Advance Care planning, DNACPR and RESPECT

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Consultant in Palliative Medicine,
Hinchingbrooke Hospital

St Johns hospice, Moggerhanger

Mr Jones, 76

- COPD, type 2 diabetes, HTN
- Recurrent chest infections
- Lives with his wife who has Alzheimers
- Increased frequency of LRTI with minimal time between courses of antibiotics. Sees own GP regularly.
- OOH call from daughter that he is unwell, fever, delerious. She says he doesn't want to go to hospital.
- What would you like to know?

- ***'Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.'***
- *International Consensus Definition of Advance Care Planning (Sudore et al 2017)*

Advance Care Planning discussions

In line with the UK Mental Capacity Act

Mental Capacity Act 2005

ACP must meet the requirements of MCA

- Assumed capacity
- Supported to make own decision even if ***unwise***
- Best interests
- Least restrictive option of their rights and freedom

Who is the decision maker?

- Patient
- ADRT
- LPA
- Doctor

Office of the Public Guardian

Form
LP1H

Lasting power of attorney

Registering an LPA costs
£110

Health and care decisions

Use this for:

- the type of health care and medical treatment you receive, including life-sustaining treatment
- where you live
- day-to-day matters such as your diet and daily routine

How to complete this form

PLEASE WRITE IN CAPITAL LETTERS USING A BLACK PEN

Mark your choice with an X.

If you make a mistake, fill in the box and then mark the correct choice with an X.

Don't use correction fluid. Cross out mistakes and rewrite neatly. Everyone involved in each section must initial each change.

Making an LPA online is simpler, cleaner and faster

Our smart online form gives you just the right amount of help exactly when you need it. **www.gov.uk/power-of-attorney**

This form is also available in Welsh. Call the helpline on 0300 456 0300.

Before you start...

Office of the Public Guardian

Form
LP1F

Lasting power of attorney

Registering an LPA costs
£110

Financial decisions

Use this for:

- running your bank and savings accounts
- making or selling investments
- paying your bills
- buying or selling your house

How to complete this form

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Mark your choice with an X.

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Before you start...

'Thinking Ahead' – GSF Advance Care Planning Discussion

the gold standards framework

Thinking ahead….

1. At this time in your life what is it that makes you happy or you feel is important to you?

2. What elements of care are important to you and what would you like to happen in future?

3. What would you **NOT** want to happen? Is there anything that you worry about or fear happening?

4. *Do you have a Legal Advance Decision to Refuse Treatment document?* **(This is in keeping with the Mental Capacity Act (2005) and enables people to make decisions that will be useful if at some future stage they can no longer express their views themselves)** ***No / Yes***

If yes please give details (eg who has a copy?)

5. **Proxy / next of kin**

Who else would you like to be involved if it ever becomes difficult for you to make decisions or if there was an emergency? Do they have official Lasting Power of Attorney (LPoA)?

Validity of an ADRT

- Must be in writing if refusing treatment which is life sustaining- *Template examples available*
- Can only be made by a person age 18+ who has capacity
- Only applies when the person is incapacitated
- Must be signed by the maker and in the presence of a witness
- Must be a specific statement about a specific treatment in a specific circumstance
- Wording must clearly state **'even if life is at risk'**

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 16 years and over

In the event of cardiac or respiratory arrest do not attempt cardiopulmonary resuscitation (CPR)
All other appropriate treatment and care will be provided

NHS
East of England

Name:

Address:

Date of birth: / /

NHS number:

Date of DNACPR order:
/ /

Reason for DNACPR decision (tick one or more boxes and provide further information)

☐ CPR is unlikely to be successful [i.e. medically futile] because:

☐ Successful CPR is likely to result in a length and quality of life not in the best interests of the patient because:

☐ Patient does not want to be resuscitated as evidenced by:

Record of discussion of decision (tick one or more boxes and provide further information)

Discussed with the patient / Lasting Power of Attorney [welfare]? Yes ☐ No ☐
If 'yes' record content of discussion. If 'no' say why not discussed.

