Decisions relating to DNACPR

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Objectives

- What are the legalities?
- What choices do patients have?
- Guidance on what to do?
- What to say to patients and their relatives?
- What about capacity?
- The practicalities

NCEPOD Data

- 2012 – snapshot audit of 543 hospitals case notes from 526 attempts at CPR
- Advisors considered that 15% of 230 cases on which they could comment were appropriate attempts
- Only 22% (122) had resus status recorded in notes and 43% (52) of these had a DNAR order including 5 requests from patients not to be resuscitated but despite this an attempt was made in all 52 patients
- 7 patients were on an end of life care pathway and had an attempted and unsuccessful resus

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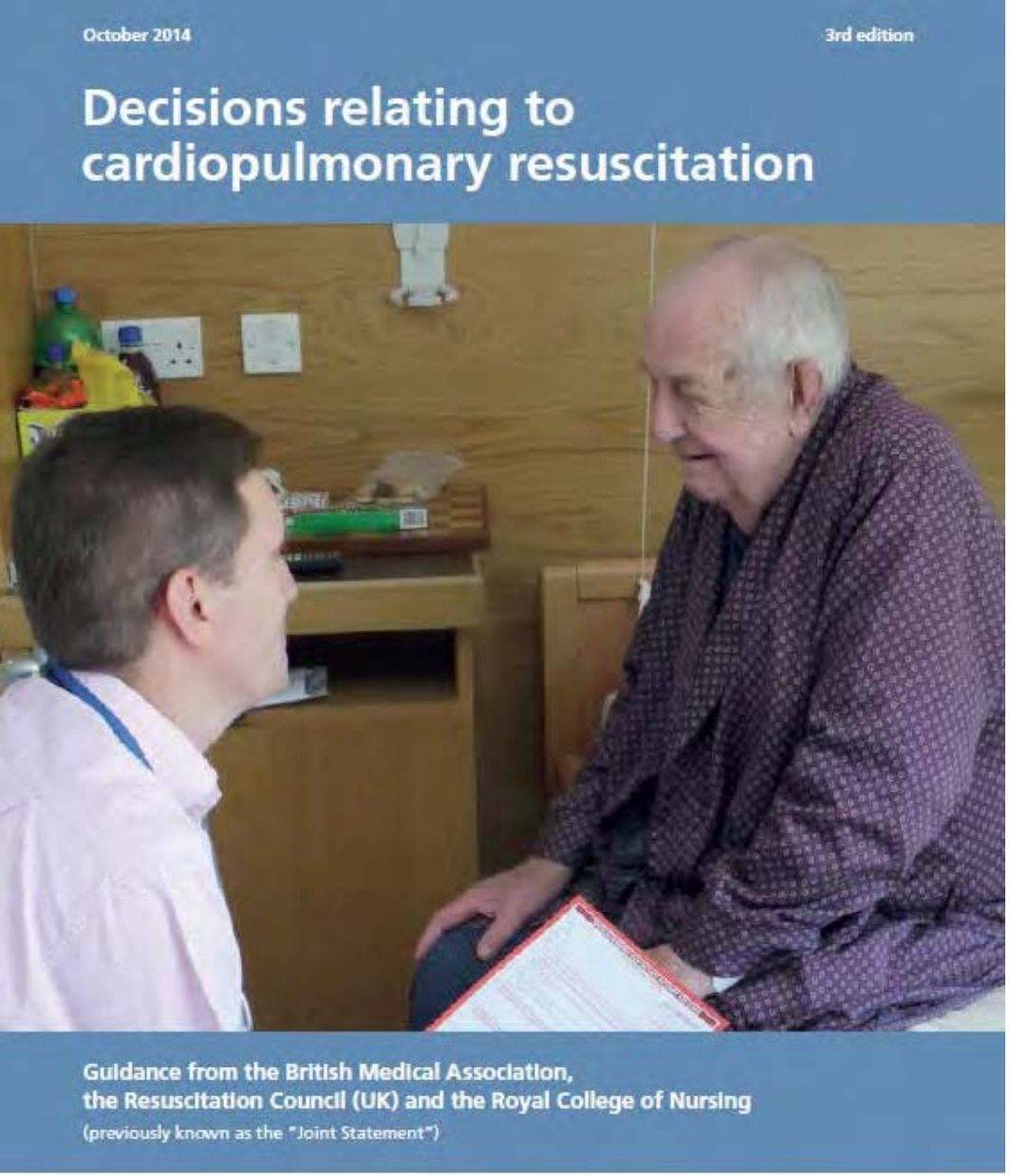
Following the Tracey case judgement

