# Making CPR Decisions

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# Learning Objectives

1. To understand the principles behind making DNACPR decisions
2. To know about local and national guidance on making DNACPR and ceiling of treatment decisions
3. To be aware of the ways in which these decisions are communicated between settings

# Principles of Clinical decision making

New GMC Guidance came into effect 9th Nov 2020

This covers the guidance for decision making and consent

They set out 7 principles

Decision making principles only apply when there is a decision to be made

Doctors cannot be required to give treatment that is contrary to their clinical judgement, but should be willing to consider and discuss people's wishes to receive treatment, even if it offers only a very small chance of success or benefit.

# 7 Principles for decision making and consent

| | |
|---|---|
| **Principle 1** | All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able |
| **Principle 2** | Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient. |
| **Principle 3** | All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it. |
| **Principle 4** | Doctors must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action. |
| **Principle 5** | Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements. |
| **Principle 6** | The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them. |
| **Principle 7** | Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible. |

# CPR

**“CPR is invasive, involving chest compressions, delivery of electric shocks from a defibrillator, injection of drugs, and ventilation of the lungs” GMC**

**Out of Hospital Cardiac Arrests:**

The initial rhythm is shockable in approximately 1 in 4 OHCA (22-25%)

A return of spontaneous circulation (ROSC) is achieved in approximately 30% of attempted resuscitations.

Approximately 9% of people survive to hospital discharge

**In Hospital Cardiac Arrests:**

The initial rhythm is shockable in 17% of cardiac arrests

ROSC is achieved in half (53%) of those who are treated by a hospital’s resuscitation team

23.6% survive to hospital discharge.

More than four out of five (83%) who survive to hospital discharge have a favourable neurological outcome.

# Making CPR status Decisions

"If a patient is admitted to hospital acutely unwell, or becomes clinically unstable in their home or other place of care, and they are at foreseeable risk of cardiac or respiratory arrest, a judgement about the likely benefits, burdens and risks of CPR should be made as early as possible"

(GMC, Treatment and Care Towards the End of Life)

# Who Can Make A CPR Decisions

**The clinical responsibility for making emergency treatment decisions, including those in relation to CPR, rests with the most senior healthcare professional attending the person at the time that a decision must be made, or a nominated deputy.**