Discussed with relatives/carers/others? Yes ☐ No ☐
If 'yes' record name, relationship to patient and content of discussion. If 'no' say why not discussed.

Discussed with other members of the health care team? Yes ☐ No ☐
If 'yes' record name, role and content of discussion. If 'no' say why not discussed.

Healthcare professional completing this DNACPR order

Name: Signature:

Position: Date: / / Time:

Review and endorsement by responsible senior clinician

Name: Signature:

Position: Date: / / Time:

Is DNACPR decision indefinite? Yes ☐ No ☐ If 'no' specify review date: / /

Professional Guidance - Resus Council / GMC

- https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

- GMC- 132. As with other treatments, decisions about whether CPR should be attempted must be based on the ***circumstances and wishes of the individual patient***. This may involve ***discussions with the patient or with those close to them, or both, as well as members of the healthcare team***. You must approach discussions sensitively and bear in mind that some patients, or those close to them, may have concerns that decisions not to attempt CPR might be influenced by poorly informed or unfounded assumptions about the impact of disability or advanced age on the patient's quality of life.

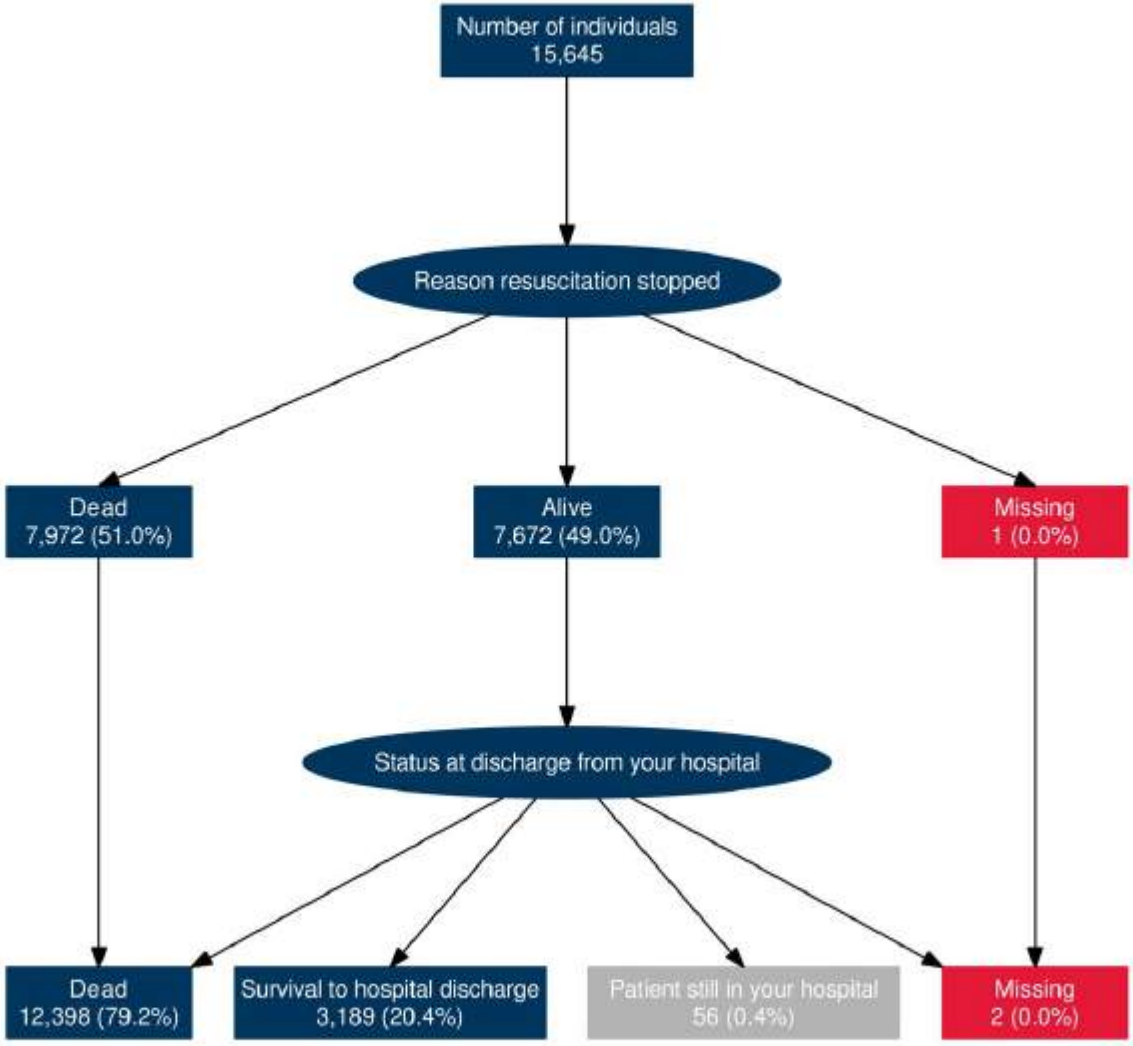
Definitions - Cardiopulmonary Arrest

- Sudden cessation of spontaneous breathing and circulation.
- Commonest causes: trauma / blood loss / cardiac arrhythmia / massive PE / cerebral bleed/thrombosis.

CPR

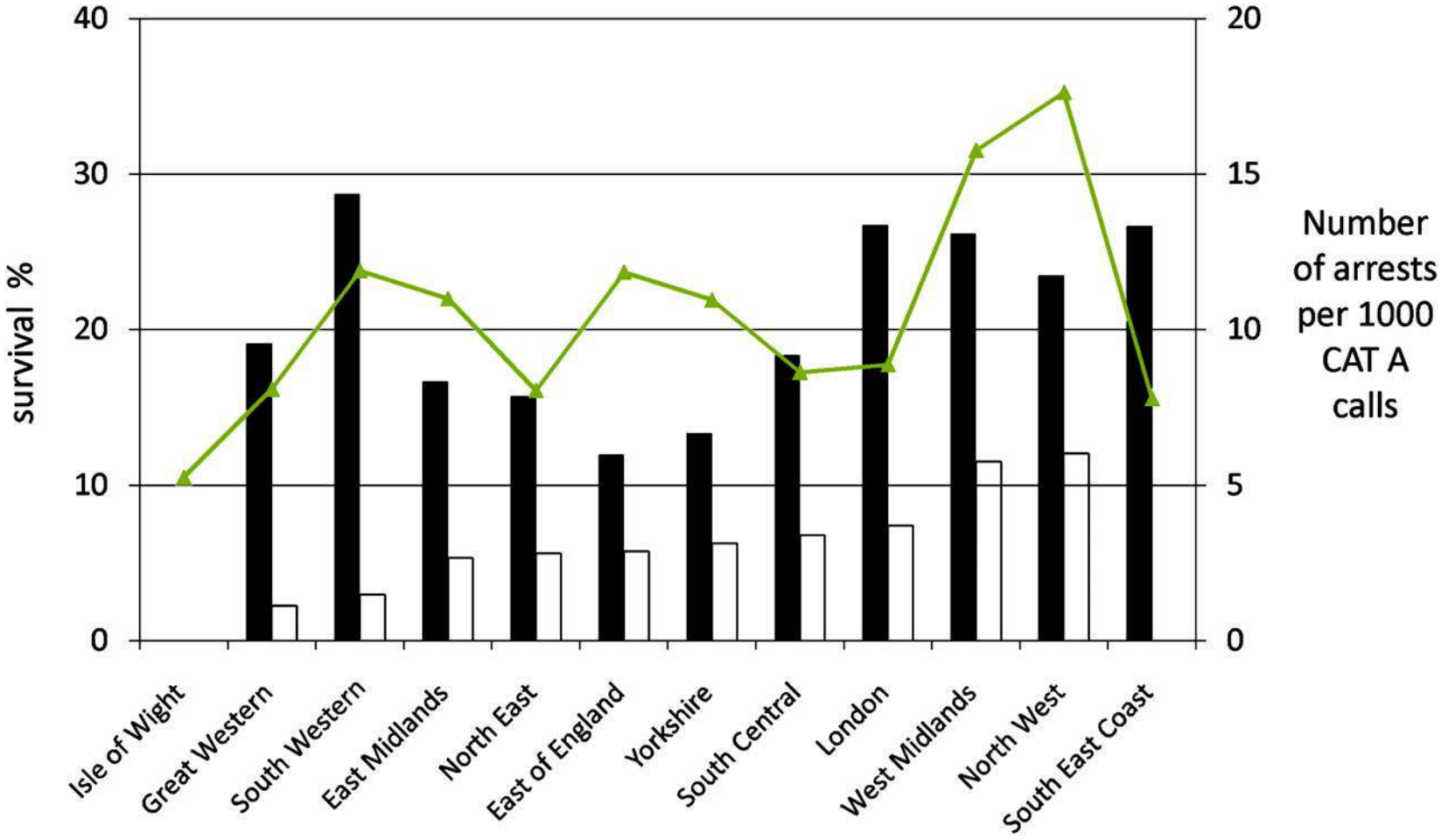
- 1960
- Intended for sudden cardiac / resp arrest
- Acute care settings (trauma, emergency med, ICU)
- Provides emergency support as a ‘holding measure’ to a technically dead patient before more intensive care can be commenced.
- NOT for prolonging dying
- Resuscitation, NOT resurrection!
- How successful is it?

