Guidance regarding Cardiopulmonary Resuscitation and DNAR Decision-Making during the COVID-19 Pandemic

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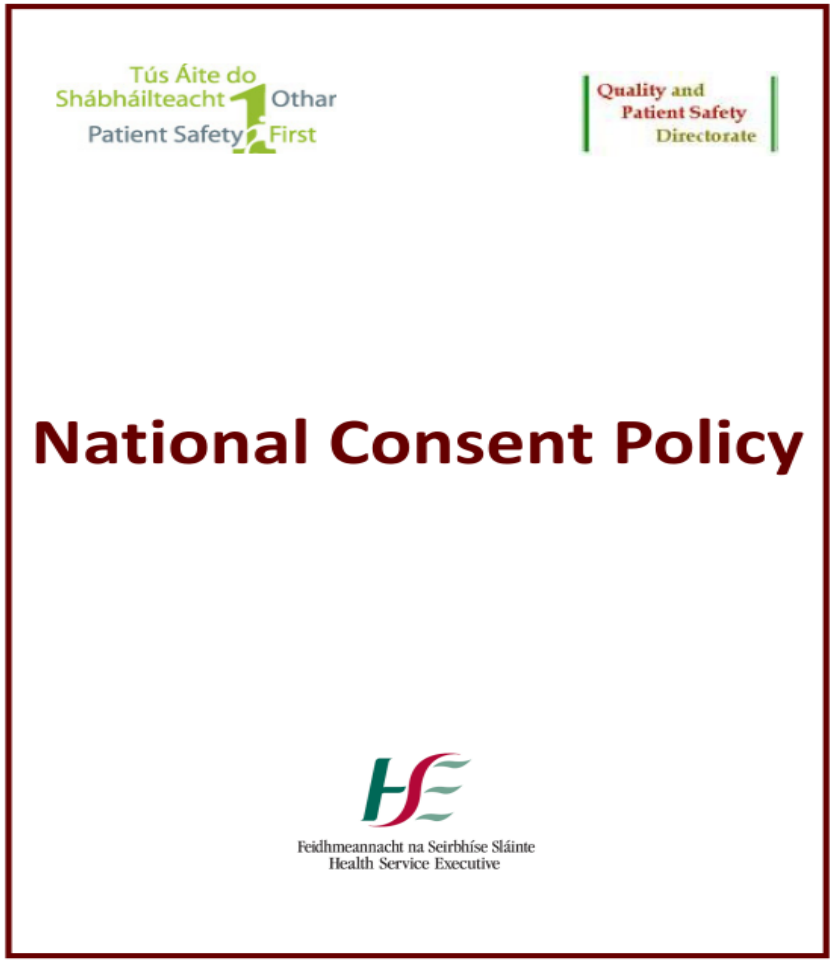
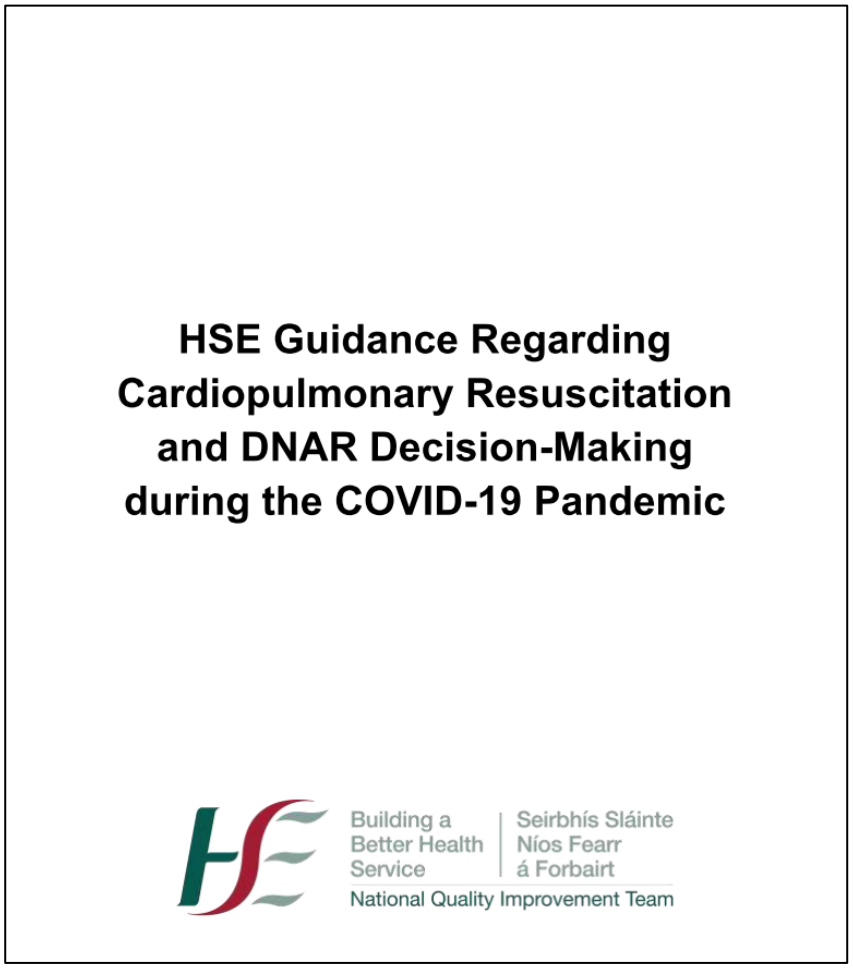