- A DNACPR decision engages article 8 of the Human Rights Act.
- Failure to make people aware of treatment options or decisions made about serious medical treatment breaches their human rights.

Result

- Knee-jerk reaction by some clinicians
- Avoiding making DNACPR decisions
- More people left in the ‘default’ position: receiving inappropriate CPR having had no chance to discuss.



- Latest situation

  New Guidance October 2014 from the BMA, RCN and Resuscitation Council

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Decisions relating to CPR 1

- If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.
- 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. However there is a presumption in favour of informing a patient of such a decision. The patient and those close to the patient have no right to insist on receipt of treatment that is clinically inappropriate.
- Healthcare professionals have no obligation to offer or deliver treatment that they believe to be inappropriate.

Decisions relating to CPR 2

- Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.
- Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

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Decisions relating to CPR 3

- When it is clear that someone is dying from an advanced, irreversible condition, clinicians must be sensitive to the patient's emotional and physical condition and to fluctuations therein. It is not uncommon for difficult discussions between healthcare professionals and patients to cause some unavoidable distress.
- However, trying to explain a DNACPR decision to some patients for whom CPR will offer no benefit will impose an unnecessary burden by causing such distress that the dying person suffers harm, which may be physical or psychological.
- In these circumstances it is permissible to not discuss a DNACPR decision

Decisions relating to CPR 4

- Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and, where appropriate, explained to the patient and those close to the patient at the earliest practicable opportunity.
- Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

What can patient's choose?

- Patients have the right to refuse CPR – we should advise them to complete an Advance Decision to Refuse Treatment – ADRT which is legally binding. Many versions available online
- Patient can appoint a Lasting Power of Attorney (LPA) for health and stipulate they can make decisions about life sustaining treatments. This person must then be consulted about resuscitation decisions and can refuse CPR on behalf of the patient. This is a legal document and has to be registered with the Office of the Public Guardian (OPG). This can take at least 10 weeks and costs £110. It is not legal until it is registered.

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What patient's can't choose

- No patient can insist on CPR and neither can their families
- DNACPR is a clinical decision

Communication

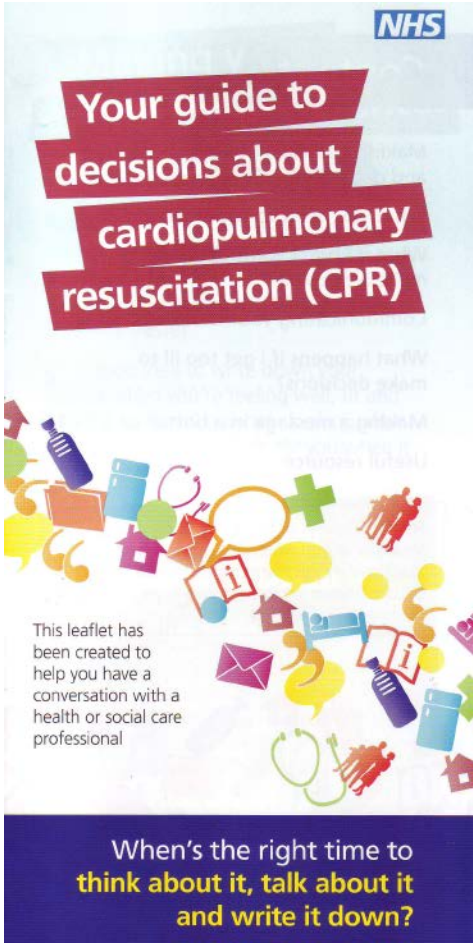
- Members of the public have no clear understanding of those situations in which CPR may be lifesaving and those in which it will not work and may do harm.

