Code A - PA (Nursing & Clinical Governance)

From: Code A - PA (Nursing & Clinical Governance)
Sent: 07 October 2004 15:42
To: Code A - Team Secretary
Subject: Next CGC Meeting

Hi Code A

Please put 'Policies' as an Agenda item for the next CGC meeting.

Attached is the front page and policy.

Code A
PA to Director of Nursing & Clinical Governance
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file CGC ned

Fareham and Gosport NHS
Primary Care Trust

DO NOT ATTEMPT RESUSCITATION (DNAR)

Rationale re wording 4.7

	Involvement of Patients
1.	Some patients do not wish to discuss CPR at any time.
2.	Some patients are unconscious or "incompetent" and cannot be asked.
3.	Some patients will have already discussed this and further discussion is unnecessary or intrusive.

	Involvement of Relatives
1.	In UK law, no one may consent on behalf of another individual.
2.	There are issues of confidentiality (the patient needs to consent to the discussion with the relatives).
3.	The patient's relatives can only express what they feel are the wishes of the patients – these are notoriously subjective and may not be accurate.

Portsmouth Combined NHS Trusts

Portsmouth Hospitals NHS Trust (PHT)

Fareham & Gosport PCT (F&G PCT)

East Hampshire PCT (EHPCT)

Portsmouth City PCT (PCPCT)

DO NOT ATTEMPT RESUSCITATION (DNAR)

POLICY PERTAINING TO ADULTS

Contents:

Originator:	Portsmouth District Resuscitation Committee Chair: Dr. Gary Smith
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1. ITEM

Policy for Do Not Attempt Resuscitation (DNAR) decisions within Portsmouth Hospitals NHS Trust (PHT), Fareham & Gosport PCT (F&G PCT), East Hampshire PCT (EHPCT) and Portsmouth City PCT (PCPCT).

2. POLICY STATEMENT

Cardiopulmonary resuscitation (CPR) can be attempted on any individual in whom cardiac or respiratory function ceases. Failure of these functions is inevitable as part of dying and, thus, resuscitation can theoretically be used on every individual prior to death. It is therefore essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom CPR is inappropriate.

It is also important to encourage the involvement of patients, and people close to the patient, in decision-making and it is essential to ensure the communication of decisions to all relevant health professionals.

Where a DNAR order has not been made and the express wishes of the patient are unknown, CPR should be initiated if cardiac or respiratory arrest occurs.

There are several important reasons for adopting a DNAR order:

2.1 The fact that certain patients who receive CPR do so with little or no prospect of either recovery from their primary illness or discharge from hospital. Overall survival to hospital discharge following cardiac arrest is in the order of 17%, but is considerably lower for certain patient groups (e.g. those with sepsis, cancer). (1)

2.2 The fact that unsuccessful CPR makes death undignified.

2.3 The need to respect the wishes of individual patients regarding their own destiny.

3. DEFINITIONS

Portsmouth Combined NHS Trusts
Includes Portsmouth Hospitals NHS Trust (PHT), Fareham & Gosport PCT (F&G PCT), East Hampshire PCT (EHPCT) and Portsmouth City PCT (PCPCT).

Do Not Attempt Resuscitation (DNAR)
A DNAR order indicates that in the event of a cardiac or respiratory arrest, cardiopulmonary resuscitation will not be initiated. DNAR orders are the overall responsibility of the Consultant in charge of the patient's care. It is emphasised that a DNAR order does not prevent other forms of treatment being provided. (2)

Cardiac Arrest
Cardiac arrest is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal gasping respiration.

Respiratory Arrest
Respiratory arrest is the cessation of spontaneous breathing.

Cardiopulmonary Resuscitation (CPR)
Cardiopulmonary resuscitation is a combination of artificial ventilation, chest compressions, drug therapy and defibrillation. (3)

Adult
A person aged 16 years and above.

Specialist Registrar (or equivalent grade)
Includes Specialist Registrar, Clinical Fellow, Associate Specialist, Staff Grade posts and a General Practitioner.

Health Care Professional

A registered or trained member of staff, including but not exclusively nurses, doctors and operating department practitioners.

Ancillary Staff

Staff employed by the trust whose duties involve elements of patient care, including but not exclusively HCSW's, Porters and Ward Domestic staff.