Part 4: Do Not Attempt Resuscitation decisions

N.B. Word ‘consent’ appears nowhere in DNAR policy

What’s Changed? Nothing (Almost!)

Non-Covid Developments

- HSE DNAR policy due to be revised this year
- Implications of “Tracey case”
- Assisted Decision-Making (Capacity) Act 2015 includes advance healthcare directives - not in force yet

Tracey Case UK Court of Appeal

- JT 63yo, metastatic lung cancer, admitted after RTA with serious cervical #.
- Intubated and ventilated, two failed extubations. Conscious and could understand and communicate in writing
- DNAR written but not discussed with JT who objected when she learned of it.
- JT later died without attempted CPR.
- Case alleging breach of JT's human rights by not informing her of DNAR.

Findings

- A presumption in favour of involving the patient; not to do so deprives the patient of the opportunity to seek a second opinion.
- Not to discuss or explain a decision about CPR a potential breach of Article 8 of the European Convention on Human Rights (the right to private and family life), which requires that individuals be notified and consulted with respect to decisions about their care.
- If a clinician 'considers that CPR will not work' the patient cannot demand it, but is still entitled to know that the clinical decision has been taken.

Not legally binding in Ireland **BUT**

- Based on article 8 of the European Convention on Human Rights, which is incorporated into Irish law
- This interpretation of the ECHR may reasonably be expected to apply in Ireland – that is, an Irish court would in a similar case likely reach the same judgment.
- Not informing of DNAR decisions may raise fears of 'hidden' decisions.

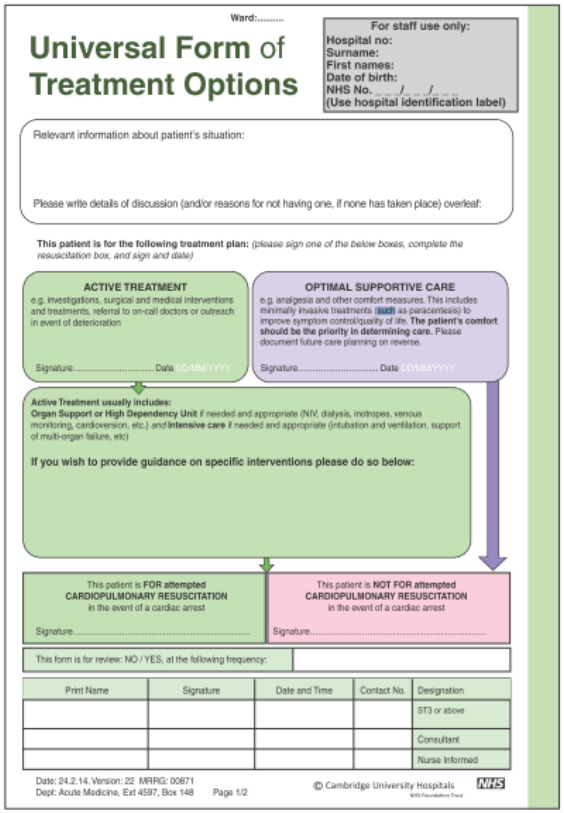
Original: "*However, it should be emphasised that this does not necessarily require explicit discussion of CPR or an 'offer' of CPR*".

