Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Measurement Framework

August 2016
Background

Healthcare Improvement Scotland has a number of work strands aimed to improve care and outcomes for patients who deteriorate in acute hospitals, one of which includes decisions, communication and documentation around resuscitation status and end of life. This work takes into account:

- the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy\(^1\), published in 2010, with the anticipated release of the light touch review in summer 2016
- Scottish Government guidance, Caring for people in the last days and hours of life: four principles\(^2\)
- the deteriorating patient workstream of the Scottish Patient Safety Programme (SPSP), which has an aim of 50% reduction in cardiac arrest rate, and
- the inspection programme for older people in hospital.

This is against a background of:

- an increasingly complex cohort of patients with multiple co-morbidities and limited reversibility of their condition (30% of acute care bed days are used by people in their last year of life\(^3\) and 75% of people in last year of life will be admitted to hospital\(^4\))
- recent legal cases that have a bearing on decisions, discussions and documentation specific to DNACPR for patients, families and legal representatives, including: Tracey v Cambridge\(^5\), Montgomery v Lanarkshire\(^6\) and Winspear v Sunderland\(^7\), and
- a strong media focus on end of life care.

SPSP also recently undertook a 90-day review of both the content and delivery method of the Acute Adult and Primary Care programmes\(^8\). This review makes a number of recommendations that are relevant in the context of the DNACPR Integrated Adult Policy:

- SPSP will focus on three core themes, one of which is deterioration
- the focus of national reporting will be on outcome measures, and
- SPSP will continue to promote the importance of relevant process measures being used locally to support the work of improvement and will continue to provide guidance on meaningful process measures.
Purpose of this measurement framework

This measurement framework has been developed and tested with the purpose of supporting local improvement by providing guidance for data collection and review at NHS board and partnership level. This will enable learning and identify opportunities for improvement around the delivery and measurement of DNACPR, which will support improved person-centred goals of care decisions, communication and documentation.

Scope

The DNACPR measurement framework is designed in accordance with:

- the DNACPR Integrated Adult Policy, and
- Decisions relating to Cardiopulmonary Resuscitation\(^{(9)}\) – a joint statement from the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council UK.

See appendices 1 and 2 for decision-making frameworks relating to discussions with patients, relatives and patients’ legal representative, and documentation.

The framework has been structured around the following three crucial concepts:

- compliance with the DNACPR Integrated Adult Policy
- compliance with recent legal changes relating to family, next of kin, power of attorney discussions, documentation, and person and family experience, and
- anticipatory care planning.

Underpinning the framework is an acknowledgement that NHS boards and partnerships should consider local governance in relation to DNACPR decisions, such as communications and documentation, and connected processes (for example, reviews of morbidity, mortality, cardiac arrests and medical emergency (2222) calls).
References

4. P. Levack & S. Wright (April 2010) Living and Dying Well Short Life Working Group, Recommendations on Palliative Care in Acute Hospitals
9. www.resus.org.uk/dnacpr/decisions-relating-to-cpr
# The DNACPR Measurement Framework

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| DNACPR 01  | % of correctly completed DNACPR forms | **Numerator:** The total number of correctly completed DNACPR forms **Denominator:** The total number of DNACPR forms reviewed | Key elements of correct documentation:  
  • demographic information  
  • date of completion  
  • signed by appropriate senior clinician within 72 hours  
  • evidence of valid review timeframe in keeping with current policy  
  • correct completion of section A or B on DNACPR form | • Review of ‘live’ DNACPR forms from random wards  
• Morbidity and mortality reviews  
• Hospital Standardised Mortality Ratio |

