The Ethics of DNACPR

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DNACPR

- Current use In Hospitals

- Majority initiated by clinicians
- 82% of those who die in hospital die with one in place
- 50% of patients with DNACPR in hospital are discharged home.
- In the front of notes, often red – problems exist with current approach

Aune S, Herlitz J, Bang A. Characteristics of patients who die in hospital with no attempt at resuscitation. Resuscitation. 2005;65(3):291-9.

Fritz ZB et al. Characteristics and outcome of patients with DNACPR orders in an acute hospital; an observational study. Resuscitation 85 (2014) 104–108

Q1: How often do you go to assess a patient (excluding post arrest patients) who has been referred to ICU and think they should have a DNACPR order?

A. Once a shift
B. Once a week on the unit
C. Once a year
D. Once in a blue moon
E. Never

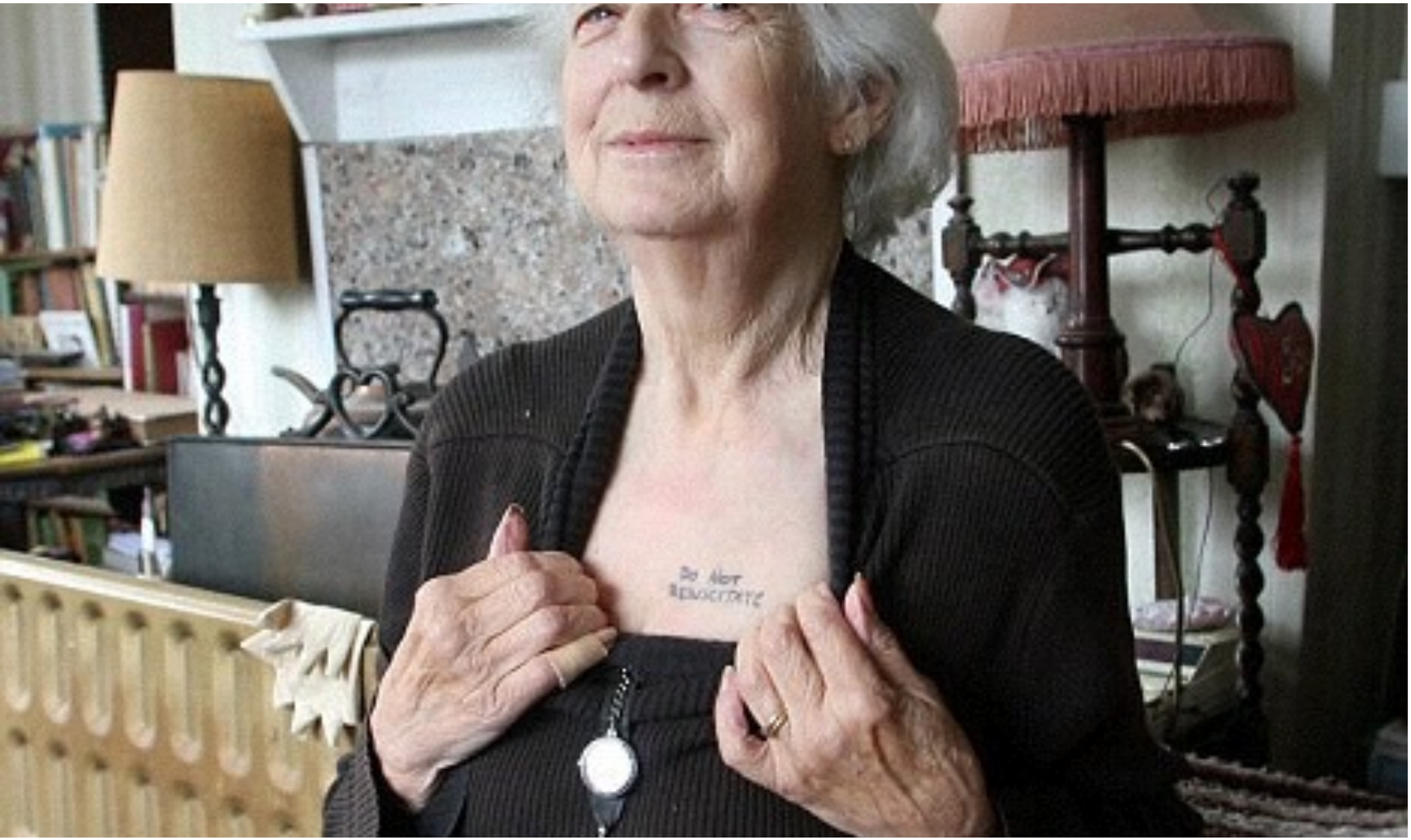
Issue 1 : Not routinely completed

- Qualitative study Cohn et al Q J Med 2013; 106:165–177
  - Completed on an ad hoc basis
- NCEPOD report (UK) 2011
  - 7/573 patients who underwent CPR were on an end of life care pathway
  - 430/522 (78%) of patients had no resuscitation status decision documented

Ethical implication:

- 'Lottery' of whether resuscitation decision gets considered

- ….How to ensure you don't get it if you don't want it?




P.T.O
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Q2: How often have you gone to a patient who has survived attempted CPR, and not admitted them to ICU because you don't think they would benefit.

A. Once a shift
B. Once a week on the unit
C. Once a year
D. Once in a blue moon
E. Never

Issue 2 : Inappropriate resuscitation attempts

- NCEPOD: 118/202 patients who had survived resuscitation were not admitted to ICU
- If no DNACPR has been discussed before then there is an expectation that invasive treatments will be attempted

Table 7.17 Reason patient was not admitted to critical care

Reason	n	%
No need for admission, patient would recover with lower level care	32	28.3
No need for admission, patient expected to die	66	58.4
No critical care beds, patient would have been admitted but no facility	2	1.8
Other	13	11.5
Subtotal	**113**	
Not answered	5	
Total	**118**	