Outcome flow



All percentages are reported as the percentage of all individuals (N=15,645).

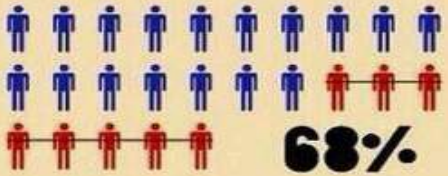
Cardiac arrest, return of spontaneous circulation (ROSC) and survival to discharge rates for UK Ambulance Services (April 2011).



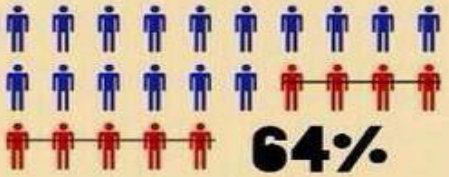
Gavin D Perkins, and Matthew W Cooke Emerg Med J 2012;29:3-5

CPR SURVIVAL RATES: ON SCREEN VS. REAL LIFE

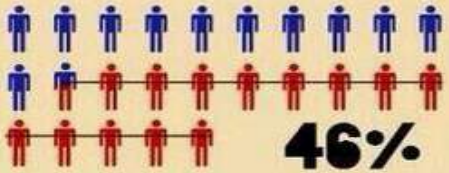
ER



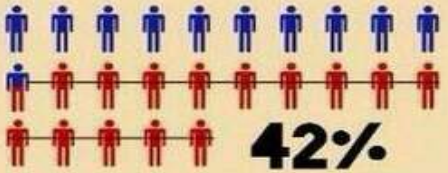
CHICAGO HOPE



GREY'S ANATOMY



CASUAL+Y



IN REAL LIFE...

12%

IN THE REAL WORLD, CPR SAVES JUST ONE IN EIGHT HOSPITAL PATIENTS.

White Coat, Black Art
with Dr. Brian Goldman

Piktochart
make information beautiful

WHEN DOES CPR HAVE THE BEST CHANCE?

