Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR): Too Far?
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Background

- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions can be an ethical and legal challenge.
- A greater emphasis has been placed on ensuring high-quality timely communication, decision-making and recording.
- National guidance requires clear documentation of DNACPR decisions, which are available in emergencies and for legal purposes.
- Since The Janet Tracy case, the focus has been on the importance of effective communication with patients and families, with accurate documentation.
- Several serious untoward incidents (SUIs) are under investigation at our Trust related to inappropriate attempted resuscitation of patients with full electronic documentation of DNACPR status; prompting further evaluation of the current practice.

Aims

1. Evaluate and improve the documentation of DNACPR decisions and the level of compliance with the Trust Policy
2. Evaluate and improve the standard of communication of decisions with patients/families and the multi-disciplinary team
3. Evaluate and improve the communication with primary care on discharge

Policy

- An electronic toolbar indicative of a DNACPR status within an electronic patient record were introduced in 2015.
- All acute admissions should have CPR status recorded and represented in the toolbar.
- Responsible consultant should be leading DNACPR decisions.
- Decisions should be re-evaluated on each admission and re-discussed with patients/families.
- On discharge, decisions should be communicated with relevant primary care individuals.
- There is an information leaflet for patients/families to aid communication.

Results

Table: Summary of DNACPR data before and after implemented changes

<table>
<thead>
<tr>
<th>Cycle 1 (DNACPR decision n=133)</th>
<th>Cycle 2 (DNACPR decision n=126)</th>
<th>P Value</th>
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</thead>
<tbody>
<tr>
<td>Resuscitation status in toolbar</td>
<td>133 (100%)</td>
<td>126 (100%)</td>
</tr>
<tr>
<td>Electronic DNACPR form completed</td>
<td>115 (85%)</td>
<td>126 (100%)</td>
</tr>
<tr>
<td>Discussion with senior doctor</td>
<td>115 (88%)</td>
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<tr>
<td>Discussion with patient/relatives</td>
<td>91 (68%)</td>
<td>89 (71%)</td>
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<tr>
<td>Communication with MDT</td>
<td>17 (13%)</td>
<td>52 (42%)</td>
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<tr>
<td>Decision made within normal working hours</td>
<td>78 (59%)</td>
<td>84 (67%)</td>
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<tr>
<td>DNACPR communicated to GP on discharge</td>
<td>27 (79%)</td>
<td>71 (90%)</td>
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Total number of patients in cycle 1 = 181, for resuscitation n=38 (27%), DNACPR n=133 (73%)
Total number of patients in cycle 2 = 175, for resuscitation n=35 (20%), DNACPR n=126 (72%)

Figure 1: No. of completed electronic DNACPR forms

Figure 2: No. of completed electronic DNACPR forms

Figure 3: No. of decisions communicated to the MDT

A very significant increase in the number of patients where the decision was communicated to the MDT.

Figure 4: Summary of discharge data

- 96% of doctors would use the electronic toolbar banner as quick reference to establish a resuscitation status in an emergency.
- However, 27% of these would also want a documented form and 15% would look through the clinical notes.
- 55% would use the discharge letter to communicate decisions to the GP, 24% would send a copy of the form and 18% would call the GP.
- Staff Quotes
  - “If any doubt that no form was complete by a senior, I would resuscitate.”
  - “I would look into clinical notes and look for any decision to define if it resuscitate.”

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Method

- Study period:
  - First cycle: January – February 2018
  - Implementation: February – June 2018
  - Second cycle: June 2018
- Data:
  - Innovative audit tool designed using Microsoft Excel
  - Obtained from electronic patient records.
  - Prospicive data collection over a week and four week study period.
  - Retrospective analysis of discharge data at week five.
- A staff survey was designed to evaluate current practice and identify any additional concerns around the subject of DNACPR decisions.
- Data analysis using Prism software.
- Inclusion:
  - All inpatients on three gerontology wards at King’s College Hospital that had a DNACPR decision.
- Exclusion:
  - Those patients who were FOR resuscitation.

Actions Implemented

Our actions implemented below have quickly instigated change, with an improvement in performance across all areas.

- Explanatory forms are now compulsory.
- New section stating which member of the nursing team has been informed of the decision.
- New focus group within Gerontology to incite cultural change of understanding and communication.
- We have distributed the patient information leaflets.
- We have presented our work locally within Gerontology and Trust-Wide at the Grand Round, at the local patient safety conference and at the end of life steering group to educate and promote discussion and to create a series of actions points.
- All DNACPR decisions and discussions will now be reviewed on admission to Gerontology.
- We are working with the Trust – Wide initiative ‘King’s Way for Wards’ to standardise decisions and handovers.

Key Outcomes

- Re-evaluation of electronic systems is a vital part of clinical governance.
- The electronic tool bar is an excellent prompt to make resuscitation and escalation decisions.
- DNACPR orders can no longer be made electronically on the e-toolbar without an explanatory legal form.
- DNACPR orders can no longer be made without documenting an informed member of the nursing team or senior doctor.
- The use of the Comprehensive Geriatric Assessment prompts communication to the GP on discharge.

References

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