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| **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) /**  **Allow A Natural Death**  **Documentation Audit**  **2017** |

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**DNACPR / Allow a natural death documentation**

**Audit 2017**

Background

Cardiopulmonary resuscitation (CPR) was first introduced in 1960 and refers to the provision of chest compressions, ventilation, the delivery of defibrillation and administration of drugs to an individual whom experiences a cardiac arrest, (BMA, Resuscitation Council {UK}, 2016). An individual, with capacity can choose not to receive CPR or the medical team caring for the individual may decide that CPR would be unsuccessful or potentially harmful and should be withheld to allow a natural death. Any decision requires careful discussion, documentation and communication in order to adhere to patient wishes and maintain their safety.

Brighton and Sussex University Hospital NHS Trust (BSUH) has adopted standardised documentation for such decisions, which is based on the guidance issued by the Resuscitation Council (UK) (RC (UK). Local guidance on its completion, validity criteria and acceptance of decision from external care settings can be found within the BSUH ‘Do not attempt cardiopulmonary resuscitation Policy’ C078. Regular audits are completed to check compliance, validity of documented decision, monitor patient safety and target training needs.

Over time the audit procedure has evolved to focus on specific aspects of the process and monitor management of issues which have arisen. An example of this is the concern raised in the Care Quality Commission (CQC) Visit Report 2016 which highlighted the omission to document an individual’s capacity assessment in relation to decisions regarding DNACPR. With this in mind, the audit reassess whether the measures taken to adjust training have influenced clinical practice.

In addition to documentation of the capacity assessment, this audit looks at the origin of the DNACPR decision and the review process on arrival to hospital.

Methodology

Data collection took place between 24th April and 3rd July 2017 across multiple directorates within BSUH. A total of 88 DNACPR forms where reviewed, 48 at the Royal Sussex County Hospital (RSCH) and 40 at the Princess Royal Hospital (PRH). Three members of the Resuscitation Services Department (RSD) assisted in the review of forms against a predetermined set of questions, inputting data directly to an excel spread sheet under the guidance of an audit protocol (appendix 1).

The table below lists the clinical areas visits.

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| --- | --- |
| **Royal Sussex County Hospital** | **Princess Royal Hospital** |
| Jowers  Valance  Catherine James and Egremont  Baily  Emerald Unit  Level 8 Tower  Level 10 - Lewes ward  Level 6a - CCU  Intensive Care Unit - ICU  Level 8a East  Level 9 South  Level 9 Haematology/oncology  Trafford Ward – Renal Unit  Acute Medical Assessment Unit - AMU | Balcombe  Pyecombe  Twineham  Hurstpierpoint  Ardingly |

The validity of a form is measured against the five criteria set within the DNACPR / Allow natural death policy:

* Correct form in correct health records
* Original red bordered form with wet ink signature present
* Patient uniquely identified (name, NHS or hospital number and DOB)
* In date if review date provided (and within 96 hours if emergency decision) and ‘indefinite’ stated if no date or review criteria
* Signed by Consultant in advance or Foundation Year 2 (FY2) or above in an emergency

With reference to the BSUH escalation protocol and where a question over validity or compliance with policy was identified during the audit a reporting safety grading flag was generated. When necessary immediate corrective action was taken or local staff advised to attend. Follow up visits were performed when feasible though limited due to patient flow and working hours. The below tables summarise the safety grading flags applied:

|  |  |
| --- | --- |
| **Safety grading** | **Meaning** |
| High | Risk to patient safety and immediate corrective action required |
| Medium | Deviation from best practice with action required but no immediate risk to patient |
| Low to Nil | No real risk / no risk identified but worthy of note and feedback |

Discussion of Results

**92% of forms viewed were valid and policy compliant**

Audit data shows that completion of the DNACPR form following a decision remains at a high standard and highlighted that the nursing staff’s knowledge of validity criteria was good.

Example

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| Staff on Balcombe Ward highlighted two forms within their unit were invalid. The first noted that a patient had a grey (carbonated copy) DNACPR form within their health records. However they were aware that this was invalid and the patient remained ‘For Resuscitation’ until the red copy with the ‘wet ink signature’ was available, reviewed or rewritten. Appropriate action was taken and the original red copy was obtained, reviewed and decision communicated amongst the team. The second form was a community decision which failed to specify a ‘valid review criteria’ or state ‘indefinite’ and staff were awaiting the Consultant ward round to amend the documentation. |

**Documentation on nursing handover sheets 100% accurate**

The methods in which nursing staff record DNACPR decisions on their handover remains inconsistent across the Trust, however information contained within was 100% accurate. All clinical areas excluding ICU make use of an electronic handover sheet to record patient details. Some choosing to denote the status with ‘N42’ or ‘DNR’ or underline the patient’s name. Highlighting the importance that such coding should be communicated to staff as part of orientation to clinical areas. Though asks the question should this process be standardised across the Trust to minimise risk?