- Witnessed arrest
- Immediate BLS
- Defib asap for VF / VT
- Generally robust health
- Non- cancer diagnosis
- CA with no or limited metastases
- Good performance status (not housebound)
- No known infection, esp chest
- Normotensive

POTENTIAL HARMS OF CPR

- Broken ribs / sternum
- Pneumothorax
- Other organ damage (heart / liver)
- Neurological disability
- Family distress witnessing CPR (beware of over-paternalising)
- Staff distress
- Diversion of resources

Reasons for DNACPR

A) <u>FUTILITY NOT A VALID REASON</u>

B) BASED ON BALANCE OF BENEFITS / BURDENS

C)PATIENT HAS VALID ADRT (specifically to REFUSE CPR)

CPR DISCUSSIONS – Who to involve?

- Patient with mental capacity
- Will they engage?
- Confidentiality

- Patient lacks mental capacity
- Most senior clinician responsible for decision
- Is there a valid and applicable ADRT?
- Is there a welfare attorney (LPA) or other legal surrogate?
- Do they have family / friends / others involved for best interests meeting?
- IMCA if no advocate (esp if benefits / burdens decision)

Be clear whose decision it is

- Are you asking or informing?
- In “Best Interests” setting, NOT asking family to make the decision
- Their views on what the patient would want will be taken into account
- Cannot insist on a treatment, or on witholding / withdrawing a treatment

What about the Cambridge ruling (Court of Appeal 2014)?

Presumption in favour of patient involvement

Unless:

Expressed wish not to discuss

Likely to cause HARM(physical/psychological

Not just distress

What if there is disagreement?

- No legal right to a treatment that is clinically inappropriate

- But offer second opinion

(not legally obliged if unanimous MDT decision)

Ethical Considerations in Medicine

- 4 cardinal principles
- Doctors have a dual responsibility-to preserve life and relieve suffering
- At the end of life ,relief of suffering increases in importance as preserving life becomes increasingly impossible.