**CPR decisions should therefore be made by:**

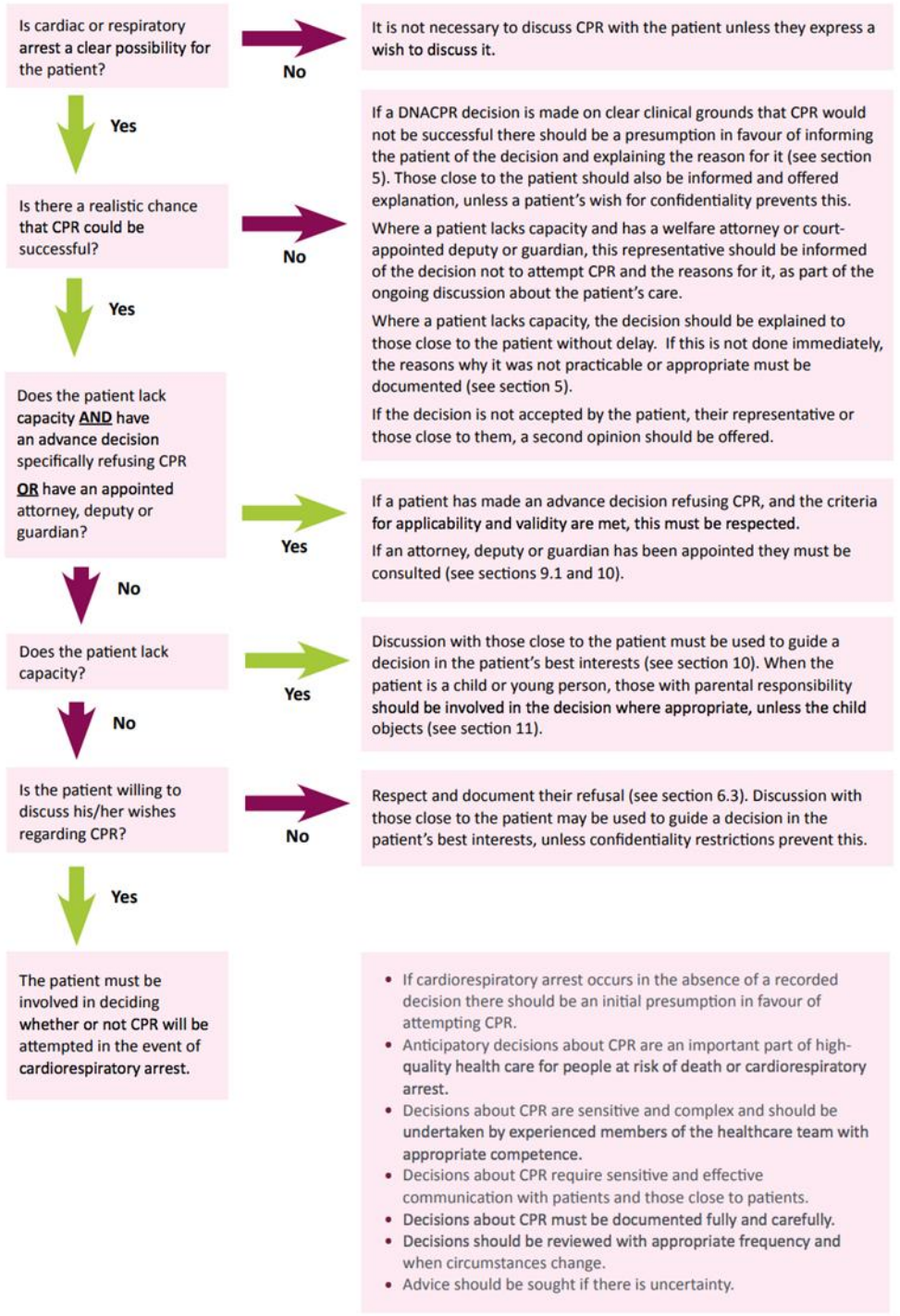
Consultant/ General Practitioner

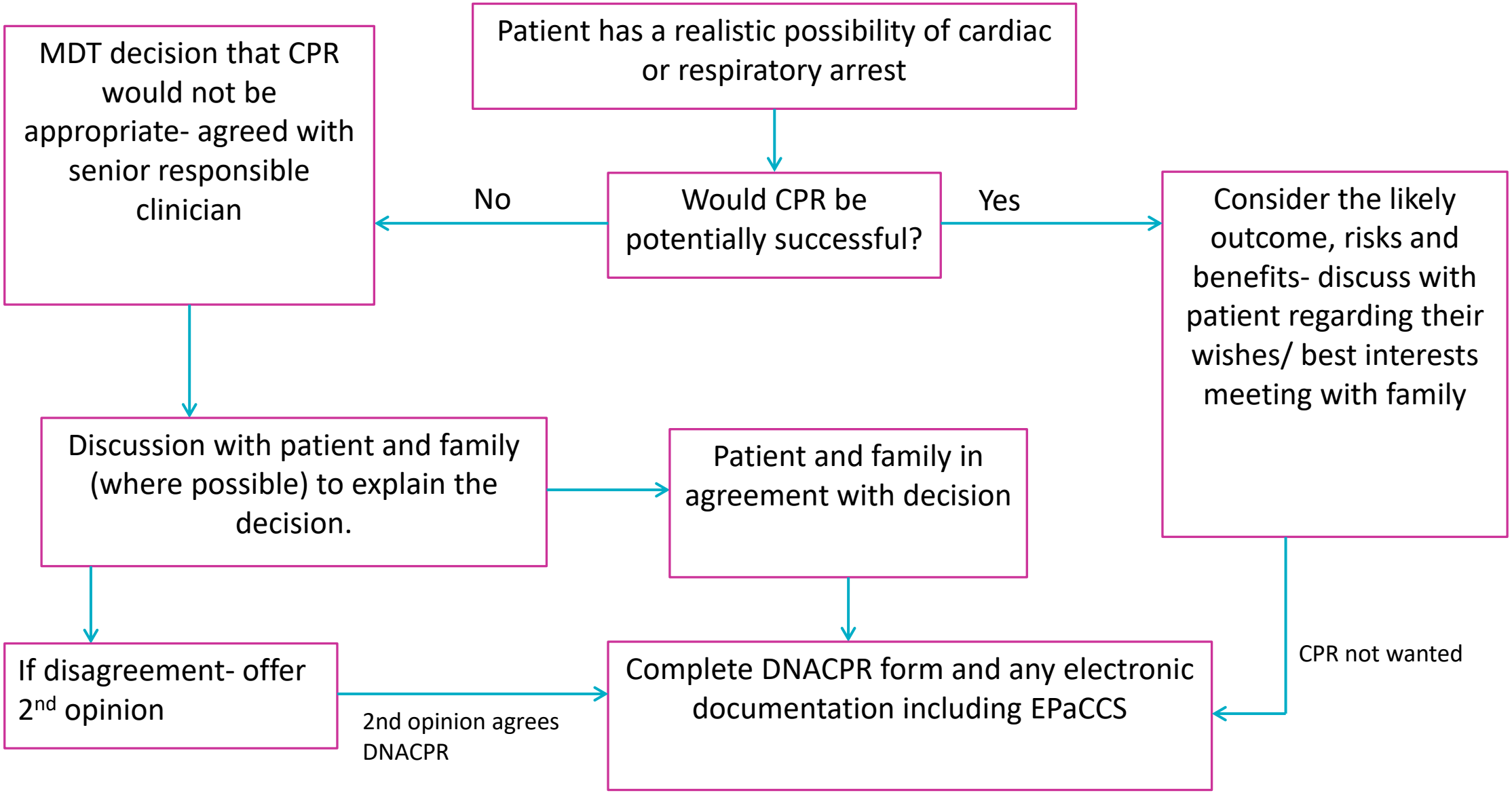
Doctor who has been delegated the responsibility by their employer

Registered nurse who has achieved the required competency

Other Professional with the required competency and is willing to lead these discussions.

# BMA CPR Decision Making Framework




Patient has a realistic possibility of cardiac or respiratory arrest
Would CPR be potentially successful?
No
Yes
MDT decision that CPR would not be appropriate- agreed with senior responsible clinician
Consider the likely outcome, risks and benefits- discuss with patient regarding their wishes/ best interests meeting with family
Discussion with patient and family (where possible) to explain the decision.
Patient and family in agreement with decision
If disagreement- offer 2nd opinion
2nd opinion agrees DNACPR
CPR not wanted
Complete DNACPR form and any electronic documentation including EPaCCS

# Reasons for making a DNACPR Decision

One of 3 reasons can be used when making a DNACPR decision:

A: CPR is unlikely to be successful

B: CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person

C: There is a valid advance decision to refuse CPR (can be in specific circumstances

# CPR Decision Making- Where CPR will not work

"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."

(BMA, 2016)

# Discussing a medical DNACPR decision

Tracey v Cambridge University Hospitals NHS Foundation Trust (2014)- changed guidance on the need to discuss the decision

A DNACPR decision must be discussed unless:

- The patient does not wish to be involved in the discussion
- The discussion is likely to cause physical or psychological harm

Patient distress is not a sufficient reason not to discuss the decision.