**Seven decisions considered invalid or failing to comply with policy**

A total of seven DNACPR forms, which equates to 8% of the total forms audited, were considered not to meet the validity criteria / standard set within policy. The invalid forms included:

* Two emergency decisions that had not been ratified by a Consultant within 96 hours
* Four forms omitted or stated a review criteria which had passed or difficult to determine
* One emergency decision which arose concern. It was for a patient who lacked capacity and the deciding Clinician had failed to involve the Lasting Power of Attorney for Health and Personal Welfare (whose existence had been highlighted in the acute floor clerking). The reason was based on limited evidence that a previous decision was in place though unavailable.

**Data suggests suboptimal review of DNACPR decisions on admission**

When consideration is given to the origin of the invalid DNACPR forms it is interesting to note that only two of the seven (29%) decisions were made during the current episode of in-patient care. The remaining five (71%) originated from either an external care setting or from a previous in-patient episode within BSUH. This suggests that suboptimal review of decisions is taking place on admission or on identification of the existence of a DNACPR decision.

The acute floor single clerking proforma provides a prompt to address DNACPR decisions and has seen recent revision during the audit period with the addition of an escalation planning section. Unfortunately, though not formally quantified, limited use of this section was noted and the author is aware that escalation planning is currently being addressed by a newly formed steering committee.

**Clinicians continue to omit to document individual capacity assessment**

Alterations made to both face-to-face and e-learning training appears to have failed to address the issue raised by the CQC, namely the omission to document the capacity assessment. Where an individual is considered to lack capacity, the clinician must make a detailed documentation of their assessment within the health records. Practice denoted by the Mental Capacity Act (2005), Decisions relating to cardiopulmonary resuscitation (BMA, RC(UK), RCN 2014) and local Trust policy. A total of 34/88 patients lacked capacity and although not all documentation from the time of decision was available due to its origin, no ‘time date and topic specific’ capacity assessments were identified. Actions required to address this will be sought from the Resuscitation Operational Management Group, (ROMG) and the local Safeguarding and Mental Capacity Act trainer.

**‘Frailty’ verses ‘Aged 94’**

Reasons documented for the decision not to attempt CPR remain difficult to assess due to their subjective nature. Clinical consideration should be given to the risk and benefit to the individual in providing CPR while remaining sensitive to their wishes. The completion guidance notes provided by the RSD suggest that sole use of the term frailty should be avoided. However its use continues and is argued by Clinicians to be an acceptable medial term. The revised single clerking makes use of the Rockwood Frailty Scale (2008) suggesting that local policy should be adjusted to reflect its use. However blanket terminology including ‘aged 94’ or ‘nursing home resident’ both of which were witnessed during the audit remain inappropriate reasons and were flagged to teams as requiring amendment. All mandatory training attended by medical professionals will continue to include discussion surrounding appropriate terminology.

**Decisions are well communicated with patients and their carers**

In line with the Court of Appeal ruling, Tracey versus Cambridge University Hospital NHS Foundation Trust (2014) decisions involving an individual with capacity should be discussed with them. Audit data shows that 96% of decisions are discussed with patients with capacity. In the two cases when not discussed, one provided the reason why, the other was a case of poor documentation as the discussion was documented within the health records.

When an individual lacks capacity, (34/88 forms) the Winspear versus City Hospitals Sunderland NHSFT (2015) ruling requires timely discussion, where practical, to take place with the patient’s carers. This was achieved in 92% (31/34) of decisions for patients who lack capacity. The three occasions where it was not discussed included:

* Discussion with relative occurred at a later date and was documented in the health records
* Stated ‘Discussed with patient’ which was highlighted to staff to challenge due to the capacity assessment
* No discussion with relative or the Lasting Power of Attorney for Health and Welfare (LPA HW) identified in the single clerking. The Doctor who made the decision was contacted and staff made aware the person should be ‘For Resuscitation’ until this and other issues with the form are amended

**Review of information and Consultant ratification is required**

Seven of the 88 decisions reviewed were not signed by a Consultant however five of these where within the 96 hour window for ratification. Of the remaining two, one expired emergency decision for a renal patient had left the acute hospital setting and returned. Showing that review of the decision, or at least documentation of the decision, had not occurred on discharge nor re-admission. Immediate action was taken and ratification by a Consultant achieved who noted their omission. The second was a decision made during the current admission and although action was taken a follow up visit was not achieved.