Ethical implication:

- Receiving unwanted treatments at the end of life
- Perceived ‘undignified’ death
- Resources being used to no (or negative) effect

Q3: How often do you wish a nice, calm conversation had been had with a patient and their family in advance about what they would and wouldn't want in the event of their deterioration, and it was all beautifully documented?

A. Once a shift
B. Once a week on the unit
C. Once a year
D. Once in a blue moon
E. Never

Issue 3: No one likes discussing this

- Patients rarely initiate discussions, doctors don't like to have discussions
- In the UK
  - 2012 50% discussed with patients or relatives in the UK (Fritz et al
- 'Tracey' judgment in the UK made in illegal not to discuss a decision to withhold CPR – to not do so deemed to be in breach of article 8 of the Human Rights act

Ethical implications..

- Patients having DNACPR 'without knowledge' and the issues associated with this – autonomy, right to private life, etc
- Some patients anxious about being resuscitated; not talking with them about DNACPR may cause as much more distress (in preparation, A Malyon)

- Unrealistic expectations about possible benefits of treatments

Why does no one like discussing it?

- Difficult for patients to know what treatments they might want – how can anyone have informed consent for the ICU?
  - Asking patients about what outcomes they would tolerate might be better
    - Rosenfeld KE, Wenger NS, Kagawa-Singer M. End-of-life decision making: a qualitative study of elderly individuals. J Gen Intern Med. 2000;15(9):620-5.)
- Fears it will change the the relationship: difficult to talk about a treatment to be withheld rather than a treatment to be given
    - Cohn S, Fritz ZB, Frankau JM, Laroche CM, Fuld JP. Do Not Attempt Cardiopulmonary Resuscitation orders in acute medical settings: a qualitative study. QJM. 2013;106(2):165-77.
- Fears that it means something else

Issue 4: Misunderstood

- Less frequently referred to outreach or receive out of hours care

  Interpretation and intent: A study of the (mis)understanding of DNAR orders in a teaching hospital Z Fritz et al Resuscitation 2010 81;9: 1138-1141

- Reduction in the urgency attached to reviewing a deteriorating patient.