Patients or their proxy are entitled to know:

1. The decision has been made
2. Request a second opinion if they disagree

# CPR Decision making- Where CPR may be effective

If CPR is a potentially successful treatment option then the normal decision making process should apply

Patients must be given the information they need to weigh up and make a decision

## Discussions should include:

- the likelihood of re-starting the person's heart and/or breathing for a sustained period
- the level of recovery that can be expected realistically after successful CPR
- the person's known or ascertainable wishes
- the person's human rights, including the right to life, the right to be free from degrading treatment (which may include the right to a dignified death) and the right to respect for a private and family life
- the likelihood of the person experiencing continuing pain or suffering that they would find intolerable or unacceptable
- the level of awareness the person has of their existence and surroundings

# What are the risks and benefits of CPR?

# Risks of CPR

Fractured Ribs

Aspiration Pneumonia

Hypoxic Brain Injury

Increased disability/ loss of independance

Damage to Internal Organs (due to hypoxia)

# Where patients lack capacity

Capacity is both time and decision specific

Where a patient's capacity is in doubt the Mental Capacity Act 2005 should be followed

Best interests' decisions:

- Where CPR will not work, the NOK/ those close to the patient must be informed of the decision
- Where CPR might work those close to the individual must be involved in the decision making.

LPAs- check the paperwork, will need LPA for Health and Welfare with authority to make decisions regarding life sustaining treatment

# Challenging Scenarios: Discussion

You are caring for a 37year old lady with metastatic ovarian cancer.

She has completed multiple lines of treatment (chemotherapy, immunotherapy) but is not able to have any more.

She has been told that she is likely to be in the last short months of her life.

She has had several previous discussions about CPR but has always insisted that she would ‘want to try’ as she has 2 young children and wants to live as long as possible.

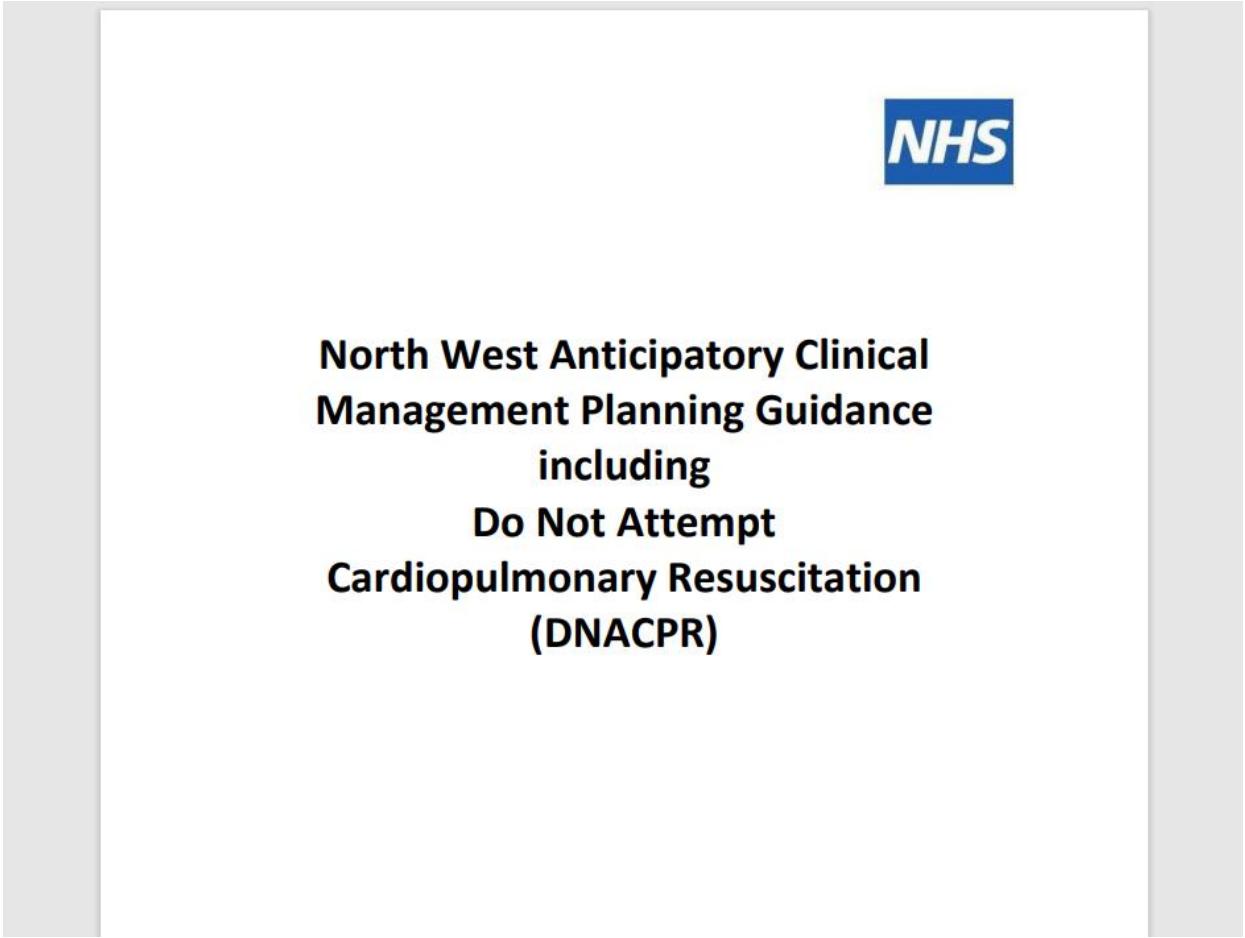
What would you say to her?