4. ROLES AND RESPONSIBILITIES

When to consider DNAR decision

4.1 For patients at risk of Cardiac Arrest a DNAR decision ideally should be considered early, so as to enhance the quality of discussion and decision making process, rather than when there is a crisis in the patients condition.

4.2 It is appropriate to consider a DNAR order in the following circumstances:

4.1.1 Where the patient's condition indicates that CPR is unlikely to be successful.

4.1.2 Where CPR is not in accord with the recorded, informed sustained wishes of a mentally competent patient.

4.1.3 Where CPR is not in accord with a valid, applicable and legal advance directive (anticipatory refusal or living will). A patient's competently made refusal, which relates to the circumstances which have arisen, is legally binding upon doctors.

4.1.4 Where 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. Such decisions are extremely difficult, and should take account of the patient's view where possible.

Who can make a DNAR decision

4.3 A PRHO, SHO and Trust Doctor cannot make a DNAR decision without consultation with a doctor, Specialist Registrar (or equivalent grade) or higher. The DNAR decision must then be documented (see below).

4.4 All DNAR decisions must be discussed with, and counter signed by, the Consultant or General Practitioner in charge (or, in their absence, the Duty On-call Consultant for the specialty or General Practitioner) within 24 hours. The order should be made after appropriate consultation and consideration of all aspects of the patient's condition.

4.5 The overall responsibility for a DNAR order rests with the Consultant or General Practitioner in charge of the patient's care (or, in their absence, the Duty On-call Consultant or General Practitioner for the specialty).

4.6 Decisions must be taken in the best interests of the patient, an assessment of which should include likely clinical outcome and the patient's known, or ascertainable, wishes.

Involving others in the DNAR decision

4.7 The perspectives of the patient, medical and nursing team, the patient's relatives or close friends, with due regard to patient confidentiality, may all be valuable in making the decision.

4.8 Where possible, patients should be asked in advance who they want, or do not want, to be involved in the discussions about the DNAR decision if they become incapacitated.

4.9 Where competent patients are at risk of cardiac or respiratory failure, or have a terminal illness, there should be sensitive exploration of their wishes regarding resuscitation. This should be carried out by the doctor (SHO and above) responsible for their care. Such discussions, and any anticipatory discussions, should be documented, signed, timed and dated, in the patient's medical records.

4.10 Although the responsibility for DNAR decisions for in-patients rests with Consultants, they should be prepared always to discuss the decision for an individual patient with other health professionals involved in the patient's care. The importance of teamwork cannot be over emphasised.

4.11 When the basis for a DNAR order is the absence of any likely medical benefit, any discussion with the patient, or others close to the patient, should aim at securing an understanding of the clinical decision that has been reached. If a DNAR decision is based on quality of life considerations, the views of the patient (where these can be ascertained) are particularly important. If the patient cannot express a view, the views of family or others close to the patient may be taken into consideration regarding what would be in the patient's best interests. Their role is to reflect the patient's views, not take the decision on behalf of the patient. Relatives and others close to the patient may be assured that their views on what the patient would have wanted will be taken into account in decision-making. However, they cannot determine a patient's best interest, nor demand, give consent to or refuse treatment on a patient's behalf. (2)

4.12 The discussions surrounding resuscitation and DNR decisions will present spiritual challenges to patients, their friends and relatives, and staff. Consequently, such discussions should ideally be unhurried and be undertaken in the appropriate environment, ensuring privacy and time for personal thought.

4.13 It is important that patients or their representatives should understand that successful resuscitation may be followed by the need for invasive life support procedures e.g., endotracheal intubation, tracheostomy, intermittent positive pressure ventilation etc.

Documentation and review of a DNAR decision

4.14 A proper understanding of the DNAR decision is impossible without knowing the rationale behind it. The entry in the medical records of the decision and the reasons for

it should be in clear unambiguous language. It should be recorded by the most senior member of the medical team available, who should ensure that the decision is effectively communicated to other members of staff. The entry must be signed, timed and dated with a review date clearly stated.

4.15 Recording in the Nursing notes should be made by the primary nurse or the most senior member of the nursing team whose responsibility it is to inform other members of the nursing team.

4.16 The DNAR decision must be reviewed on a regular basis as the patient's condition may change. The decision must be reviewed if the clinical situation changes. As the overall responsibility for a DNAR order rests with the Consultant or General Practitioner in charge of the patient's care (or, in their absence, the Duty On-call Consultant for the specialty or General Practitioner), their involvement in the review process is vital.