As with all decisions...Document carefully

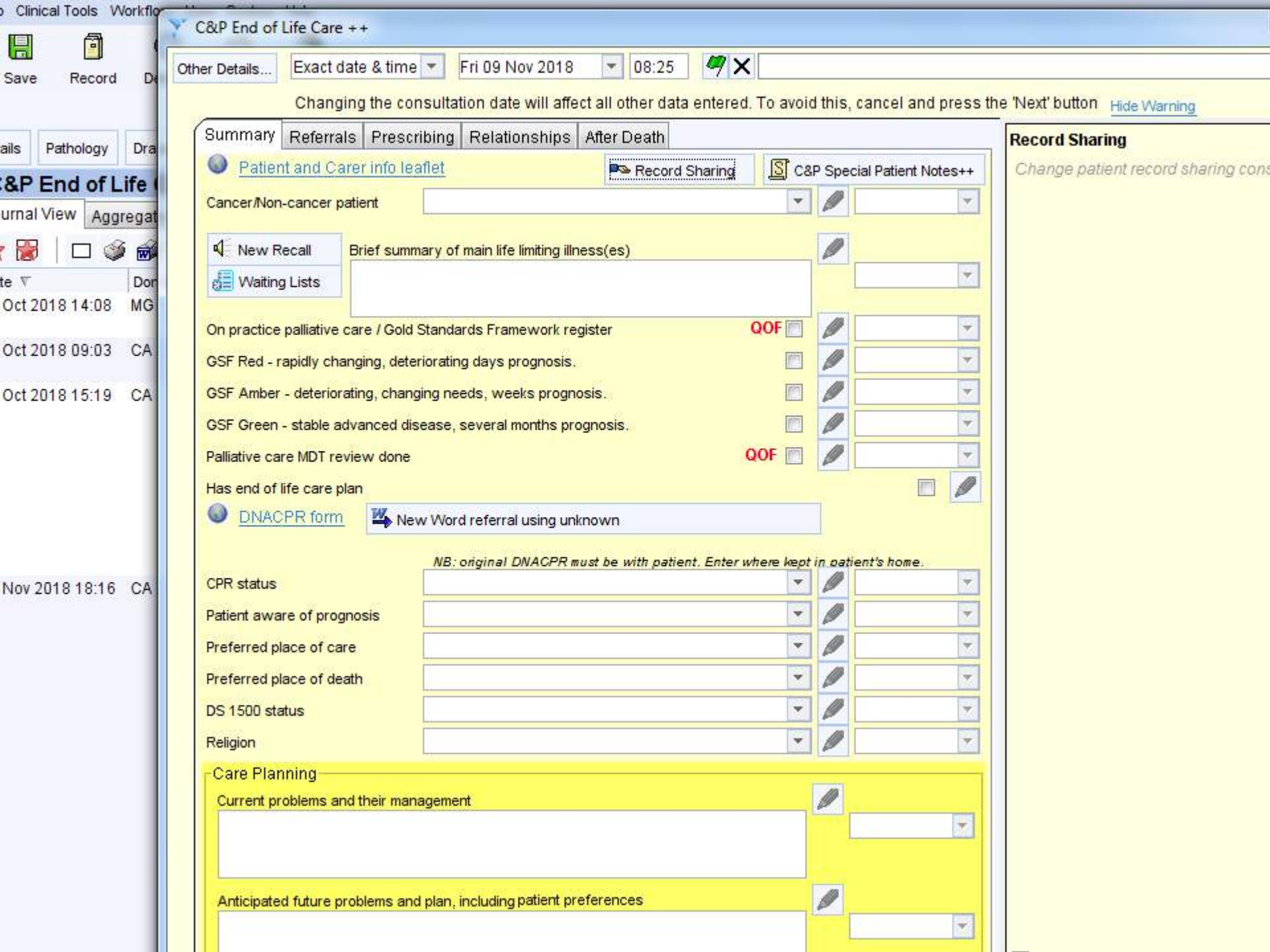
- Attempts to involve patient
- Rationale for decisions
- Who was involved / consulted
- Reasons why discussion would be harmful
- Any conflict

OTHER CEILINGS OF TREATMENT

- Antibiotics (oral vs IV)
- Ventilation (invasive vs NIV vs optiflow)
- Artificial hydration and nutrition (PEG / NG)
- Hospitalisation vs Home / Hospice-based care
- Ward vs ITU
- Don’t forget ICD’s !

WHERE TO RECORD?

Systm One (EPaCCS)
Web-based
Accessible across care boundaries
Including OOH primary care, ambulances, A&E


Clinical Tools
Save
Record
Pathology
Oct 2018 14:08
Oct 2018 09:03
Oct 2018 15:19
Nov 2018 18:16
C&P End of Life Care ++
Other Details...
Exact date & time
Fri 09 Nov 2018
08:25
Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button
Hide Warning
Summary
Referrals
Prescribing
Relationships
After Death
Patient and Carer info leaflet
Record Sharing
C&P Special Patient Notes++
Cancer/Non-cancer patient
New Recall
Waiting Lists
Brief summary of main life limiting illness(es)
On practice palliative care / Gold Standards Framework register
QOF
GSF Red - rapidly changing, deteriorating days prognosis.
GSF Amber - deteriorating, changing needs, weeks prognosis.
GSF Green - stable advanced disease, several months prognosis.
Palliative care MDT review done
QOF
Has end of life care plan
DNACPR form
New Word referral using unknown
NB: original DNACPR must be with patient. Enter where kept in patient's home.
CPR status
Patient aware of prognosis
Preferred place of care
Preferred place of death
DS 1500 status
Religion
Care Planning
Current problems and their management
Anticipated future problems and plan, including patient preferences
Record Sharing
Change patient record sharing cons

Other Details... | Exact date & time | Fri 09 Nov 2018 | 08:25

Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button Hide Warning

Summary | Referrals | Prescribing | Relationships | After Death

Housing details

Family and informal carer aware of prognosis

Leaflet for carer - the final days of life

Has appointed person with personal welfare LPA (MCA 2005)

Lasting Power of Attorney info

Power of Attorney can be recorded within the Relationship dialog box.