What would you do?

# CQC: Protect, respect, connect – decisions about living and dying well during COVID-19

- DNACPR decisions need to be recognised as part of wider conversations about advance care planning and end of life care, and these decisions need to be made in a safe way that protects people's human rights.
- People must always be at the centre of their care, including advance care planning and DNACPR decisions.
- Everyone needs to have access to equal and non-discriminatory personalised support around DNACPR decisions, that supports their human rights.
- Clinicians, professionals and workers must have the knowledge, skills and confidence to speak with people about, and support them in, making DNACPR decisions.
- People, their families and representatives need to be supported, as partners in personalised care, to understand what good practice looks like for DNACPR decisions.
- People, their families and/or representatives, clinicians, professionals and workers need to be supported so that they all share the same understanding and expectations for DNACPR decisions.
- People need to have more positive and seamless experiences of care, including DNACPR decisions, when moving around the health and care system.
- There must be comprehensive records of conversations with, and decisions agreed with, people, their families and representatives that support them to move around the system well.
- Integrated care systems need to be able to monitor and assure themselves of the quality and safety of DNACPR decisions.
- Health and social care providers must ensure that all workers understand how to speak up, feel confident to speak up and are supported and listened to when they speak up.
- CQC must continue to seek assurance that people are at the centre of personalised, high-quality and safe experiences of DNACPR decisions, in a way that protects their human rights.

# NW Guidance



NHS

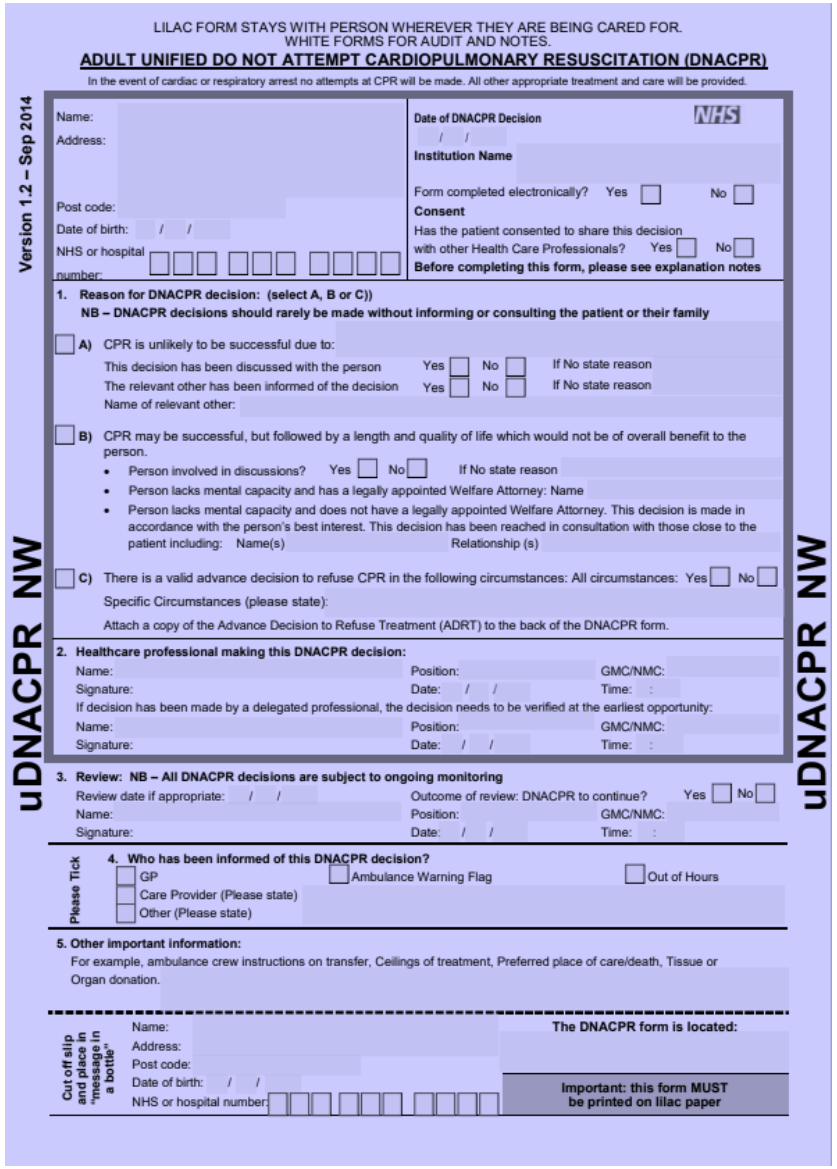
North West Anticipatory Clinical Management Planning Guidance including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

