CRASH TEAM & DNACPR INDUCTION

Anthony Freestone
Head of Resuscitation
Teams

• 2222 Adult Cardiac Arrest
• 2222 Adult Medical Emergency
• 2222 Paediatric Cardiac Arrest
• 2222 Major Haemorrhage Team
• 2222 Fast bleep, Trauma team, Mobile team
• 2222 Neonatal emergency
• 2222 Antenatal emergency/cardiac arrest
• 2222 Postnatal emergency/cardiac arrest
• 4444 Major Incident
• (9)999 Paramedics
Cardiac Arrest/Medical Emergency

- ST 3+ in Medicine (core)
- F2 (core)
- F1 (core)
- Duty Resuscitation Officer (core)
- Acute Response Team (core)
- Critical Care Outreach (optional)
- Nurse In Charge of Hospital

- ALS
- ALS
- ALS
- ALS/Airway & Intravascular (EZ-IO)
- ALS/Airway & Intravascular (EZ-IO)
- ALS
- BLS/AED – To support ward area

- Resident ICU Anaesthetist

2222 (2nd Responder)

MEDICAL EMERGENCY BREIFING - DAILY @ APPROX 09.15 ON AMU FOR THE TEAM
DNACPR

AUGUST 2016
Background

- 3262 ‘2222’ calls in Trust during Apr 15 – Mar 16
- 283 cardiac arrests
- 78% non-shockable (56% PEA arrest, 22% Asystole)
- Survival rates to discharge 23.9% with full neurology (15% nationally)
- 11 cases obvious missed opportunity for DNACPR (many more less obvious cases)
- 2015 DNACPR audit for 2015 showed 14% forms compliant (7/50)
DNACPR & The Law

• Do we have to make decisions for all patients?

• Who’s decision is it?

• What is the legal position regarding DNACPR decisions?
DNACPR is a Medical Decision

- Consultant/GP in charge of the patient’s care
- Patients have the right to refuse treatments but cannot demand them
- Doctors cannot be forced to perform what they believe to be inappropriate procedures
- As doctors we have a **LEGAL DUTY** to involve patients and relatives in decision-making unless, it is likely to cause **physical/psychological harm**
- Patients have a right to a **second opinion**
The court found that doctors have an obligation to discuss DNACPR decisions with patients unless to do so would cause *actual* physical or psychological harm.

Failure to do so would be a breach of Article 8 of the **European Convention of Human Rights**.

- Requires respect for private and family life.
- Could lead to professional misconduct proceedings and potential litigation for Trusts who have acted unlawfully...
Joint Statement

“When CPR has no realistic chance of success, it is important to make decisions when they are needed, and not to delay a decision because a person is not well enough to have it explained to them or because their family or other representatives are not available; nevertheless, a clear plan should be made to explain and discuss the decision with the person and/or their representatives at the earliest practicable opportunity”

BMA, Resuscitation Council UK, RCN Oct 2014
• What if a patient does not have capacity?

• What might we want to ask about?
• In England and Wales ADRT are covered by the MCA 2005.
• An ADRT refusing CPR will be valid and therefore, legally binding if:
  – The person was **18 years old** or over and had capacity when the decision was made
  – The ADRT is in **writing, signed and witnessed**
  – It includes a statement that the advance decision is to apply, even if the person’s ‘**life is at risk**’
  – The ADRT has **not** been withdrawn previously
  – The person has **not** since the ADRT was initially made - **appointed a LPA**
  – The person has not done anything clearly **inconsistent** with its terms
  – The circumstances match those in the written, witnessed **ADRT**

• If it does **not** meet the above criteria - it should still be taken into consideration as part of a best interests decision...
The Form

2 out of 3 forms are non-compliant

- Complete **ALL** sections of the form
- Only consider appropriate terminology
- **Must be endorsed by Consultant within 48 hours**
- Review **48 hours** prior to discharge & sign back of form
- **ALWAYS make sure the TOP original copy goes with the patient/or care setting have it**
- Inform relevant people: NWAS, OOH, and the GP - who will have to review within 7 days
**DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNA CPR)**