ADRT info

Has ADRT (Advance Decision to Refuse Treatment) (MCA 2005)

Current Relationships

Record Carer | Record Community Matron

Record Macmillan Nurse | Record District Nurse

Record other relationships:
Record Relationship

Housing details

Date | Selection | ...

No previous values

Show recordings from other templates

Show empty recordings

ReSPECT

Recommended

Summary

Plan for

Emergency

Care and

Treatment

www.respectprocess.org.uk

ReSPECT

ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future **emergency** in which they are unable to make or express choices.

It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

ReSPECT Recommended Summary Plan for Emergency Care and Treatment for: Preferred name

1. Personal details

Full name

NHS/CHI/Health and care number

Date of birth

Address

Date completed

2. Summary of relevant information for this plan (see also section 6)

Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded.

Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse Treatment, Advance Care Plan). Also include known wishes about organ donation.

3. Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care (you may mark along the scale, if you wish):

Prioritise sustaining life, even at the expense of some comfort

Prioritise comfort, even at the expense of sustaining life

Considering the above priorities, what is most important to you is (optional):

4. Clinical recommendations for emergency care and treatment

Focus on life-sustaining treatment as per guidance below
clinician signature

Focus on symptom control as per guidance below
clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

CPR attempts recommended Adult or child	For modified CPR **Child only, as detailed above**	CPR attempts **NOT** recommended Adult or child
clinician signature	clinician signature	clinician signature

5. Capacity and representation at time of completion

Does the person have sufficient capacity to participate in making the recommendations on this plan? **Yes / No**

Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility) who can participate on their behalf in making the recommendations? **Yes / No / Unknown**
If so, document details in emergency contact section below

6. Involvement in making this plan

The clinician(s) signing this plan is/are confirming that these recommendations have (circle at least one):

- **A** been recorded after discussion involving this person, who has sufficient mental capacity to participate in making relevant decisions
- **B** where appropriate, been discussed with a person holding parental responsibility
- **C** in the case of a person who does not have sufficient mental capacity to participate in relevant decision-making, been made in accordance with capacity law
- **D** been made without involving the patient (or best interests/overall benefit meeting if the patient lacks capacity)

If **D** has been circled, state valid reasons here. Document full explanation in the clinical record.

Date, names and roles of those involved in discussion, and where records of discussions can be found:

7. Clinicians' signatures

Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC Number	Signature	Date & time
Senior responsible clinician				

8. Emergency contacts

Role	Name	Telephone	Other details
Legal proxy/parent			
Family/friend			
GP			
Lead Consultant			
Other			

9. Confirmation of validity (e.g. for change of condition)

Review date	Designation (grade/speciality)	Clinician name	GMC/NMC/ HCPC number	Signature

ReSPECT

The plan is created through conversations between a person and their health professionals.

ReSPECT can be complementary to a wider process of advance/anticipatory care planning.