4.17 A DNAR decision is automatically invalid once the patient leaves the care of Portsmouth Combined NHS Trusts, unless specifically documented by the Consultant or General Practitioner in charge of the patient's care. In this rare situation excellent communication is vital between multi-disciplinary team

On-going patient care

4.18 It is essential for the patient, their relatives and all health care workers to understand that the operation of a DNAR order is entirely consistent with the application of vigorous medical treatment and nursing care, including the administration of adequate analgesia.

4.19 DNAR order does not imply that current therapy will necessarily be withdrawn or that additional therapy will not be started.

4.20 A DNAR decision and including review period remains valid if the patient is transferred between different sites of Portsmouth Combined NHS Trusts.

5. EVIDENCED BASED PROTOCOL FOR PRACTICE

Action	Rationale	Evidence	Potential Risks/Harm
DNAR decisions are made when CPR is inappropriate.	Patients will receive CPR in appropriate circumstances	1	That patients will have inappropriate CPR attempts
If a DNAR is considered appropriate the SHO or above will examine the patient.	A doctor responsible for their care, who has the experience to make an informed decision, reviews the patient.	2	That patients do not receive the appropriate treatment.
The DNAR decision should be discussed with the nursing staff, the patient, their relatives and friends where possible and appropriate.	The nursing staff, patient and relatives are kept informed of the patients management plan.	2	That the patient and relatives are not kept informed.

Action	Rationale	Evidence	Potential Risks/Harm
The ultimate decision about the DNAR decision is that of the specialist registrar or Consultant responsible for the patients care.	Experienced medical practitioners make the decision, with the patient's best interests having been considered.	2	The DNAR decision is made by an inexperienced person and is potentially not in the patient's best interest.
The DNAR decision is communicated to all members of the multi-disciplinary team both verbally and in writing.	All health care professionals involved in the patients care should be aware of the DNAR decision.	2	That patients will have inappropriate CPR attempts
The DNAR decision is documented with a rational and review date in the Medical notes, signed, dated and timed by the specialist registrar or Consultant responsible for the patients care.	The documentation is clear and a made by an experienced medical practitioner.	2	If the DNAR decision is not clear then patients may have inappropriate CPR attempts
The DNAR decision should be reviewed, as appropriate, for each individual patient.	That timely review occurs so that the DNAR decision remains appropriate.	2	That the patient's DNAR status becomes inappropriate.
A clear plan of care is written in the patient's notes and communicated both verbally and documented.	That the patient receives appropriate medical and nursing care.	2	That the patient does not receive appropriate medical and nursing care.

6. FORUM FOR DISCUSSION

Portsmouth District Resuscitation Committee

Combined PCT's Cardiopulmonary Resuscitation Policy Review Group

PHT Sub-Group of Clinical Governance Committee

Clinical Governance Committees of EHPCT, F&G PCT & PCPCT

7. AUDIT STANDARDS/AUDIT TOOL

Aspects of Care/Outcomes	Expected Standard/Target	Source of Data Collection
All resuscitation attempts are appropriate and adhere to the DNAR policy.	100% of Cardiac Arrests	Attendance at the cardiac arrest call, follow up and review of the Cardiac Arrest Record Form by Resuscitation Department.
All DNAR decisions are fully documented as per policy.	100% of DNAR decisions	Patient notes.

8. TRAINING

All medical and nursing staff employed by Portsmouth Combined NHS Trusts have read this policy in conjunction with the guidelines from the BMA (2).

For further information and guidance they can contact the Resuscitation Department, PHT.

9. RISK MANAGEMENT

This policy has been written in response to recommendations from the BMA, RCN and Resuscitation Council (UK) (2). The aim is to ensure that CPR attempts in Portsmouth Combined NHS Trusts are always appropriate and in the patients best interests.

10. ASSOCIATED DOCUMENTATION

1 Gwinnutt C, Columb M, Haines R. Outcome after cardiac arrest in adults in UK hospitals: effect of the 1997 guidelines. Resuscitation 2000;47:125-135

2 Decisions Relating to Cardiopulmonary Resuscitation. A joint statement from the British Medical Association, the Royal College of Nursing and the Resuscitation Council (UK). Feb 2001. www.resus.org.uk

3 Resuscitation Guidelines 2000. Resuscitation Council (UK). www.resus.org.uk