Irish Medical Journal
Established 1867

Issue: Ir Med J; Vol 114; No. 6; P384

Discussion and Documentation of "Do Not Attempt Resuscitation" Decisions in an Inpatient Population

A. McDonough, S. O'Hanlon

St. Columcille's Hospital, Dublin.

Abstract

Aims

To audit practices around discussion and documentation of resuscitation status in our hospital.

Methods

A chart review of all one hundred and six inpatients to audit adherence to hospital "Do not attempt resuscitation" (DNAR) policy.

Results

Mean age was 79.8 years. Twenty-seven patients (25.5%) had a DNAR order in place. No DNAR forms were fully complete. Twenty DNAR forms (74.1%) had not been discussed with the patient or there was no documentation of a reason as to why the decision had not been discussed. Median time from admission to DNAR status was 5 days (range 0-254).

Conclusion

A systematic approach to advance care planning is needed, particularly in older inpatients with frailty. This should be coupled with staff education, to create a culture where discussing and appropriately documenting advance care planning is part of routine care.

Introduction

Survival to discharge is less than 20% for in-hospital cardiac arrest. [1, 2] Discussing resuscitation status and ceilings of treatment should be a routine part of inpatient care, particularly for older people or those with frailty. However, it is frequently neglected until a patient is acutely unwell. The Clinical Frailty Scale (CFS) [3] is a useful tool for providing predictive information about outcomes in older patients. The CFS is routinely determined for older patients admitted to our hospital.

The National Consent Policy recommends that discussions around DNAR orders occur for patients with "an identifiable risk of cardiorespiratory arrest". [4] In the wake of the Covid-19 pandemic, there was renewed focus on making early decisions around ceilings of treatment. [5]

The documentation of discussions about resuscitation can be time-consuming. The discussion itself can be difficult, particularly for acutely unwell patients or those with cognitive impairment. The National Consent Policy recommends that DNAR decisions be made with patients themselves, or with family members if they cannot participate [4] . Decisions should be carefully documented by a senior decision maker. Our hospital's DNAR form reflects these recommendations.

The inpatient population in our model 2 hospital, St. Columcille's Hospital, includes many older patients with frailty, acutely admitted or transferred for rehabilitation. Access to anaesthetics, intensive care or non-invasive ventilation requires transfer to a tertiary centre. Given these limitations, discussing ceilings of treatment and resuscitation status is highly relevant. We aimed to audit existing practices, with a view to improvement.

Methods

A chart review was carried out for all one hundred and six inpatients on one day in May 2019 to audit adherence to the standards of our hospital DNAR policy. Data was extracted on demographics, CFS and resuscitation status. Basic statistical analysis was carried out, using the 2-sample t test to compare groups.

Results

The mean age of inpatients was 79.8 years (SD=12.67). On admission, the mean CFS was 5 or mildly frail (SD=1.46). Sixteen patients (15.1%) had a CFS of 7 or more, and thirty (28.3%) had a diagnosis of dementia.

Twenty-seven patients (25.5%) had a DNAR order in place. Of these, twenty-five patients (92.6%) had their resuscitation status documented in the nursing notes. Twenty-seven patients (100%) had a DNAR form in their medical notes, but none were fully completed. Nine DNAR forms (33.3%) were missing a review date. On thirteen forms (48.2%), the decision had not been endorsed by a consultant. Twenty DNAR forms (74.1%) had not been discussed with the patient or there was no documentation of a reason as to why the decision had not been discussed.

