Clinical audit improving patient experience and involvement
From ‘not for cardiopulmonary resuscitation’ to ‘allow a natural death’

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Background : The Christie

- The Christie has been pioneering cancer research breakthroughs for over 100 years and is the largest single site cancer centre in Europe.
- Treating more than 40,000 patients each year, 175 Inpatient beds
- Presentation today, brief background around cardiac arrests in hospital, governing body recommendations, best practice......and its important we get it right
- Popular misconceptions publicly around resuscitation and end of life care
- History of lack of improvement in previous audit cycles
Resuscitation Council (UK)

- Most arrests are predictable
- With evidence of deterioration prior to 50-80% of cardiac arrests
- In hospital cardiac arrest, are more commonly non-shock cardiac arrest rhythms which have poor prognosis
- Therefore we don’t expect good outcomes,
- Where cardiac arrest/death is expected a decision should be made in advance re DNAR
Time to Intervene?

• A report by the National Confidential Enquiry into Patient Outcome and Death published in June 2012
• A review of patients who underwent cardiopulmonary resuscitation as a result of in-hospital cardio respiratory arrest between 1st and 14th November 2010
• DNAR decision would have been appropriate in 85% of cases
• Confusion between DNAR and “for full and active management”
GMC Statement

• ‘Our guidance for doctors is clear. Where a patient is at risk of death, a decision about whether or not to attempt CPR should be taken at an early opportunity. For relatives, it is traumatic and upsetting if a decision not to attempt CPR (DNAR), has not been discussed or explained.
should include the option of paediatric paddles in areas where children are treated. Defibrillators with an external pacing facility should be located strategically.

9. Responsibility for checking resuscitation equipment rests with the department where the equipment is held and checking should be audited regularly. The frequency of checking will depend upon local circumstances but should ideally be daily.

10. A planned replacement programme should be in place for equipment and drugs with funding allocated for this purpose.

10. Decisions Relating to Cardiopulmonary Resuscitation

It is essential to identify:

- patients for whom cardiorespiratory arrest is an expected part of the process of dying and in whom cardiopulmonary resuscitation (CPR) is inappropriate
- patients who do not wish to receive CPR.

Detailed guidance on decisions relating to CPR has been published in 2007 in a Joint Statement by the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (see www.resus.org.uk). This should be used as the main source of reference to guide clinical practice.

Based on this guidance we recommend the following:

1. Each institution should have a written policy about CPR decisions (including do not attempt resuscitation (DNAR) decisions) that is available to staff and, on request, to patients and those close to them.

2. Every decision about CPR must be made on the basis of individual assessment of each patient. There is no place for local policies that allocate CPR or do not attempt resuscitation (DNAR) decisions to groups of patients.

3. Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest. Institutions should ensure that there is a clear and explicit resuscitation plan for all such patients.

4. If CPR would not re-start the heart and breathing, it should not be attempted.

5. If CPR is not in accord with a valid advance decision (formerly called advance directive or “living will”) that is applicable in the current clinical circumstances, or with the recorded, sustained wishes of a patient with capacity, it should not be attempted.

6. Where successful CPR may not be followed by a length and/or quality of life that are in the best interests of the patient, the informed views of a patient with capacity are of paramount importance in planning decisions about CPR.

7. All healthcare organisations should have arrangements in place to ensure that appropriate decisions about CPR are made for patients who lack capacity. Such arrangements must comply with the law. For more detailed guidance, including the different legal situations in England and Wales, Scotland and Northern Ireland please refer to the Joint Statement.

8. If cardiorespiratory arrest occurs in a patient for whom no resuscitation plan has been established, and the wishes of the patient are unknown, resuscitation should be initiated.

9. Communication and the provision of information are essential parts of good quality care. All healthcare institutions should provide patients, whenever appropriate, with information about CPR and resuscitation decisions and be able to offer additional advice and support from appropriately trained staff. Discussion about resuscitation should not be forced on patients who indicate that they do not wish to discuss this topic.

10. Decisions concerning the resuscitation status of a patient must be clearly communicated to the appropriate members of the multidisciplinary team involved in the patient’s care.

11. DNAR decisions apply only to CPR and not to any other aspects of treatment. It should be made clear to patients, those close to patients and to members of the healthcare team that all other appropriate treatment will continue to be considered and provided.

12. DNAR decisions should be reviewed whenever clinically appropriate, but particularly when there is a significant change in the patient’s clinical condition or when the patient is transferred from one healthcare setting to another.

13. The overall responsibility for a DNAR decision rests with the most senior healthcare professional responsible for the patient’s care. When a DNAR decision is made it should be recorded clearly, together with the reasons for it and the names and designation of those involved in the discussion and decision. If no discussion takes place either with the patient or with those close to them, the reasons for this should be recorded. The use of an easily identifiable, dedicated form to record DNAR decisions is recommended.
Objectives

To ensure the Christie is:

- Delivering against Resuscitation guidelines from Resuscitation Council (UK)

- Meeting standards set out in the Christie NHS Trust Resuscitation Policy

- Undertaking and documenting appropriate discussions between medical teams/patients and families where patients are not for resuscitation
Audit process
Standards

• Decisions regarding patients who are not for Resuscitation are discussed with the patient and/or relative. (100%)

• The following details were clearly stated (100%):
  