**SECTION 1**

**Blackpool Teaching Hospitals**

**Date and time of DNA CPR order**

**Consultant/VGP**

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

### Reason for DNA CPR order

- The patient's condition indicates that CPR would not be successful because:
- CPR is not in accordance with the wishes of a patient who is mentally competent and has capacity.
- CPR is not in accordance with a valid and applicable advance decision to refuse treatment.
- Successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain because:
- CPR is not in accordance with the wishes of a person properly authorised to make decisions regarding life-sustaining treatment on behalf of the patient under the Mental Capacity Act.
- The patient has been commenced on an individual plan of care for the dying person.

### Summary of discussions:

- Has the patient been consulted/informed? **YES**
- Has the patient agreed for the patient's relatives or friends to be consulted/informed? **NO**
- Has the patient's partner, relatives or friends been consulted/informed? **YES**
- Has a HAP (Health and Welfare) been consulted/informed? **NO**
- Relevant others involved in discussions:

### If no discussions have taken place with the patient or relevant others, state why not:

**SECTION 2**

**SECTION 3**

**Doctor making the DNA CPR order:**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print name</th>
<th>GMC Number</th>
</tr>
</thead>
</table>

**Position**

<table>
<thead>
<tr>
<th>Bleep no (hospital)</th>
<th>Contact no (community)</th>
</tr>
</thead>
</table>

**Date**

| Time | |
|------||

**SECTION 4**

**FOR HOSPITAL/HOME DNA CPR ORDERS**

Endorsement by the Consultant within 48 hours:

**SECTION 5**

**Prior to hospital/hospital discharge or community DNA CPR orders inform RNAs/PA**

<table>
<thead>
<tr>
<th>E-mail</th>
<th>p4043045</th>
</tr>
</thead>
</table>

**SECTION 6**

**Ambulance crew instructions**

Confirm that DNA CPR order has been reviewed and remains valid (see patient's notes).

If, while in transit, the patient suddenly deteriorates - continue journey to destination - take appropriate action as per instructions on order.

**Top copy**

To keep with documents in patient's care setting. Due to abnormal physiological parameters transferred and file in notes at patients destination.

**Middle copy**

File in patient's notes (hospital/hospital admission/discharge/primary care (community)).

**Bottom copy**

Keep with patient's notes (hospital/hospital).
Appendix 1: 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

Does the patient lack capacity **AND** have an advance decision specifically refusing CPR **OR** have an appointed personal welfare attorney?

- Yes
- No

Does the patient lack capacity?

- Yes
- No

Is the patient willing to discuss his/her wishes regarding CPR?

- Yes
- No

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

- It is not necessary to discuss CPR with the patient unless they express a wish to discuss it.

- If a DNA-CPR 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.

- Where the patient lacks capacity and has a personal welfare attorney, 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.

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

- Discussion with those close to the patient must be used to guide a decision in the patient’s best interests.

- Respect and document their wishes. Discussion with those close to the patient may be used to guide a decision in the patient’s best interests, unless confidentiality restrictions prevent this.

- If cardiopulmonary arrest occurs in the absence of a recorded decision there should be an initial presumption in favour of attempting CPR.

- Anticipatory decisions about CPR are an important part of high-quality health care for people at risk of death or cardiopulmonary arrest.

- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team with appropriate competence.

- Decisions about CPR require sensitive and effective communication with patients and those close to patients.

- Decisions about CPR must be documented fully and carefully.

- Decisions should be reviewed with appropriate frequency and when circumstances change.

- Advice should be sought if there is uncertainty.
Clinicians must.....

- **Discuss** Resuscitation issues with patients before making a decision where possible regarding DNACPR
- **Inform** the patient of the final decision and consider offering a second opinion
- **Involve** or **inform family members** if the patient consents
  - If the patient **lacks capacity** consult a family member or other people concerned with the patient’s welfare, if there is nobody - consider IMCA
- **Record** discussions and decisions in the clinical record
- **Fully complete** a DNACPR form (V5)
- **Be aware** of the Trust’s policy (CORP/PROC/003)