  The over-interpretation of DNAR Stewart, M. et al Clin Gov 2011 16;2:119-128

Issue 5: Difference in care

- Chen – reduction in treatment for heart failure

  Chen JL, et al (2008) Impact of do-not resuscitate orders on quality of care performance measures in patients hospitalized with acute heart failure. Am Heart J 156: 78–84.

- Cohen – best predictor of not being admitted to ICU

  Cohen RI, et al(2009) The impact of donot-resuscitate order on triage decisions to a medical intensive care unit. J Crit Care 24: 311–5.

- Brizzi – DNR order an independent predictor of one month mortality

- Brizzi M, et al(2012) Early do-not-resuscitate orders in intracerebral haemmorhage; frequency and predictive value for death and functional outcome. A retrospective cohort study. Scandinavian J of trauma, Resusciation and Emergency Medicine 2012, 20;36

- Kazaure – increased mortality in surgical patients

  Kazaure H, et al (2011) High mortality in surgical patients with do-not-resuscitate orders: analysis of 8256 patients. Arch Surg 146: 922–8.

- Beach and Henneman and Moffat– scenario experiments

  Henneman EA et al(1994) Effect of do not-resuscitate orders on the nursing care of critically ill patients. Am J Crit Care 3: 467–72.

  Beach MC et al (2002) The effect of do-not-resuscitate orders on physician decision- making. J Am Geriatr Soc 50: 2057–61.

  Moffat S, Skinner J, Fritz Z. Does resuscitation status affect decision making in a deteriorating patient? Results from a randomised vignette study. J Eval Clin Pract. 2016.

Ethical Implication…

- Discrimination, lack of equity

..and feeds into all of the above:

- Reluctance to write them
- Reluctance to talk about them
- How much information you give a patient

We tried to address the ethical problems we saw in current DNACPR practice in hospitals.

Aims of an alternative approach

- Remove the *ad hoc* nature of consideration
- Improve discussions
- Improve care for those in whom a decision not to resuscitate had been made
    - Remove ‘resus’ labeling
    - Shift dichotomy to goals of care
    - Encourage forward thinking
    - Provide instruction if a patient deteriorates
- Maintain clarity about resuscitation

Universal Form of Treatment Options (UFTO) development

- Designed iteratively using adapted delphi method
  - Focus groups, interviews, questionnaires, feedback, usability, pilots
- with
  - Patients
  - Nurses
  - Doctors
  - Resuscitation officers
  - Behavioural economist

Universal Form of Treatment Options

Addressograph

Relevant information about patient's situation, and reasons for chosen treatment plan:

Details of discussion (and/or reasons for not having one, if none has taken place) overleaf

This patient is for the following treatment plan: *(please sign one of the below boxes, complete the resuscitation box, and sign and date)*

ACTIVE TREATMENT

e.g. investigations, surgical and medical interventions and treatments, referral to on-call doctors or outreach in event of deterioration

Signature.....
Date.....

OPTIMAL SUPPORTIVE CARE

e.g. analgesia and other comfort measures. This includes minimally invasive treatments (such as paracentesis) to improve symptom control/quality of life. **The patient's comfort should be the priority in determining care.** Please document future care planning on reverse.

Signature.....Date.....

Active Treatment usually includes:
Organ Support or High Dependency Unit if needed and appropriate
(NIV, dialysis, inotropes, venous monitoring, cardioversion, etc.)

If you wish to provide guidance on specific interventions please do so below:

This patient is **FOR attempted CARDIOPULMONARY RESUSCITATION** in the event of a cardiac arrest	This patient is **NOT FOR attempted CARDIOPULMONARY RESUSCITATION** in the event of a cardiac arrest
Signature.....	Signature.....