Communication

- Poor communication remains a cause of most complaints
- Need for training

- Provide information
- Provide explanation
- Check understanding

- Fully document all explanations and decisions



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Ideal situation
Advance Care Planning

Make shared decisions with patients:

- When they are well enough to understand
- Have time to reflect
- Have time to discuss
- Use non-medical language

At the same time discuss other aspects of care and treatment.

- DNACPR & Treatment Escalation Plan (TEP)

Discussions

- Don’t offer CPR as a treatment choice to a patient if you do not clinically think it is appropriate
- If not appropriate inform the patient of your reasons as to why you would not resuscitate
- Explain to patients about natural death and what occurs
- Patients often assume a heart attack and cardiac arrest are the same thing. Be clear that if their heart stops naturally you will not try to restart it
- Chances of survival
- ITU and intubation
- Quality of death and dignity

When to discuss

- If a patient tells me they know they are going to die and we discuss where they want to be at the end of life I don't then specifically discuss resuscitation with them unless they mention it
- If a patient tells me they want to be resuscitated I talk them through the reasons why I wouldn't resuscitate and make it clear it is a clinical decision
- If they refuse to have the form in their house I will say I cannot make them have the form in the house but make them aware of the consequences of the decision. Often the relative will ask you for the form at the door
- I will tell these patients if they are admitted to the hospice they will not be for resuscitation

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What if no DNACPR form is done?

- If no DNACPR form ambulance crew have to resuscitate
- Decision to not resuscitate and stop treatment can only be made in the hospital by clinical team
- Nursing home patients will be inappropriately resuscitated by ambulance crew and taken to hospital
- Patient may receive inappropriate treatment in the hospital
- Undignified death
- Distress for relatives and nursing home staff
- Staff will be questioned by managers
- Decision then has to be made by A&E team who don't know the patient and have little information

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What's important

- For many patients the discussions and forms should be completed well in advance of the dying phase so everyone knows what the plans are
- It is important to make the decision not to resuscitate and do the forms
- Recognising dying – allows us to make appropriate and individual decisions
- When is it possible to reverse a problem and rescue a deteriorating patient and when it is not
- CPR is a default setting from a lack of decision making rather than part of a considered management plan for the patient
- Understanding of the underlying medico-legal issues