New: *"[if] CPR would not be clinically indicated …should be explained sensitively but honestly to the person (or those close to the person). They should be helped to understand the severity of their condition, the inappropriateness of CPR and that a DNAR decision is necessary*."

Advance healthcare directive	Advance care planning
Refusal of treatment is legally binding	Refusal of treatment is not legally binding (but moral force)
Legal document: signature, witnessed, formalities	Healthcare document: no need for signature, formalities
Can only be drawn up by person themselves	Even if the person is unable with support to express their own goals and preferences, discussion between the clinician and those close to the person often allows an appropriate advance care plan to be developed.
No need for any healthcare professional input	Generally developed with or on initiative of healthcare professional
Often more relevant to future care	Often more relevant to current care

One Size Fits All?

- Think Ahead
- Let Me Decide
- POLST
- UFTO



Ward:.....

Universal Form of Treatment Options

For staff use only:
Hospital no:
Surname:
First names:
Date of birth:
NHS No. __ __ __ / __ __ / __ __ __ __
(Use hospital identification label)

Relevant information about patient's situation:

Please write details of discussion (and/or reasons for not having one, if none has taken place) overleaf:

This patient is for the following treatment plan: *(please sign one of the below boxes, complete the resuscitation box, and sign and date)*

ACTIVE TREATMENT
e.g. investigations, surgical and medical interventions and treatments, referral to on-call doctors or outreach in event of deterioration

Signature..... Date: DD/MM/YYYY

OPTIMAL SUPPORTIVE CARE
e.g. analgesia and other comfort measures. This includes minimally invasive treatments (such as paracentesis) to improve symptom control/quality of life. **The patient's comfort should be the priority in determining care.** Please document future care planning on reverse.

Signature..... Date: DD/MM/YYYY

Active Treatment usually includes:
Organ Support or High Dependency Unit if needed and appropriate (NIV, dialysis, inotropes, venous monitoring, cardioversion, etc.) and **Intensive care** if needed and appropriate (intubation and ventilation, support of multi-organ failure, etc)

If you wish to provide guidance on specific interventions please do so below:

This patient is **FOR attempted CARDIOPULMONARY RESUSCITATION** in the event of a cardiac arrest

Signature.....

This patient is **NOT FOR attempted CARDIOPULMONARY RESUSCITATION** in the event of a cardiac arrest

Signature.....

This form is for review: NO / YES, at the following frequency:

Print Name	Signature	Date and Time	Contact No.	Designation
				ST3 or above
				Consultant
				Nurse Informed

Date: 24.2.14. Version: 22 MRRG: 00871
Dept: Acute Medicine, Ext 4597, Box 148 Page 1/2

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Does the Patient have the **mental capacity** to be involved in decisions regarding treatment escalation and CPR? **Yes** ☐ **No** ☐
If 'No' : Decisions regarding treatment/CPR must be made following Best interest principles of the Mental Capacity Act 2005

For staff use only:
Hospital no:
Surname:
First names:
Date of birth:
NHS No. __ __ __ / __ __ / __ __ __ __
(Use hospital identification label)

Documentation of Discussions

These decisions HAVE been discussed with patient/relatives/partner/IMCA (give brief overview of discussion)

These decisions have NOT BEEN discussed with the above for the following reasons

Please record date and time when discussion has taken place:

FUTURE CARE PLANNING:
Many patients wish to be involved in advance care planning, so that their wishes can still be acted upon should they lose decision-making capacity in the future. Please offer patients and families the opportunity to discuss the following and document below:
- **Understanding of disease and prognosis**
- **Important values and goals of care**
- **Preferences for future place of care and potential treatments**

This may be useful for any patient, but is particularly important in those with incurable or progressive disease. Attach relevant documents where necessary.