Three decisions, all originating from external care settings or previous admission detailed review criteria which had passed or difficult to quantify:

* Review after surgical interventions for infection
* If condition improves
* This admission or discussion with family

As highlighted above this supports the notion that decisions do not attract optimal review on transition between care settings. This potentially also indicates that Doctors do not wish to interfere with decisions made by other clinicians despite the individual now being within their care. An expired decision poses great risk to the individual, supporting the need for continual updates and training on the DNACPR decision and documentation process.

Finally it was noted during the audit process that on two occasions new decisions were documented on DNACPR forms with a box 7, which were superseded in 2014. Great effort was made to identify the source of the supply which was tracked to the emergency department at the PRH. These were removed from circulation.

**Conclusion and Action Plan**

To summarise the key points raised by the audit data and suggested action require:

* Documentation of DNACPR decisions remains high with 92% validity and policy compliance.
* Electronic nursing handovers were found to be 100% accurate at the time of printing although inconsistent in the mark applied. Support from the Chief Nurse will be requested to gain standardised practice across the Trust.
* Measures put in place to address the documentation of capacity assessment have failed to have the desired effect. Further support shall be sought from the ROMG committee and the clinical lead for Safeguarding and Mental Capacity.

* Review of DNACPR decisions made prior to the current admission to the care setting and on discharge is suboptimal. A change of practice should be addressed through regular mandatory training sessions and liaison with the clinical lead for the acute floor that developed the pathway to monitor completion of the escalation of care.
* The RSD shall await further input from the work being completed by the ‘Escalation of Care’ steering committee. Though consideration will be given to the inclusion of documentation of escalation planning within subsequent audits.
* Nursing knowledge of the DNACPR process should be commended although there remains some confusion over the acceptance of community decisions. This highlights a need to continue with regular updates within training. It is also suggested that with an increase in personnel within the RSD regular ward visits should be made to monitor decisions and provide on the spot training for all members of the multi-disciplinary team.

References

British Medical Association, Resuscitation Council (UK), Royal College of Nursing Decisions relating to Cardiopulmonary Resuscitation, 3rd Edition, 1st Revision (2016)

Department of Health (2005) Mental Capacity Act. London, HMSO

K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. Scale CMAJ2005:173:489-495

Tracey vs Cambridge University Hospital NHS Foundation Trust (2014) EWCA 822

Winspear v City Hospitals Sunderland NHS Foundation Trust (2015) EWHC 3250 (QB)

Contributions with thanks

Colin Elding – Resuscitation Service Manager

Alan Street – Resuscitation Practitioner

Appendix 1

**DNACPR / Allow a natural death**

**Trust wide audit 2017**

Actions of staff member conducting audit

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|  | **Actions** |
| 1 | Introduce self to Nurse in Charge (NIC) and explain purpose of visit to clinical area |
| 2 | Obtain handover sheet and:   * Check highlighted DNACPR orders against patient’s health records |
| 3 | Record any discrepancies and immediately inform the NIC |
| 4 | Where there are no DNACPR orders in place check health records to check for decisions not communicated |
| 5 | Check validity criteria   * Right form in right health records * Original red bordered form with wet ink signature * Patient uniquely identified * In date if review date stated and in date and in time (96 hours) for emergency decision * If no review date or review criteria INDEFINITE is stated * Signed by appropriate healthcare professional (Consultant or F2 and above) |
| 6 | Any issues raised with validity were addressed using the flag escalation document |
| 7 | Where an individual lacks capacity   * Inspect health records for documentation of capacity assessment which is date, time and topic specific |
| 8 | If no documentation of the capacity assessment is found highlight to the nurse in charge and request that the parent team review the decision and document the capacity assessment |
| 9 | Thank ward area for their time |
| 10 | Record findings on data collection sheet |