Name	Signature	Date and Time	Designation
			ST3 or above (consultant to countersign within 72 hours)
			Consultant
			Nurse Informed
Please complete DETAILS OF DISCUSSIONS, and, when appropriate, FUTURE CARE PLANNING on reverse			

Assessment of UFTO

- Before and after study
- Contemporaneous case controls
- One hospital, Non-randomised, but outcomes were blinded…

- Fritz Z, et al. (2013) The Universal Form of Treatment Options (UFTO) as an Alternative to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Orders: A Mixed Methods Evaluation of the Effects on Clinical Practice and Patient Care. PLoS ONE 8(9): e70977. doi:10.1371/journal.pone.0070977

  http://www.plosone.org/article/info:doi/10.1371/journal.pone.0070977

Global Trigger Tool Analysis on those patients in whom a decision not to attempt resuscitation was made

	DNAR period (May-July 2010) n = 103	UFTO period (Nov 2010-Jan '11) n = 118	Between group difference (95% CI)	P-value§
Harm rate per 100 admissions	68.9	37.3	31.6 (12.2 to 51.1)	0.001
Harm rate per 1000 patient days	34.7	21.8	12.9 (2.6 - 23.2)	0.01
Harms contributing to patient death (categories H and I)	23/71 (32%)	4/44 (9.1%)	23.3% (7.8% to 36.1%)	0.006
Harms preventable on any level (categories 2-4)	66/71 (93%)	43/44 (98%)	-4.8% (-13.4% to 5.6%)	0.40

§P-value calculated using Fisher's Exact test for categorical variables, and a z-test for rates

Summary of UFTO changes

- Change in culture
- Change in reasoning and nature of discussions
- Earlier recognition of palliative care needs
- Reduction in objective harms occurring to those who were not for attempted resuscitation

Other national and international work

- Treatment Escalation Plan in Devon – M. Mercer et al
- 'Deciding Right' in the North East – C. Regnard et al
- 'Physician Orders for Life Sustaining treatment' (POLST) in the US
- Review of current practice and problems – systematic review and other work - G. Perkins et al

Recommended **S**ummary **P**lan for **E**mergency **C**are and **T**reatment (**ReSPECT**)

- Stakeholders from all clinical specialties, and patient and public groups
- Iterative process
- Using available evidence nationally and internationally
- Usability testing in different settings
- Public Consultation
- Piloted in 6 sites…

Even more ambitious…

- Cross care settings
- Involve patients (very) early
- Facilitate conversations and decisions which respect both patient preferences clinical judgment.

ReSPECT

Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below

clinician signature

Focus on symptom control as per guidance below

clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child

clinician signature

For modified CPR **Child only, as detailed above**

clinician signature

CPR attempts **NOT** recommended Adult or child

clinician signature

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend			
GP			
Lead Consultant			
Other			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

Main aspirations

- Help patients get the right treatment at the right time:
  - Active treatments for those who would benefit from them
  - No invasive treatments for those who don't want them
- Understand what outcomes patients would be happy with rather than offering them a menu of treatments choices
- Start conversations with patients early
- Have conversations with more people
- Facilitate good clinical decision-making and communication

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ReSPECT

Recommended Summary Plan for Emergency Care and Treatment

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

The plan is created through conversations between a person and their health professionals. The plan is recorded on a form and includes their personal priorities for care and agreed clinical recommendations about care and treatment that could help to achieve the outcome that they would want, that would not help, or that they would not want.

ReSPECT can be for anyone, but will have increasing relevance for people who have complex health needs, people who are likely to be nearing the end of their lives, and people who are at risk of sudden deterioration or cardiac arrest. Some people will want to record their care and treatment preferences for other reasons.

Please note:
People should not expect to use the ReSPECT process until it has been established in their locality.