Print name, signature, designation and date and time (clinical team, **patients**, relatives and/or lasting powers of attorney may write if they wish)

Does patient require Community DNACPR form on discharge? Yes ☐ **No** ☐

Note: this form may be temporarily revoked in context of a procedure which may induce cardiac arrest- e.g. cardiac pacing/angiogram/surgical intervention
Instructions for REVIEW: If the patient's situation changes a new form can be completed and this form should have a line put through it and be filed in the patient's notes.

Date: 24.2.14. Version: 22
Dept: Acute Medicine, Ext 4597, Box 148
Please file behind ALERT sheet when active, and within clinical notes once cancelled
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Covid 19 & DNAR

Fundamental principles of good clinical practice in DNAR decision-making and advance care planning remain the same.

- Having timely discussions
- Eliciting preferences, educating
- Balancing benefit and harm
- Non- discrimination

So, what's different then?

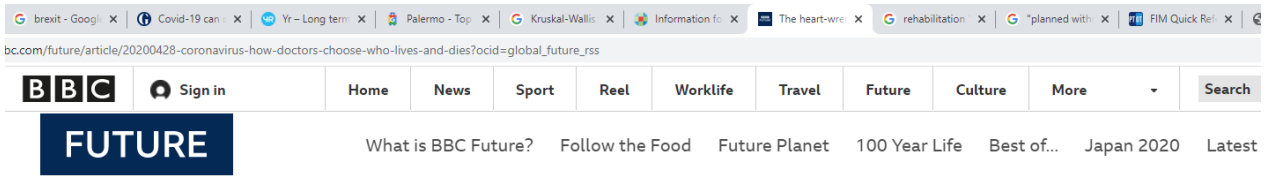
- New challenges - More difficult to get it right
- New pitfalls - New ways to get it wrong

New challenges

- Nature of severe Covid-19 alters benefit/harm of CPR and added urgency to need for advance planning
- Communication in an age of PPE, masks, restricted visiting and face to face consultations
- Risk to staff during CPR/ PPE issues - serious risk of aerosol exposure and infection from some procedures.
- Planning in case of shortage of resources: if too few beds for those with severe Covid needing and wanting ICU

ITV REPORT 2 April 2020 at 12:10am

Coronavirus patients could have treatment withdrawn to save others if hospitals become overwhelmed



HEALTH

The heart-wrenching choice of who lives and dies

Ventilators 'are being rationed for those most likely to survive coronavirus'

FINANCIAL TIMES

"NHS 'score' tool to decide which patients receive critical care"

New pitfalls

‘Pandemicization’ of decision-making

- Allowing surge precautions to influence other care
- Conflating not for ICU with not for hospital admission/ CPR
- Discriminatory group decision-making – especially abuse of scoring systems, older people, people with disabilities, residential care

Coronavirus: GP surgery apology over 'do not resuscitate' form

1 April 2020

Coronavirus pandemic

Purpose new guidance

- Restate existing policy to deal with challenges and avoid pitfalls

- Incorporate relevant new guidance from Department of Health
  - *Ethical Framework for Decision-Making in a Pandemic,*
  - *Ethical Considerations Relating to Critical Care in the context of COVID-19*
  - *Ethical Considerations for Personal Protective Equipment (PPE) Use by Health Care Workers in a Pandemic .*

- Stronger emphasis on advance care planning: In specified circumstances "*it is the responsibility of the senior clinical decision maker to ensure that advance care discussions occur in a timely manner*".

General Principles

- A decision not to attempt CPR applies only to CPR.
- DNAR decisions should be made in the context of the person's overall goals and preferences as well as the likelihood of success and the potential risks and harms.
- If a person with decision-making capacity refuses CPR, this should be respected
- General presumption in favour of CPR…**but**

- When a person lacks decision-making capacity, does not have an advance healthcare directive, but those close to the person with knowledge of their goals and preferences consider they would not want CPR, a DNAR decision should be documented by the senior clinical decision maker.