  Date, Time, Name, Designation and Signature

On the Not for CPR form

On the AaND form

And in the medical notes
Audit process

- Re-audit
- 6 monthly retrospective audit review
- Poor Form completion
- Poor documentation of discussion
- Change to documentation
- Trust wide forum
- SpR feedback
- Action Plan

Only 53% recorded discussion in the medical notes
Allow a Natural Death (AaND)

In the event of a cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment, and care planned will be provided.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>NHS/hospital number</td>
<td></td>
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</tbody>
</table>

A decision has been made that is not for resuscitation

1. Does the patient have the capacity to communicate decisions about CPR
   - YES/NO
2. If NO to 1, are you aware of a valid advance decision refusing CPR which is relevant to the current condition
   - YES/NO
3. If NO to 1, has the patient appointed a welfare attorney to make decisions on their behalf
   - If YES, they must be consulted
   - YES/NO

All other decisions must be made in the patients best interest and comply with current law

Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful, or not in the patients best interest

Communication

Discussion with patient, only, (at patients request)

The decision has been discussed with the patient and persons closest to the patient

The decision has only been discussed with the person(s) closest to the patient because

Name of individual(s), relationship to patient

This has not been discussed with the patient or closest person(s) because the care plan is known and may cause distress. End of life discussion has been documented in the medical notes, or other rationale, please comment

Escalation/Limitations of care

AaND + LCP
AaND + active ward care only
AaND + level 2 care
AaND + level 3 care
AaND + plan for discharge

Oxygen therapy
- IV/IVAB
- non invasive respiratory support / cardio vascular support
- invasive respiratory support + other organ support

Completion of form by

Signature/designation of most senior member of medical team making decision
date/time

Discussed with Senior Registrar on call
name/date/time

Has the patients own consultant been informed/consulted

Signature/designation of nursing shift leader/coordinator
date/time

Signature of patient
date/time

Signature of closest person consulted/relationship to patient

If AaND order is cancelled cross out form and state rationale/date/time in medical notes

The Christie Resuscitation Committee January 2012.

Top copy to be kept at front of patient’s notes, Bottom copy to be sent to: CCU outreach/resuscitation
Objectives (Re-audit)

• Determine if the introduction of amended documentation as a result of the Not for CPR audit action plan has improved communication between medical staff, patients and their families and thus improved their experience by promoting high quality end of life care.
Audit Results
Percentage of patients and relatives having a discussion

March 2012: 35% Patients, 37% Relatives
Sept 2012: 55% Patients, 69% Relatives
Sept 2013: 55% Patients, 74% Relatives
Audit Results
Percentage of patients and/or relatives having a discussion

March 2012: 35% Patients, 37% Relatives
Sept 2012: 55% Patients, 69% Relatives
Sept 2013: 55% Patients, 74% Relatives

* Includes 8 patients where discussion did not take place but appropriate reasons were recorded
Audit Results

- 47 Allow a Natural death forms audited in September 2013

Mar 2012 n=57, Sept 2012 n=42, Sept 2013 n=47
Background: Definitions

• Not for Cardiopulmonary Resuscitation (Not for CPR or DNAR)

• Allow a Natural Death (AaND)
Conclusions

- AaND was developed as a response to audit results and promotes early discussion and decision making regarding limitations or escalation in care.
- AaND has been successfully implemented within this specialist cancer trust; the results demonstrate improved communication. Due to
  - Education at the time of implementation
  - Improved understanding of end of life issues among clinical staff.
  - SpR survey
  - Medical staff found it easier to break bad news using accepted techniques.
Outcome

• Better experience for patients at the end of life and their relatives:

• For families it is very important to receive reassurance that medical and nursing teams are not withholding care but supporting their loved ones despite life limiting cancer. The AaND process clarifies that all appropriate high quality supportive care will continue until the patient dies or is discharged home.
Outcome

• Better experience for patients at the end of life and their relatives:

• The AaND form enables medical staff to be more confident in discussions and as a result, it seems to have improved the quality of documentation in the patient notes.
Conclusions

• Better experience for patients at the end of life and their relatives:

• The report of the National Confidential Inquiry into Patients Outcome and Death: Cardiac Arrest Procedures: Time to intervene (2012) was published after the introduction of The Christie AaND documentation. Its findings had strong similarities to the local results and support the revisions to wording introduced in the new AaND documentation.
Further improvements

• Continue with education for staff around
  • Communication between staff re AaND
  • Understanding the AaND process
  • How to communicate with patients and relatives.
• Minor changes to the form – more space for designation and signature
• Programme of re-audit including re-survey of staff
Christie targets for improvement
NCEPOD – Time to Intervene 2012

• Aim for 90% compliance to DW pts +/- relatives/carers
• Aim for early discussion i.e. at ward rounds around escalation/limitations in care, to prompt AaND discussions and orders being completed
• Aim to reduce “out of hours” completion of AaND to 10%
• Aim to reduce number of inappropriate cardiac arrest calls by 50%
Acknowledgements

• Ewa Zasada – Chair Resuscitation Committee
  - consultant in anaesthesia and critical care

• Joanne Woolley – clinical audit manager

• Any questions?
References

• RCUK – www.resus.org.uk
• NCEPOD Time to intervene - National Confidential Enquiry into Patient Outcome and Death 2012 – www.ncepod.org.uk
• Treatment and care towards the end of life – good practice in decision making GMC 2010 www.gmc-uk.org
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