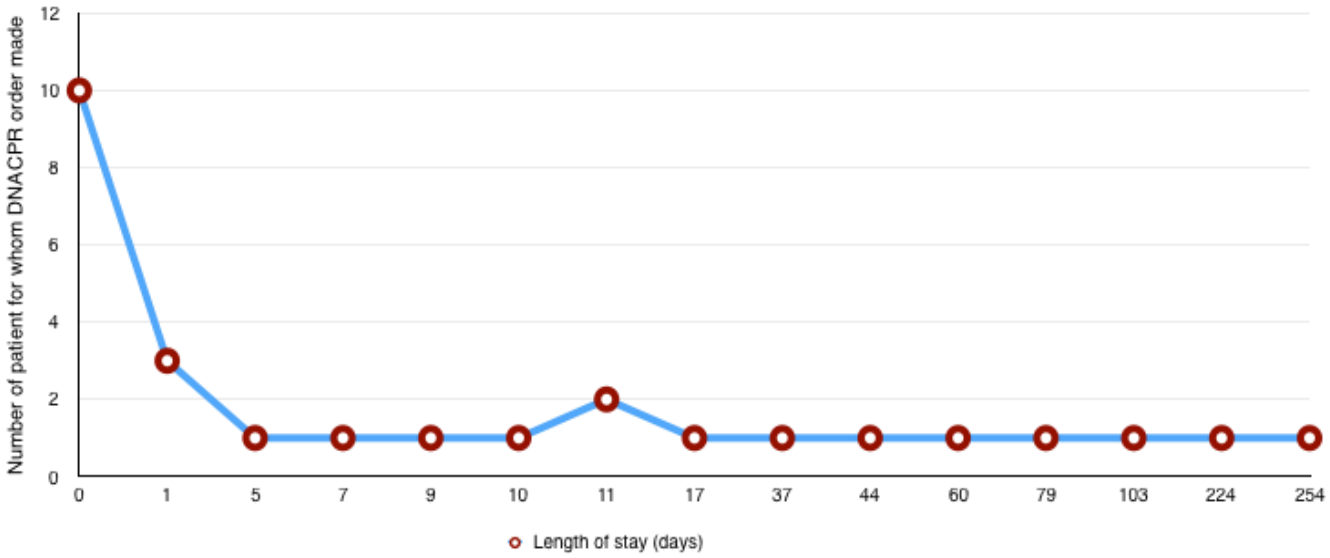

Fig.1: Time from admission until DNACPR order put in place.

Patients with a DNAR order in place were significantly older (85.8 years versus 77 years, p=0.0009) and had a higher CFS (5.8 versus 4.9, p=0.03).

Median time from admission until DNAR was put in place was 5 days (Range 0-254, IQR=37) (Fig.1). Thirteen (48.2%) of those with a DNAR had it in place within 24 hours of admission. This group were significantly older (90.9 versus 81.1 years, p=0.004). Their CFS was not significantly different to those who had a later DNAR order.

Discussion

In our hospital, patients who were older and had a higher CFS were more likely to have a DNAR order, and it was in place at an earlier stage in their admission. While the CFS is not a comprehensive assessment of a patient's functional status, it could be considered when discussing the appropriateness of resuscitation in older people, particularly for doctors who are unaccustomed to these discussions.

The timing of DNAR decisions is also relevant, with sometimes prolonged periods between admission and the DNAR decision being made, reflecting the lack of a systematic approach to advance care planning. The introduction of Treatment Escalation Plans, which focus on the interventions a patient will or will not receive [6], is one option to consider prior to re-audit. This would be particularly useful for our older population with frailty, to promote routine advance care planning and review.

DNAR forms are seldom completed in their entirety, with important details frequently overlooked. This can lead to confusion around appropriate interventions. [7] Patient and family involvement in discussions is not always documented, contrary to national guidelines. [5] Discussions with patients may not always be appropriate due to an acute illness, but documenting the reasons for their exclusion is the expected standard of care and the focus of staff education.

Although this data was collected prior to the Covid-19 pandemic, reflecting on our practices around discussion of resuscitation status is all the more relevant today. As DNAR decisions are increasingly being made on admission, in the emergency department and on acute hospital wards, our practice should be in line with national recommendations [4]. The ongoing challenge is to create a culture in our hospital where patients are supported by staff members to engage in planning for their future care.

Declaration of Conflicts of Interest:
The authors have no conflicts of interest to declare.

Corresponding Author:
Anna McDonough
St. Columcille's Hospital, Dublin.
E-mail: amcdonough@stjames.ie

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