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| DNACPR 02a | % of case note entries compliant with case law relating to DNACPR documentation of patient and family involvement | **Numerator:** The total number of case note reviews with documented evidence of patient/family involvement in DNACPR decisions  
**Denominator:** The total number of DNACPR cases reviewed  
**Compliance:** (Numerator / Denominator) * 100 | Review patient notes with DNACPR in place to confirm the following criteria:  
Has the DNACPR been discussed with patient/next of kin/power of attorney?  
**YES** – is there documented evidence of the following:  
• Date  
• Signature of clinician  
• Key persons present – clinician, patient and/or next of kin/power of attorney  
• Clarification of patient/family understanding of decision  
**NO** – is there documented evidence of the following:  
• Date  
• Signature of clinician  
• Reason not discussed, for example concerns for psychological or physical harm, refusal by patient and/or not practicable or appropriate for those close to the patient  
• Plan for future discussion | • Review of notes with ‘live’ DNACPR forms  
• Morbidity and mortality reviews  
• Cardiac arrest/2222 call reviews  
• Global Trigger Tool reviews |
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| DNACPR 02b | Number of inappropriate CPR attempts where a DNACPR was in place             | **Numerator**: The total number of CPR attempts where there was a DNACPR in place    | It would be useful to have narrative on any that are highlighted as being inappropriate to identify learning around communication in relation to DNACPR status, for example within teams and between transitions of care and care interfaces | • Cardiac arrest/2222 call reviews  
• Cardiac arrest audit forms  
• Morbidity and mortality reviews |
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| DNACPR 03a | % of true cardiac arrests with post event DNACPR       | **Numerator:** The total number of true cardiac arrests where a DNACPR order was placed post resuscitation  
**Denominator:** The total number of true cardiac arrests reviewed  
**Compliance:** (Numerator / Denominator) * 100                                                                 | **Inclusion:** New DNACPR decision within 20 minutes of return of spontaneous circulation (ROSC)  
**Exclusion:** New DNACPR decision >20 minutes post ROSC or where it is clear that the initial CPR attempt was provided due to an unexpected sudden catastrophic event resulting in the decision that further CPR would not be a further treatment option | • Cardiac arrest audit forms  
• Cardiac arrest/2222 call reviews  
• Morbidity and mortality reviews  
• DNACPR post event                                                                                             |
| DNACPR 03b | % of CPR attempts stopped within 10 minutes            | **Numerator:** The total number of cardiac arrests reviewed where resuscitation attempts were stopped within 10 minutes  
**Denominator:** The total number of cardiac arrests reviewed  
**Compliance:** (Numerator / Denominator) * 100                                                                 |                                                                                                                                                                  | • Cardiac arrest audit form  
• Cardiac arrest/2222 call reviews                                                                                                             |
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| DNACPR 03c   | Total number of patients with no evidence of DNACPR decisions where death would not be unexpected due to advanced illness, significant frailty and/or co-morbidity | **Numerator:** total number of patients with no evidence of DNACPR decisions where:  
  - a person is at an advanced stage of dying from an irreversible condition so CPR is contraindicated  
  - a person has advanced illness such as cancer, and/or end organ failure, and significant frailty, with deteriorating health such that CPR will not work | Example of standard question to healthcare staff in clinical areas would be:  
  “Would you have concerns about attempting to resuscitate any patients at risk of cardiac arrest **but** who currently have no DNACPR decision in place?”                                                                 | • Clinical visits to ask question and live review of notes  
• Cardiac arrest/2222 call reviews  
• Morbidity and mortality reviews |
Appendix 1: Decision-making framework

Is cardiac or respiratory arrest a clear possibility for the patient?

- Yes
- No

If yes, it is not necessary to discuss CPR with the patient unless they express a wish to discuss it.

If a DNACPR 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 (see section 5). Those close to the patient should also be informed and offered explanation, unless a patient’s wish for confidentiality prevents this.

Where a patient lacks capacity and has a welfare attorney or court-appointed deputy or guardian, 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.

Where a patient lacks capacity, the decision should be explained to those close to the patient without delay. If this is not done immediately, the reasons why it was not practicable or appropriate must be documented (see section 5).

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

Does the patient lack capacity AND have an advance decision specifically refusing CPR OR have an appointed attorney, deputy or guardian?

- Yes
- No

If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, this must be respected.

If an attorney, deputy or guardian has been appointed they must be consulted (see sections 5.1 and 10).

Does the patient lack capacity?

- Yes
- No

Discussion with those close to the patient must be used to guide a decision in the patient’s best interests (see section 10). When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate, unless the child objects (see section 11).

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

- Yes
- No

Respect and document their refusal (see section 6.3). 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.

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

- If cardiorespiratory 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 cardiorespiratory 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.

More information at: www.resus.org.uk/dnacpr/decisions-relating-to-cpr
Appendix 2: Decision-making and legal representatives (Scotland)

Patient lacks capacity to make a decision about CPR

- Do they have a legal representative (Welfare Attorney or Court appointed Welfare Guardian)?
  - YES
    - Does the legal representative have stated powers to consent to medical treatment (register is held by the Office of Public Guardian)?
      - YES
        - Does the clinical team judge that CPR would be of overall benefit for the patient?
          - YES
            - Does the legal representative agree that CPR would be of overall benefit for the patient?
              - YES
                - Document all discussions and the recommendation that CPR is to be attempted in the event of a cardiac arrest
              - NO
                - Having carefully considered the legal representative’s view does the clinical team still disagree and wish to offer CPR?
                  - YES
                    - Request the Mental Welfare Commission to nominate an independent doctor to determine whether the treatment should be authorised (see section 10.2)
                  - NO
                    - Document all discussions and complete a DNACPR form for the patient

- NO
  - Consult those close to the patient to help you to determine if offering CPR is likely to benefit the adult

- Does the legal representative agree with the clinical team that the likely burdens of CPR would be greater than the benefit for the patient (and that a DNACPR decision is appropriate)?
  - YES
    - Offer a second opinion and give serious consideration as to whether to respect the legal representative’s view that CPR would, on balance, provide more benefit than unacceptable burden for the patient
  - NO
    - If the clinical team maintain that CPR cannot be justified they may complete a DNACPR form for the patient. All discussions must be documented. The legal representative has the right to take the matter to court if they disagree.

In all situations, where CPR will not work it should not be offered. This decision and the reasons for it should be explained carefully to those representing and those close to the patient. Where there is objection to or disagreement with this decision, a second opinion should be offered. The court may be asked to make a declaration if it is not possible to resolve the disagreement.

More information at: [www.resus.org.uk/dnacpr/decisions-relating-to-cpr](http://www.resus.org.uk/dnacpr/decisions-relating-to-cpr)