Improving communication and recording cardiopulmonary resuscitation decisions

Collectively the British Medical Association, Resuscitation Council and Royal College of Nursing (2014) have updated their guidance on 'Decisions relating to cardiopulmonary resuscitation'. Responding to public and professional debate following the court case R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014], the revision emphasizes high quality communication and recording of such decisions. Both are a focus of Care Quality Commission hospital inspections.

Significant failures in establishing and recording patients' resuscitation status were also found in the National Confidential Enquiry into Patient Outcome and Death (2012) report *Time to Intervene – a review of patients who underwent cardiopulmonary resuscitation as a result of in-hospital cardiorespiratory arrest*. The report discovered that only 10% of the patients had their resuscitation status documented. Many patients were denied a dignified death.

Consulting patients

The 2014 British Medical Association, Resuscitation Council and Royal College of Nursing guidance addresses some contentious issues that arise in clinical practice. Foremost, should every patient be consulted regarding resuscitation? It is clearly good practice to take account of the patient's wishes, although the courts recognize that on occasions the decision to consult is one of the utmost sensitivity and difficulty. However, they also argue there should be a presumption in favour of patient involvement, and that there should be convincing reasons not to involve the patient:

'Doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them' (British Medical Association et al, 2014).

If a patient indicates that he/she does not wish to discuss resuscitation, this should be respected and documented, taking a 'best interest decision'. A patient information leaflet may be helpful – the British Medical Association, Resuscitation Council and Royal College of Nursing model patient information leaflet from 2008 is currently under review. The discussion, or reasoning behind not discussing, should be carefully documented.

A patient's relatives should also be consulted if a patient has capacity and is happy for disclosure. If a patient lacks capacity, then the patient's likely wishes, feelings, beliefs and values should be discussed with those close to him/her in order to help make a best interest decision. The family are not the final decision makers and this may need sensitive explanation. In both circumstances such actions should be documented. For those patients who are 'unbefriended', the merits (or not) of resuscitation should be discussed with their advocate (welfare attorney or guardian) if they have one, or else consideration should be given to appointing an Independent Mental Capacity Advocate (seek local guidance). This is unnecessary if resuscitation is clearly thought to be inappropriate (British Medical Association et al, 2014).

Clinical staff are not required to provide treatment considered to be inappropriate. The Tracey case emphasizes the patient's (or relatives') potential access to a second opinion. If communicating the endorsement of a do not resuscitate decision by all members of the multidisciplinary team is not accepted, a second opinion should be considered. This is not a legal obligation. Conversely, if a patient with capacity refuses resuscitation, or a patient lacking capacity has a valid and applicable advance decision refusing treatment, specifically refusing resuscitation, this must be respected.

Assessing capacity

A mental capacity assessment is essential for all patients in whom a resuscitation decision is considered. Patients with capacity are able to understand and retain information regarding the value and limitations of resuscitation. They are also able to weigh up the information given and communicate their decision. The mental capacity assessment should be clearly documented and its correct application and documentation is rightly a focus of Care Quality Commission scrutiny. The mental capacity assessment result may be temporary. It is good clinical practice if patients potentially needing a resuscitation decision are routinely discussed at each ward/board round. Likewise patients with an existing resuscitation decision should be reviewed if their clinical condition has changed (either for better or worse). Relocation of a patient within the hospital (e.g. from intensive care or high dependency unit to a ward) should also trigger review.

Senior medical and nursing staff should consider adopting a culture where any member of the care team prompting a resuscitation decision or review is applauded. Conversely, in the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision. On discharge the resuscitation decision should be reviewed; the patient's GP may have a view. The resuscitation decision should be documented within the discharge summary.

Treatment escalation?

Since 2013 the author's own trust has used the Devon-wide treatment escalation plan and resuscitation decision record. Currently in its tenth version, the form is used widely in the community, primary care and by trusts within the county. Such an initiative is endorsed by the British Medical Association et al's (2014) joint statement: 'a decision form that is used, recognized and accepted across geographical and organisational boundaries is a basic recommendation'.

Crucially, in addition to resuscitation status it has the benefit of guiding carers and health-care providers regarding the need (or not) for escalation of the indi-

vidual's care to an acute hospital. Arguably it may also allow easier discussion regarding resuscitation status with the patient, given that other treatment options (such as intravenous fluids, antibiotics) are explored. The form includes the need or not to activate a combined intensive care team/medical registrar emergency response in the acute hospital. It also incorporates a formal mental capacity assessment.

