  - ePCS
  - Liverpool Care Pathway
  - DN Verification of Death
CHANGING NEEDS IN PALLIATIVE CARE
SUPPORTIVE AND PALLIATIVE ACTION REGISTER
Sources of Information

- Patients – booklet
- Professionals – children
Any questions?