Do Not Attempt CardioPulmonary Resuscitation (DNACPR) compliance audit 2014

Northern Ireland Western Health and Social Care Trust - Altnagelvin Hospital.
Dr S. Roberts and K. Mackey (Resuscitation Officer)

AIM/BACKGROUND

To **assess compliance** with the Western Health and Social Care Trust Do Not Attempt CardioPulmonary Resuscitation **(WHSCT DNACPR) policy** and **national guidance** on DNACPR within Altnagelvin Hospital.

The policy was introduced following recommendations from the **NCEPOD report 'Time to Intervene?'** relating to **decision making, documentation and communication of DNACPR decisions.**

METHOD

A **3 part questionnaire** was developed to:

1. assess **accurate completion** of the DNACPR form.
2. assess **documentation** of the DNACPR decision in patients' notes.
3. assess **staff knowledge** of the DNACPR policy.

Data collected from **21 clinical areas** between December 2013 and March 2014.

27 clinical notes were reviewed and **67 staff members** were questioned.

Data entered and analysed by the Audit and Governance Department using Excel.

OUTCOME/RESULTS

- Of the **27** completed DNACPR forms **74%** were located at the **'front of patients'** notes as per the policy so could be easily located in the event of an emergency.
- **100%** of forms had the patients details and reason for decision documented.
- Some sections of the DNACPR forms were not accurately completed i.e. names of MDT or relatives.
- **Documentation** of the **DNACPR decision** in the **patients' notes** occurred but needs **additional information added such as any communication/discussion with patient and /or next of kin**.
- **Only 41%** of **decisions** were documented **during the acute medical admission**.
- **Over 70%** of cases **were discussed** with **patient** and/ or **next of kin**.
- **A significant number** of medical staff **haven't read the DNACPR policy;** although they have a **reasonable understanding** of the process.
- **Over 60%** of staff questioned **couldn't correctly identify** those on their ward **with a DNACPR decision** in place.
- There was **uncertainty** surrounding the **DNACPR decision** on **discharge** of the patient.

CONCLUSION

- **Whilst there are areas of good practice, there are also areas of the DNACPR policy that need to be highlighted for improvement e.g. decision as part of the admission process and review of the decision prior to discharge.**
- **Although the DNACPR decision is made by medical staff, it is important that it is communicated to the patient and/ or next of kin and documented in the patient notes.**
- **Communication is essential amongst all clinical staff in order to minimise the chance of inappropriate arrest calls and further work needs to be undertaken to ensure this occurs at every handover.**
- **Training of medical staff and information given during induction/ forums/ via the intranet can help to ensure we are adhering fully to the policy. Additional work needs to be undertaken with DNACPR workshops to address and clarify the issues highlighted in this audit.**

REFERENCES

- Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy. Western Health and Social Care Trust, December 2012
- "Decisions relating to Cardiopulmonary Resuscitation" October 2007
- Cardiopulmonary Resuscitation Standards for Clinical Practice and Training, updated 2008.
- Treatment and care towards the end of life: good practice in decision making. General Medical Council, 2010
- NCEPOD Report "Cardiac arrest procedure: Time to intervene?" Regional compliance, June 2012

Decisions on discharge
N'
Admission
Communication with staff
Patients and/ or
Relatives