The use of the treatment escalation plan and resuscitation decision record in this trust has played a significant part in achieving an observed to predicted survival to hospital discharge ratio of 1.41 (national mean 1.0) (Resuscitation Council (UK), 2014). Should the patient be sufficiently well for discharge, the treatment escalation plan and resuscitation decision record form is photocopied for the trust medical records and the original travels with the patient.

The twelve frequently asked questions regarding resuscitation decision making and recording shown in *Table 1* are consistent with both the British Medical Association et al (2014) guidance and National Confidential Enquiry into Patient Outcome and Death (2012) recommendations. They summarize some of the points discussed and may be worth cascading within health-care organizations. **BJHM**

Gavin Lloyd
Consultant Emergency Physician and Trust Lead Clinician for Resuscitation
Emergency Department
Royal Devon & Exeter NHS Foundation Trust
Exeter
Devon EX2 5DW
(gavin.lloyd@nhs.net)

British Medical Association, Resuscitation Council (UK), Royal College of Nursing (2014) Decisions relating to cardiopulmonary resuscitation. www.resus.org.uk/pages/DecisionsRelatingToCPR.pdf (accessed 14 April 2015)

National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2012) Time to Intervene. NCEPOD, London (www.ncepod.org.uk/2012cap.htm accessed 21 April 2015)

R (On behalf of David Tracey personally and on behalf of the Estate of Janet Tracey (Deceased)) v (1) Cambridge University Hospitals NHS Foundation Trust (2) Secretary of State for Health [2014] *EWCA Civ* 822: 54

Resuscitation Council UK (2014) National Cardiac Arrest Audit (NCAA) Overview and status - Updated July 2014. www.resus.org.uk/pages/NCAA.htm (accessed 21 April 2015)

KEY POINTS

- The lack of an appropriate resuscitation decision record indicating 'do not resuscitate' denies the patient a dignified death.
- Doctors should be wary of being too ready to exclude patients from discussing resuscitation on the grounds that their involvement is likely to distress them.
- A clearly documented mental capacity assessment is essential for all patients in whom a resuscitation decision is considered.

Table 1. Twelve things a doctor should know about a resuscitation decision record

Which of my patients should have a resuscitation decision record?	Take a view. A guide is 'would I be surprised if this patient were to die within the next 6–12 months?'. If the answer is no, he/she needs one
Who should make the decision/complete the form?	Ideally the most senior medical clinician looking after the patient. A junior clinician completing the form should consult with a registrar or consultant
Do I discuss the decision with the patient?	There should be a presumption in favour of patient involvement. There should be convincing reasons not to involve the patient. If your patient indicates that he/she does not wish to discuss resuscitation, this should be respected and documented – take a 'best interests' decision
Should I discuss the decision with the family?	Yes if the patient lacks capacity. It's the patient's choice if he/she has capacity
What should I do if my patient lacks capacity and has no one close?	Consult the patient's advocate if he/she has one, or else consider appointing an Independent Mental Capacity Advocate
How do I indicate that my patient lacks capacity?	This should be clearly assessed and documented. Given that a patient's capacity may vary, it is good clinical practice to review resuscitation status and ceiling of care if your patient regains capacity
What if my patient wants resuscitation that I think will be ineffectual?	You are not required to provide treatment you consider to be inappropriate. Consider offering a second opinion
What if my patient declines resuscitation that I believe will be effectual?	If a patient with capacity refuses resuscitation, or a patient lacking capacity has a valid and applicable advance decision refusing treatment, specifically refusing resuscitation, this must be respected
When should my patient's resuscitation decision record form be reviewed?	It is good clinical practice if patients potentially needing a resuscitation form are routinely discussed, and those with an existing resuscitation decision record reviewed at each ward/board round, particularly when the patient's condition has changed
What do I do with the resuscitation decision record form on patient discharge?	Review the resuscitation decision record form decision and/or ask the patient's GP to do the same. Communicate this decision within the discharge summary
The existence of a treatment escalation plan/resuscitation decision record form ≠ not for resuscitation	Should your trust combine a resuscitation decision record with a treatment escalation plan, beware staff misinterpreting the existence of a patient's form as 'not for resuscitation', even though the form may indicate 'for resuscitation'. Good education throughout such a significant change in practice is required
Choking, tracheostomy tube problems and temporary 'do not resuscitate' suspensions	A resuscitation decision record form indicating 'not for resuscitation' does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged. Choking, or a displaced or blocked tracheostomy tube are good examples. Apply common sense. Similarly, it may be appropriate to suspend a do not resuscitate decision temporarily during some procedures, e.g. cardiac catheterisation, pacemaker insertion or surgical operations