Audit questions

Appendix 2

Summary table of findings by question

|  |  |  |
| --- | --- | --- |
| **Specific area of audit** | **Findings** | **Safety grading** |
| Nurse handover sheet accurately reflects patients current status | 87/87 (100%) handover sheets accurately reflected the correct ‘resuscitation status’ of all patients at the time of printing (total adjusted as ICU do not have handover sheets). However:   * 1/87 Patient not on the handover sheet as new admission (AMU) * 2/87 new decisions following daily review, staff were aware of decision in both cases (Valance/Balcombe) | Low |
| DNACPR form in correct health records (right patient) | 88/88 (100%)  No issue found | Nil |
| Red copy with ‘wet ink signature’ present | 87/88 (98%) Red copy was present  1/88 Only grey copy present, staff were aware patient remained ‘For Resuscitation’ and later obtained and reviewed original red copy from home (Balcombe) | Nil |
| DNACPR form correctly filed in front of the working health records | 86/88 (97%) filed correctly  2/88 DNACPR forms loose leaf within temporary set of health records | Low |
| Patient uniquely identified on red and grey (if present) form (Name, NHS or hospital number and DOB) | 86/88 (97%) Uniquely identified  2/88 Address labels only applied to red copy therefore no details on grey copy | Medium  Immediate correction made |
| Origin of decision | 57/88 (65%) Current BSUH decision  14/88 (16%) Community decision  15/88 (17%) Previous BSUH decision  02/88 (02%) Other acute Trust | NA |
| Section 1 - completed with clear indication of capacity versus no capacity | 86/88 (97%) clear indication of capacity   * 52/88 patients with capacity * 34/88 considered to lack capacity | Nil |
| 2/88 lacked indication of capacity | High  Medical team informed |
| **Specific area of audit** | **Findings** | **Safety grading** |
| Section 1 – Documentation of capacity assessment in health records  N = 34 | 18/34 (53%) no additional documentation of mental capacity assessment  8/34 (24%) community/historical decisions unable to locate original documentation  8/34 (24%) additional documentation only as part of >75 pro-forma not ‘time, date, topic specific  (8+18) 26/34 (76%)  No documentation of assessment | Medium |
| Section 2 - completed (reason given and adequate detail provided) | 5/88 (7%) questionable reason   * Frail (current) * Previous DNAR, frail unlikely to be successful (current) * Aged 94 and Alzheimer’s (Community) * Futility and previous community DNAR order present, frail + unlikely to be unsuccessful (current) * Frail, NH resident, likelihood increase morbidity (historic BSUH) | Medium  Medical team / NIC informed need to review |
| Section 3 (Q1) - completed with appropriate summary of communication with patient (WITH CAPACITY) | 50/52 (96%) patients with capacity appropriate summary of communication | Nil |
| Section 3 (Q2) - if no consultation with patient (WITH CAPACITY) suitable reason given (physical/psychological harm- Tracey judgement) | * 1 discussion fully documented in health records * 1 reason given | Medium |
| 34 patients of whom lack capacity   * 16, 47% documented discussion * 9, 26% reason given for no discussion * 9, 26% box 3 left blank | Medium |
| **Specific area of audit** | **Findings** | **Safety grading** |
| Section 4 - completed with appropriate summary of communication with relatives or friends or reasons why no discussion or involvement (Winspear judgement) | 59/88 (67%) summary of discussion with family documented  Remaining 29 (33%) had no summary of discussion   * 25, 86% considered to hold capacity * 4, 14% no documented discussion |  |
| * 2 clear documentation of discussion with family in health records * 1 stated ‘fully discussed with patient’ * 1 no discussion with family nor patient Emergency Department documentation mentions Lasting Power OF Health and Welfare but no involvement - invalid form multiple reasons | Low |
| Medium |
| High |
| Section 5 – completed (Consultant making decision or authorising emergency decision) immediately or within 96 hours | 81/88 (92%) ratified by a Consultant  7 (8%) were emergency decisions unsigned by a Consultant of which:   * 5 were valid as WITHIN 96hr * 2 expired * Renal - decision from February 2017 immediately reviewed/ ratified by Consultant * Twineham – NIC informed ‘for resuscitation’ until ratified. On follow up unable to locate | High |
| Section 5 – Active review date, or review criteria or INDEFINITE stated. | 76/88 (86%) had a documented and active review date (which includes 4 community decisions with no review date, presumed indefinite)  Remaining 12:   * 7 Emergency decision not requiring a review date * 5 Invalid |  |
| 2 No review criteria  3 Expired review criteria   * Review after surgical intervention for infection * If condition improves * This admission or discussion with family | High  NIC and Teams made aware |
| **Specific area of audit** | **Findings** | **Safety grading** |
| Section 6 – completed (junior doctor completing and signing form) with date and time recorded | 37/88 (42%) Emergency decision by FY2 or above  1 Junior Doctor failed to document the date and time of decision however the form had been signed by Consultant | Low |