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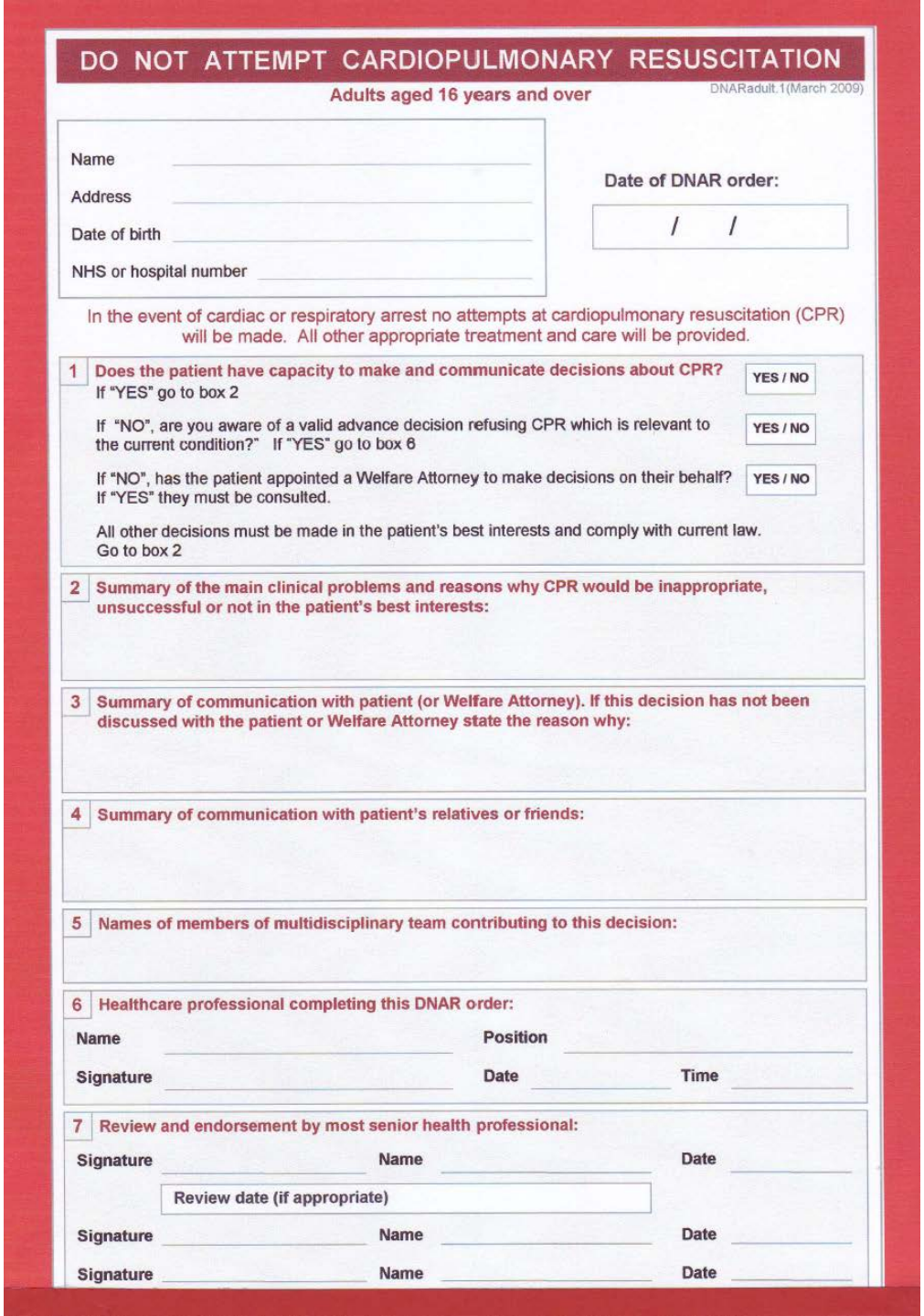
2009

National DNACPR Template



DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

DNARadult.1(March 2009)

Name

Address

Date of birth

NHS or hospital number

Date of DNAR order: / /

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? YES / NO
If "YES" go to box 2

If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If "YES" go to box 6 YES / NO

If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? YES / NO
If "YES" they must be consulted.

All other decisions must be made in the patient's best interests and comply with current law.
Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:

3 Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4 Summary of communication with patient's relatives or friends:

5 Names of members of multidisciplinary team contributing to this decision:

6 Healthcare professional completing this DNAR order:

Name Position

Signature Date Time

7 Review and endorsement by most senior health professional:

Signature Name Date

Review date (if appropriate)

Signature Name Date

Signature Name Date

Mental capacity

- All adults should be assumed to have capacity unless there is clear evidence to the contrary

- A person is regarded as legally unable to make a decision for themselves if they are unable to do any of the following:
- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making that decision
- Communicate their decision

What if the patient lacks capacity?

- You must find out if they have an ADRT refusing CPR or an LPA or CAD or guardian
- The Mental Capacity Act 2005 says all decisions should be made in the patients best interests if they lack capacity
- Sensitive and careful explanation is often needed to help people to understand that the intention is to spare the patient traumatic and undignified treatment that will be of no benefit, as they are dying, not to withhold life-saving treatment, and not to withhold any other care or treatment that they need.
- In the case of dementia patients don't base the decision on their lack of capacity base it on their physical condition
- Many of them will have other co-morbidities

If the patient lacks capacity?