Introducing ReSPECT
ReSPECT has been introduced in some localities as part of a formal research evaluation taking place over 3 years. Alongside this it is now moving into the next phase in which health and care communities wishing to adopt ReSPECT can be offered access to the materials that they will need to start planning implementation. Interested organisations should join the Implementation Network.

www.respectprocess.org.uk

In summary…

- Do Not Attempt Resuscitation Decisions associated with problems in initiating, discussing and documenting decisions, and can have unintended effects

- Understanding which outcomes are tolerable to patients rather than asking which treatments are desired might facilitate discussions and decision-making

ReSPECT Summary

- ReSPECT has been designed to address issues with the current approach to resuscitation decisions
- The ReSPECT process encourages early conversations with individuals to understand what their priorities are and what is important to them
- It is not just intended for those approaching the end of life, and is not just for those who would not benefit from or desire attempted resuscitation
- It has been developed iteratively from stakeholders throughout the country, and is builds on national and international evaluations of alternative approaches to resuscitation decisions.

Thank you…

Patients and staff

NIHR, Wellcome trust

Colleagues in Cambridge and Warwick, the Resuscitation Council, and all of those working on ReSPECT

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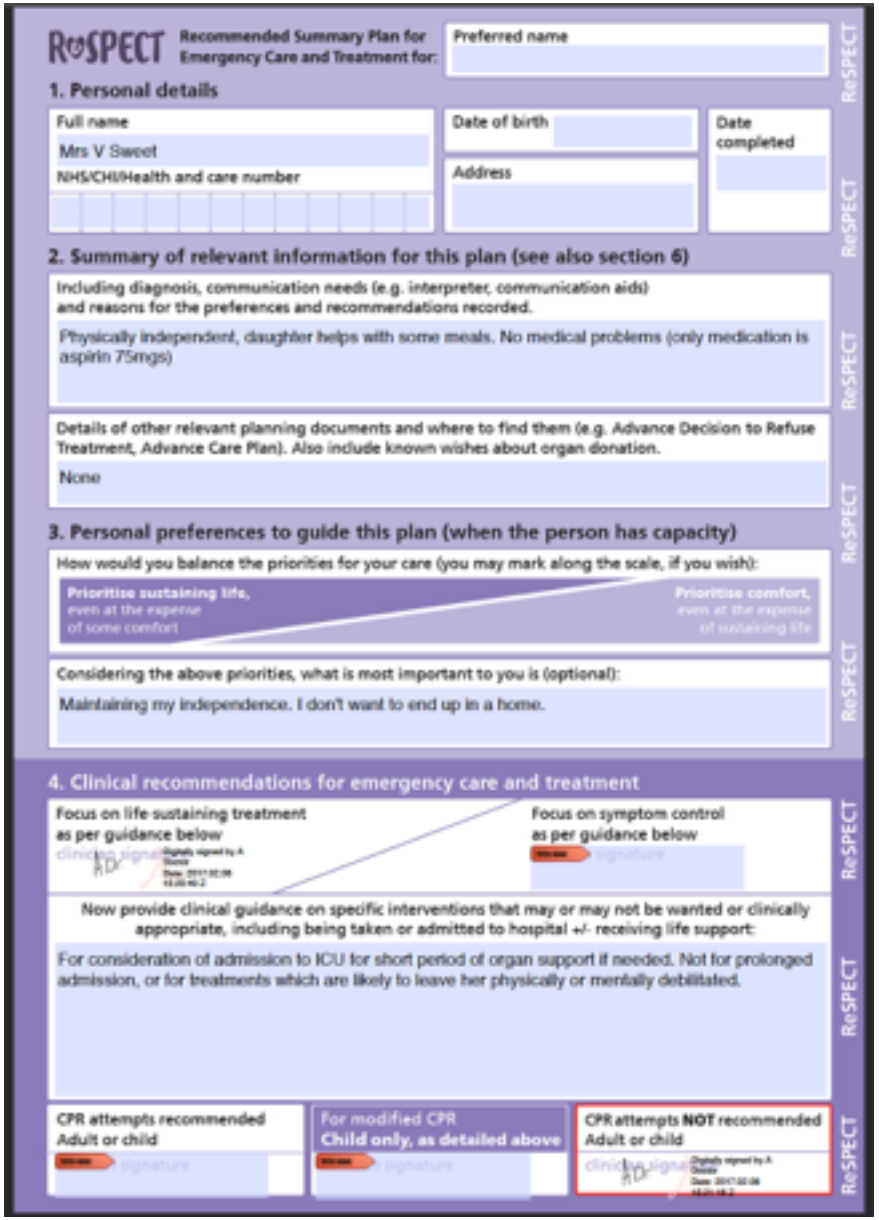
Case study 1

