

Recognising When CPR Won't Work: An Audit of Clinical Practice in NHS Tayside

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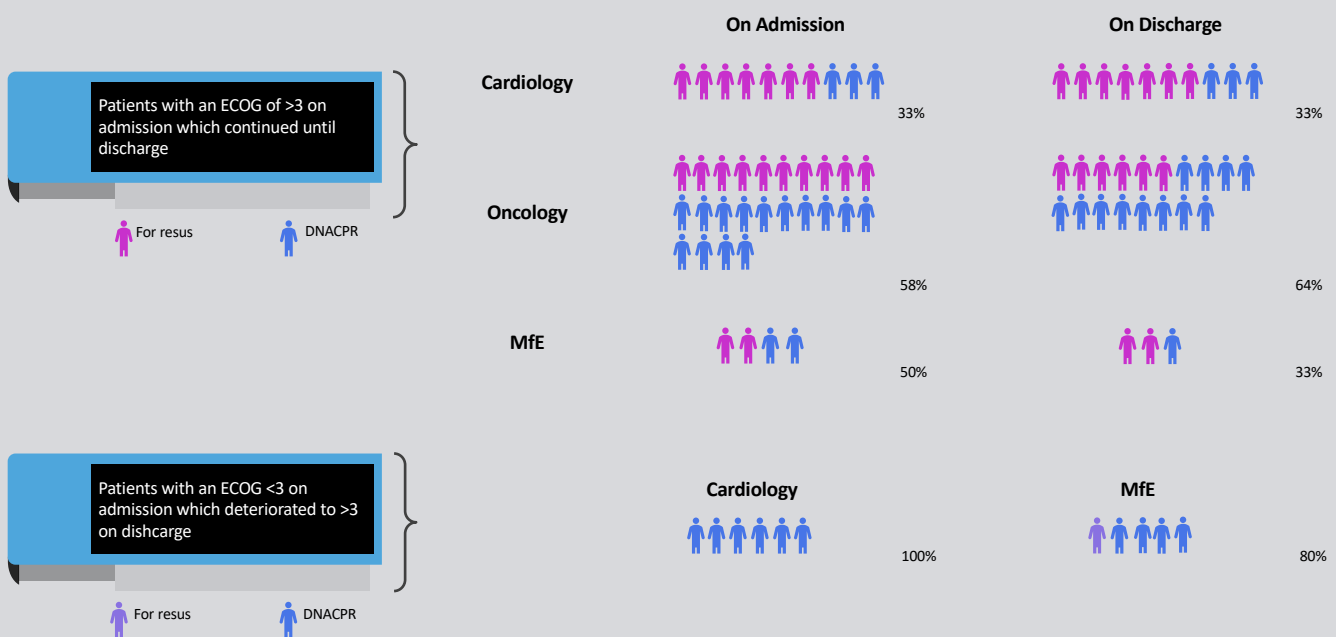
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It is widely acknowledged that patients with an ECOG of 3 or greater (i.e.: spending more than 50% of time in a chair or bed), are unlikely to have successful resuscitation and that DNACPR forms should be considered in this group of patients.

Our aims were to determine whether NHS Tayside is appropriately completing DNACPR forms in this group of patients and when this is happening in the patient journey.

Notes and Key Information Summaries (KIS) were retrospectively audited for all patients admitted to the Cardiology and Oncology wards in Ninewells Hospital, as well as the Medicine for the Elderly Rehabilitation (MfE) ward in Perth Royal Infirmary in October 2016.

Data collected included patient age and diagnosis; ECOG performance status on admission and discharge (as determined by the data collector); resus status on admission; implementation of DNACPR during admission; and discharge outcome (e.g.: home, death).



Of the patients whose performance status deteriorated, most were admitted with either sepsis or an acute deterioration of their chronic disease (e.g.: decompensated heart failure), and had a background of stable though ultimately non-curative disease (e.g.: malignancy, ischaemic heart disease). It was recognised that they were failing to improve and likely would not survive the admission, and as such performing CPR may not be successful or in their best interests; DNACPR forms were appropriately put in place. Overall, 50% of the patients under cardiology and 40% of MfE patients within this group died during their admission, again demonstrating correct DNACPR form completion.

More action is required however in completing DNACPR forms for those with a pre-existing poor performance status. While some patients performance statuses improved during their admission, most notably in oncology (possibly an indication that their poor performance status was a consequence of their symptoms rather than frailty/comorbidity), overall, most patients who were admitted with an ECOG of 3 or greater remained as such. It is important that we recognise the frail patient on admission and acknowledge that decisions around CPR are important.

Further to this, patients being admitted to hospital with a poor performance status and no DNACPR form may indicate a missed opportunity in primary care. Future discussion with our colleagues in the community is warranted.

Key Points:

1. Clear recognition of the deteriorating patient and appropriate implementation of DNACPR forms
2. Proactivity is required in completing DNACPR forms for those with a pre-existing poor performance status