# DNACPR and People with Learning Disabilities or Autism

In May 2019 the National Medical Director (Prof Powis) wrote a letter with regards to Learning Disability, death certification and DNACPR orders. In it he said that:

**"The NHS is clear that people should not have a DNACPR on their record just because they have a learning disability, autism or both. This is unacceptable. The terms "learning disability" and "Down's syndrome" should *never* be a reason for issuing a DNACPR order or be used to describe the underlying, or only, cause of death. Learning disabilities are not fatal conditions."**

**You can read the full letter here:** https://www.england.nhs.uk/coronavirus/documents/c1146-do-not-attempt-cardiopulmonary-resuscitation-dnacpr-and-people-with-a-learning-disability-and-or-autism/



LILAC FORM STAYS WITH PERSON WHEREVER THEY ARE BEING CARED FOR.
WHITE FORMS FOR AUDIT AND NOTES.

**ADULT UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)**

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

Version 1.2 – Sep 2014

uDNACPR NW

Name:
Address:
Post code:
Date of birth: / /
NHS or hospital number:

Date of DNACPR Decision / /
NHS
Institution Name
Form completed electronically? Yes ☐ No ☐
Consent
Has the patient consented to share this decision with other Health Care Professionals? Yes ☐ No ☐
Before completing this form, please see explanation notes

1. Reason for DNACPR decision: (select A, B or C))
NB – DNACPR decisions should rarely be made without informing or consulting the patient or their family

☐ A) CPR is unlikely to be successful due to:
This decision has been discussed with the person Yes ☐ No ☐ If No state reason
The relevant other has been informed of the decision Yes ☐ No ☐ If No state reason
Name of relevant other:

☐ B) CPR may be successful, but followed by a length and quality of life which would not be of overall benefit to the person.
- Person involved in discussions? Yes ☐ No ☐ If No state reason
- Person lacks mental capacity and has a legally appointed Welfare Attorney: Name
- Person lacks mental capacity and does not have a legally appointed Welfare Attorney. This decision is made in accordance with the person's best interest. This decision has been reached in consultation with those close to the patient including: Name(s) Relationship (s)

☐ C) There is a valid advance decision to refuse CPR in the following circumstances: All circumstances: Yes ☐ No ☐
Specific Circumstances (please state):
Attach a copy of the Advance Decision to Refuse Treatment (ADRT) to the back of the DNACPR form.