- 92 year old lady
- Physically independent and mentally well.
- Develops a pneumonia and is brought into hospital.
- A ReSPECT form is discussed with her.
- Clear that, while she would like to continue living for as long as possible, she would only want to do so if she can retain her independence. She does not want to end up ‘ in a home’ or unable to do things for herself.
- She explicitly says “ I do not want a lingering death, if my time comes, it’s come”.
- The doctor explains that they are not expecting her to die because of the pneumonia, that they will treat her with antibiotics, but that she may deteriorate before she gets better. He advises that in this situation it may be necessary to move her to ICU to ‘put her on a machine to help her lungs for a bit’ but, if it became apparent that she was not responding, or would end up in a very dependent state, that they would stop these invasive treatments. She agrees to this, but emphasises that she ‘certainly wouldn’t want her heart restarted’ .



ReSPECT

Recommended Summary Plan for Emergency Care and Treatment for:

Preferred name

1. Personal details

Full name

Mrs V Sweet

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Physically independent, daughter helps with some meals. No medical problems (only medication is aspirin 75mgs)

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

None

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

Maintaining my independence. I don't want to end up in a home.

4. Clinical recommendations for emergency care and treatment

Focus on life sustaining treatment as per guidance below

clinician signature

Focus on symptom control as per guidance below

signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

For consideration of admission to ICU for short period of organ support if needed. Not for prolonged admission, or for treatments which are likely to leave her physically or mentally debilitated.

CPR attempts recommended Adult or child

signature

For modified CPR **Child only, as detailed above**

signature

CPR attempts **NOT** recommended Adult or child

clinician signature

Case study 2

- 67 year old woman
- COPD with home oxygen and nebulsiers – ETT 20 years
- 3-4 hospital admissions with exacerbations a year; several admissions to ICU, each requiring long weans.
- After most recent admission, stated she did not want to have another admission to ICU, and was not even sure whether she wanted to go back to hospital again.
- The GP enquires what she means by this: would she want to go back if intravenous antibiotics were needed again, to try to stop her dying from an infection?
- Yes, she agrees – she would be happy with care on the ward, and even non invasive ventilation, but if she was struggling, she does not want to be intubated. She knows her family will disagree with this decision, and says she is too scared too talk with them about it. A ReSPECT form is completed, and she is encouraged to also write an ADRT.

Case study 1 – ideal outcome would be:

- In the event, she does not need admission to ICU
- Discharged home after 5 days.
- On discharge, the conversations surrounding ReSPECT are revisited, and she has not changed her mind about her views; they are therefore communicated to her GP and she is offered the ReSPECT form to keep at home with her. .

ReSPECT **Recommended Summary Plan for Emergency Care and Treatment for:**

Preferred name
Jane

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth asdsada

Address

Date completed
asdasda

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

COPD, reduced ETT, multiple admissions with COPD, requireing long wean on ventilator when admitted to ICU.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

She is considering wrtiting and ADRT - please check with GP whether this has also been completed

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

Being able to breath; i do not want my breathing to deteriorate any further, and I do not want to go back on a ventilator

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

For admission to hospital but for ward based care only - consider NIV but NOT invasive ventilation

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

ReSPECT