- In some circumstances, the senior clinical decision maker may judge that the harms of CPR outweigh the potential benefits and that a DNAR decision is appropriate. He or she should explain this to the person and seek their views.

- Some people may be so unwell that death may be imminent and unavoidable and/or a cardiorespiratory arrest would represent the terminal event in their illness or decline. In such circumstances, a DNAR decision is necessary as CPR would not be clinically indicated but may cause harm to the person and increase their suffering.

- Non Discrimination:
  - *An individual should not be obliged to put a DNAR order or advance healthcare directive in place to gain admission to a long-stay care setting...*
  - There should be no discrimination for or against persons who have or are suspected to have COVID-19 in relation to DNAR decisions.
  - The pandemic does not justify deviating from that approach by making DNAR decisions on a group basis.

- Role of family or friends
  - *If the person is unable to participate in discussions after being given appropriate supports… those close to them may have knowledge of their previously expressed goals and preferences. However, [their role] is not to make the final decision regarding CPR or to 'consent' to a DNAR decision as this authority does not exist under current Irish law. The purpose of these discussions is to help the senior clinical decision maker make the most appropriate decision having regard to the goal and preference of the person.*

When there is disagreement about the balance of benefits and risks of CPR

Many disagreements result from miscommunication and misunderstandings…In many such cases, continued discussion will lead to agreement, and an ultimate decision should be deferred pending further discussion.

If disagreement persists, an offer of a second, independent opinion should be made.

Where all previous efforts at resolution have proven unsuccessful it may be necessary for parties to consider obtaining legal advice.

Miscommunication

- CPR is not a cure for ordinary dying
- “Would you like CPR?” – an invitation to sign your own death warrant?
- Need for education, direction from healthcare professionals

A physician who merely spreads an array of vendibles in front of his patient and then says "Go ahead, choose, it's your life" is guilty of shirking his duty...

Inglefinger, NEJM 1980

Out-of-Hospital Cardiac Arrest Register

OHCAR Ireland

At the heart of evidence

Ireland: Seven year period 2012 – 2018

- OHCAR cases of arrest in Residential Care Facility = **1,239**
- Number of survivors = **28** (**2.3%**)
- Urban setting, witnessed arrest, shockable rhythm and early defibrillation predicted survival.
- Call response time for survivors was median 9 minutes
- Successful OHCAR CPR even less likely during Covid-19?

Emergency Radiology | Published: 09 November 2017

Use of whole body CT to detect patterns of CPR-related injuries after sudden cardiac arrest

- 85% rib fractures
- 31% sternal fractures
- 13% mediastinal haematoma
- 10% pneumothorax
- 8% pneumomediastinum
- 3% haemothorax
- 8% abdominal injuries

'If the expected outcome is death, a procedure less dignified and peaceful could hardly be devised'.

(Saunders 1992)

Reviewing DNAR orders

- Some DNAR decisions are made in the context of a severe acute illness.
  - Such decisions should be kept under review, especially if the person's clinical condition, including their ability to express their own goals and preferences, improves significantly.
  - In some cases, it may be helpful to put down a date for review of the decision although that should not preclude earlier reconsideration.

- Other DNAR decisions are made because of severe chronic diseases or where a person is approaching the end of life. These circumstances are unlikely to change and it is not necessary that such DNAR decisions are reviewed unless the person wishes and indicates this.

Disseminating DNAR decisions

- If an ACP or DNAR decision is made, it is important that procedures are in place locally to ensure that staff who may not be familiar with the person can rapidly determine the most appropriate care in an emergency.
- An agreed local procedure is also required to ensure an ACP or DNAR decision made in one setting and intended to apply in another setting can be communicated when the person moves.
- For DNAR decisions, this requires that staff in the second setting are aware of the DNAR and can be confident that it was made appropriately. This would require, at a minimum, information on who had made the decision, why, whether the person had been involved (and if not, why) and whether a review was envisaged. If the person has capacity, they should be asked if their wishes have changed.