2. Healthcare professional making this DNACPR decision:
Name: Position: GMC/NMC:
Signature: Date: / / Time: :
If decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:
Name: Position: GMC/NMC:
Signature: Date: / / Time: :

3. Review: NB – All DNACPR decisions are subject to ongoing monitoring
Review date if appropriate: / / Outcome of review: DNACPR to continue? Yes ☐ No ☐
Name: Position: GMC/NMC:
Signature: Date: / / Time: :

4. Who has been informed of this DNACPR decision?
Please Tick
☐ GP ☐ Ambulance Warning Flag ☐ Out of Hours
☐ Care Provider (Please state)
☐ Other (Please state)

5. Other important information:
For example, ambulance crew instructions on transfer, Ceilings of treatment, Preferred place of care/death, Tissue or Organ donation.

Cut off slip and place in "message in a bottle"
Name:
Address:
Post code:
Date of birth: / /
NHS or hospital number:

The DNACPR form is located:

Important: this form MUST be printed on lilac paper

uDNACPR NW

# Documenting and Communicating Decisions

There are several documents in use across the NW.

At present the one most widely used in L&SC is the NW uDNACPR form

It is the health care staff's responsibility to ensure communication of the form to other relevant organisations.

The use of an EPaCCS system is recommended to ensure communication of the decision across settings.

It is recommended where the person is at home, the ambulance service is informed, using their warning flag procedure following local procedures.

# Reviewing DNACPR Decisions

A CHANGE OF CLINICAL CIRCUMSTANCES

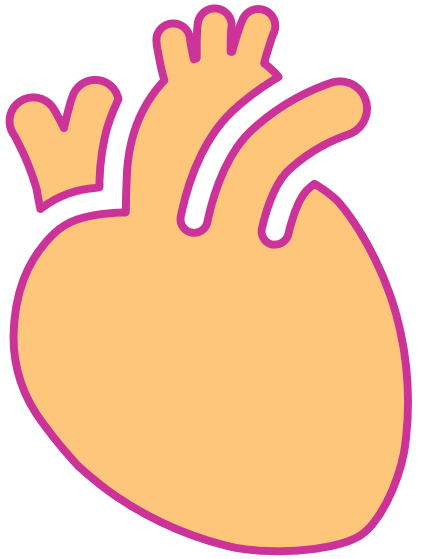
A REQUEST FROM THE PATIENT OR FAMILY

A CHANGE OF SETTING

Reassessing the decision regularly does not mean burdening the individual and their family with repeated decision-making discussions, but it does require staff to be sensitive in picking up any change of views during discussions with the individual or their family. Where an individual has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

# Suspending and Cancelling DNACPR Decisions

Uncommonly, some individuals for whom a DNACPR decision has been established may develop Cardiac Arrest from a **readily reversible cause**. In such situation's CPR would be appropriate, while the reversible cause is treated, unless the individual has specifically refused intervention in these circumstances.



In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision.

If the decision is cancelled, the document should be crossed through with two diagonal lines in black ball-point ink and the word '**CANCELLED**' written clearly between them, dated, signed and name printed by the health care staff.

The cancelled document is to be retained in the person's notes.

It is the responsibility of the health care staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision.

# Questions?

# References


North West Anticipatory Clinical Management Planning Guidance including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), 2023 https://www.england.nhs.uk/north-west/north-west-coast-strategic-clinical-networks/our-networks/palliative-and-end-of-life-care/for-professionals/north-west-anticipatory-clinical-management-planning/

BMA, Resus UK and NMC Joint Guidance, Decisions Relating to Cardiopulmonary Resuscitation, 2016 https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf

CQC, Protect, respect, connect – decisions about living and dying well during COVID-19, April 2021 https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19

Resuscitation Council UK, 2021 Resuscitation Guidelines https://www.resus.org.uk/library/2021-resuscitation-guidelines/epidemiology-cardiac-arrest-guidelines

NHS England, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and people with a learning disability and or autism, March 2021 https://www.england.nhs.uk/coronavirus/documents/c1146-do-not-attempt-cardiopulmonary-resuscitation-dnacpr-and-people-with-a-learning-disability-and-or-autism/