- If the patient has not made an ADRT and has no attorney then the treatment decision rests with the most senior clinician
- If CPR may work then the decision must be made in the patients best interests and the family must be involved in discussions whether it is appropriate to do CPR
- Ensure families understand they are there to help inform the decision-making process rather than being the decision makers
- If the senior clinician does not believe CPR would be successful then families should be informed of this decision

If the patient lacks capacity?

- If they have an ADRT this is legally binding
- If they have an attorney or guardian this person must be consulted
- They can refuse CPR for the patient if this decision is within their remit
- If the senior clinician does not believe CPR would be successful they should inform the attorney or guardian and explain their reasons
- Attorneys or guardians cannot insist on CPR
- If CPR may be successful then a best interests decision is made taking into account the views of the attorney or guardian
- If there is disagreement between attorneys or guardians and the healthcare team and this cannot be resolved with discussion or a second opinion then the Court of Protection may be asked to make a declaration

Who can sign DNACPR forms?

- Individual organisations have their own policies
- Ideally the form is supposed to follow the patient through all care settings
- However, some nursing home groups will only accept a GP signing the form as they have their own new end of life care policies. They may insist a new form is completed even if the patient comes from a hospital with one
- In hospital a consultant should validate the form if a junior doctor has signed it
- In the community some nurses have completed training to have the discussions with patients and families and to sign the forms. It is good practice for the GP to validate the form. Some paramedics have not accepted a form signed only by a nurse
- A CPR decision form in itself is not legally binding.

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Reviewing DNACPR forms

- Nursing homes insist the form is reviewed, signed and dated by the GP every 12 months
- CQC inspectors flag up if the form has not been reviewed in nursing homes

The terminology

- Initially DNAR
- Changed to DNACPR because of the misconception about DNAR as resuscitation is not only about CPR
- However, DNACPR has a negation, namely a negation to provide CPR
- All terminology implies that something is not going to be done and can lead to the misconception that we are witholding treatment
- This can result in reluctance from the patient and family to accept the outcome
- Suggestion that we should use a different term
  ALLOW NATURAL DEATH
- Implies all measures will be taken for comfort, continuation of treatment but at the point of death no intervention will be made

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Elderly patients condemned to early death by secret use of do not resuscitate orders

Elderly patients are being condemned to an early death by hospitals making secret use of "do not resuscitate" orders, an investigation has found.

A charity for the elderly said the disclosures were evidence of 'euthanasia by the backdoor,' with potentially-lethal notices being placed on the files of patients simply because they were old and frail Photo: Alamy

By Laura Donnelly, and Alastair Jamieson
7:04PM BST 15 Oct 2011

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The orders – which record an advance decision that a patient's life should not be saved if their heart stops – are routinely being applied without the knowledge of the patient or their relatives.

On one ward, one third of DNR orders were issued without consultation

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WIFE'S FURY AT DEATH ORDER

Family handed form telling doctors not to revive husband

AN INVESTIGATION has been launched after doctors issued a "do not resuscitate" order on a terminally ill man without telling tell him or his wife.

Margaret Wilson, 72, said she was horrified to find the form telling medics treating her husband John, 79, to let him die in the event of his heart stopping. NHS Lothian chiefs have apologised to the Wilsons and have launched an inquiry.

Full story – Page 5

WIFE'S FURY AT ORDER TO ENSURE NATURAL, PEACEFUL AND DIGNIFIED DEATH AT HOME.....

.....doesn't have quite the same headline impact!!!

Goals we should aim for

- Ensure all patients who are approaching the end of life have a DNACPR form completed where this is possible
- Prevent inappropriate resuscitation attempts and hospital admissions
- Ensure dignity at the end of life

Consultant mobile numbers

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Any questions?

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for families facing terminal illness