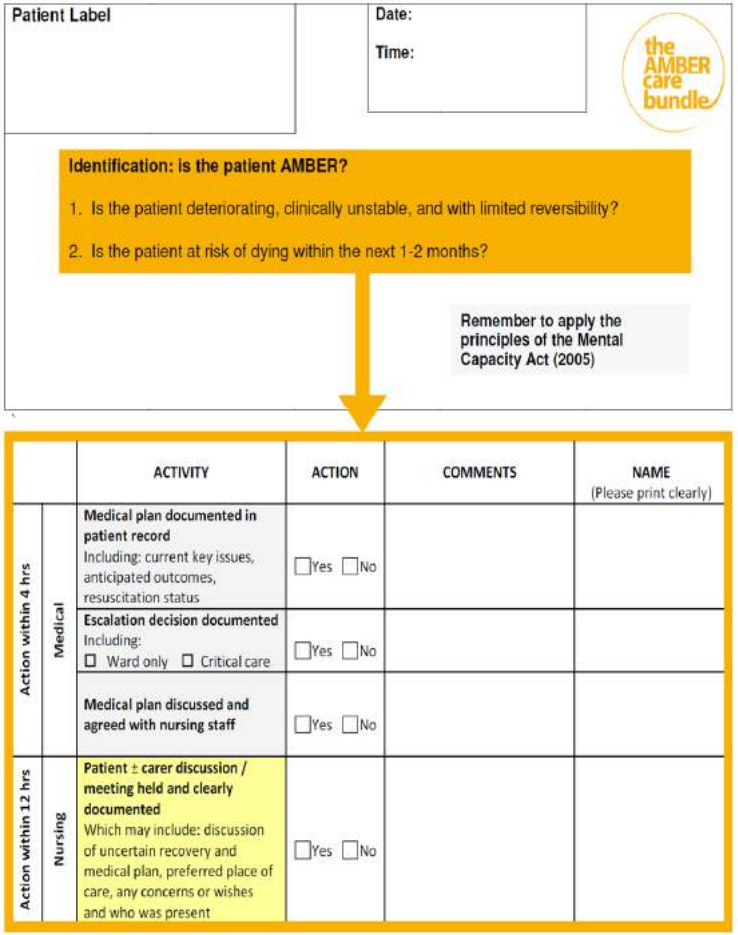
AMBER

Ward staff identify patients….

- Deteriorating, clinically unstable , limited reversibility?
- At risk of dying in this admission?

- Communication aid
- Discussion with patient& family
- Ceiling of care
- DNAR
- PPC and PPD

Discharge summary



Patient Label

Date:

Time:

the AMBER care bundle

Identification: is the patient AMBER?

1. Is the patient deteriorating, clinically unstable, and with limited reversibility?
2. Is the patient at risk of dying within the next 1-2 months?

Remember to apply the principles of the Mental Capacity Act (2005)

		ACTIVITY	ACTION	COMMENTS	NAME (Please print clearly)
Action within 4 hrs	Medical	**Medical plan documented in patient record** Including: current key issues, anticipated outcomes, resuscitation status	☐Yes ☐No		
		Escalation decision documented Including: ☐ Ward only ☐ Critical care	☐Yes ☐No		
		Medical plan discussed and agreed with nursing staff	☐Yes ☐No		
Action within 12 hrs	Nursing	**Patient ± carer discussion / meeting held and clearly documented** Which may include: discussion of uncertain recovery and medical plan, preferred place of care, any concerns or wishes and who was present	☐Yes ☐No		

In practice…..

- ACP is incredibly useful for clinicians who do not know the patient and at a time when patient cannot make their own decisions

- How do terminally ill patients die?
  - Increasing somnolence
  - Loss of consciousness over time
  - Cheyne Stokes Respiration.
  - Heart stops

REFERENCES

- BMA, RCN, Resuscitation Council (UK) 2014 Decisions relating to cardiopulmonary resuscitation. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing
- Thomas K and Lobo B. Advance Care Planning in End of Life Care. OUP 2011
- www.southcentral.nhs.uk/what-we-are-doing/end-of-life-care/dnacpr-acp-documents
- Key Statistics from the National Cardiac Arrest Audit 2016/17. Resuscitation Council
- www.respectprocess.org.uk
- http://www.goldstandardsframework.org.uk/advance-care-planning
- **Gavin D Perkins, and Matthew W Cooke Emerg Med J 2012;29:3-5 Cardiac arrest, return of spontaneous circulation (ROSC) and survival to discharge rates for UK Ambulance Services (April 2011).**
- **https://www.gov.uk/power-of-attorney**

QUESTIONS ?