Service Priorities and Programmes

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"Do-Not-Attempt Cardiopulmonary Resuscitation" (DNACPR) Orders at the Acute Medical Night Admission Ward in a Regional Hospital

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Introduction

With the promulgation of revised Guidelines on DNACPR by HA on 20 January 2016, regular audit was recommended to review this important aspect of clinical care. Currently the United Ambulatory Care Centre (UACC) of UCH serves as the location for admitting patients requiring hospitalised medical care at nights.

Objectives

To review the DNACPR orders issued at UACC, and to look for issues for improvement.

Methodology

Patients with DNACPR orders issued within the period were reviewed. Copies of initially signed DNACPR forms were retrieved. Case notes for their corresponding hospitalizations were investigated. Demographic information of patients along with their medical backgrounds, communication and decision-making processes, outcomes and survival status were collected with relevant data analyzed.

Result

89 patients were admitted through UACC at night with DNACPR orders issued. Men 46%. Mean age 79.5. Clinical conditions triggering the DNACPR decisions: terminal illness (53%), poor response to optimal therapy (28%), profound neurological damage (11%), and others (7%). Their predominant background illnesses were: cancer (36%), organ failure (17%), dementia or neurodegenerative disorder (25%), and complex (14%). Mortality rates at one week, 1 month and 2 months were 46%, 63% and 69% respectively. 9% were mentally competent while 81% were not.
Majority of the DNACPR decisions (94%) were made following the doctors' discussions with competent patients or with family members of incompetent patients. Of 8 competent patients, corroborative discussions with their family member(s) were identified in 4 cases. Family members of incompetent patients, as approached by

doctors for discussions were: spouses (18%), children (67%), other relatives (8%). In case of incompetent patients, with advancing age (means 85 vs 74; $p < 0.05$), their children were more likely than spouses to be approached by the doctor for discussing DNACPR.
The recorded basis of DNACPR orders were: futility (79%); autonomy (2%); both futility and autonomy (15%)
Documentation of specialist participation (by signature or endorsement) was found in 30% of the initially signed DNACPR forms. The cumulative rates of completion by specialists' signatures over the following 1 to 4 days were respectively: 64%, 83%, 89% and 91%.
4 incidences of Section VII usage were noted. Two patients died shortly (0 and 3 days) afterwards. Two others died at later dates (65 and 72 days).
The absence of a specialist's signature in 8 forms (9%) were associated with following circumstances: DNACPR order revoked following specialist's review or regret on the part of the family; Section VII used and the patient died soon afterwards; DNACPR Form for Non-Hospitalized Patient in place; endorsement by specialist available; no specialist endorsement was documented.
Issues identified: quality for documentation of clinical judgement, communication and decision; challenges in using Section VII - highlighting the need for proper advance care planning.