National Confidential Enquiry into Patient Outcome and Death
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NCEPOD *Improving the quality of medical and surgical care*

News Release

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A third of in-hospital cardiac arrests and subsequent attempts to resuscitate could have been prevented, national enquiry says

Better assessment on hospital admission and recognition and response when acutely ill patients deteriorate could have prevented cardiac arrest and the subsequent resuscitation attempts in a third of cases, the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has revealed in its latest report *Time to Intervene*? The national enquiry is calling for improvements in recognition and response to patient deterioration and decision-making around what care is likely to benefit acutely unwell patients, including do not attempt cardiopulmonary resuscitation (DNACPR) decisions.

Report author and NCEPOD Lead Clinical Co-ordinator Dr George Findlay commented: “The recognition of acute illness, response to it and escalation of concerns to consultants when patients are deteriorating is not happening consistently across hospitals.”

The report showed that patient assessment on admission was deficient in 47% of cases, and there were warning signs that the patient was deteriorating and might arrest in 75% of cases. However, the warning signs were not recognised in 35% of those patients, not acted on in 56% and not communicated to senior doctors in 55% of cases. NCEPOD Advisors found a lack of input from senior clinicians in the 48-hours prior to cardiac arrest.

“Senior doctors must be involved in the care planning process for acutely ill patients at an earlier stage, and support junior doctors to recognise the warning signs when a patient is deteriorating,” Dr Findlay said. “The lack of senior input fails patients by both missing the opportunity to halt deterioration and also by failing to question if CPR will actually improve outcome.”

The report found that even when a DNACPR decision had been made it was not always followed, and 52 patients underwent CPR despite their explicit DNACPR decision.

Dr Findlay explained that performing CPR is the current default decision doctors take where no explicit alternative care pathway exists “but this does not excuse

lack of clarity around the role of CPR for individual patients. CPR status must be considered and recorded for all acute admissions, if not on initial admission, then at the first consultant review,'' Dr Findlay said.

In one case (case study 11), hospital nursing staff expressed concern about a very elderly, acutely ill patient with severe dementia. The patient had no CPR plan and was dying. When the patient went into cardiac arrest, CPR was performed for 10 minutes until a senior doctor halted the procedure. All the patient's reviews had been carried out by junior doctors. NCEPOD Advisors reported: "This was an undignified end of life that need not have happened."

Key findings

- Assessment on admission was considered deficient in 47% of the cases under review.
- 38% of in-hospital cases of cardiac arrests (and subsequent resuscitation attempt) could have been avoided if patient care had been properly managed.
- 75% of cases displayed clear warning signs that the patient was deteriorating. Of these patients the signs were not recognised in 35%, not acted on in 56% and not communicated to senior doctors in 55% of cases.

Key recommendations

- CPR status must be considered and recorded for all acute admissions.
- When patients continue to deteriorate prior to consultant review there should be escalation of care to a more senior doctor.
- Each hospital must have a plan for the management of the patient's airway during cardiac arrest.
- Each hospital should audit all CPR attempts and assess what proportion should have had a DNACPR decision in place prior to arrest.

NCEPOD Chairman Mr Bertie Leigh said that he hoped this report would prompt a rethink on the limits of what is possible, and act as a wake up call to the NHS: "In nearly half of all the cases we reviewed there was a failure to formulate an appropriate care plan on admission, and a failure, often over several days, to find out what the patient's wishes were – and to carry them out."

"We are at a crossroads. All of us need to recognise and accept the limits of what can be achieved in medicine to the benefit of the patient, and a 'ceiling of treatment' described and agreed with the patient wherever possible. Doctors should only administer CPR where a patient has consented, or if the doctor is satisfied it is in the patient's best interests."

Ends

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Report author is available for interview

Notes to editors

- NCEPOD is an independent charitable organisation that reviews medical and surgical clinical practice and makes recommendations to improve the quality of the delivery of care. We do this by undertaking confidential surveys covering many different aspects of care and making recommendations for clinicians and management to implement.
- 593 hospitals returned data.
- NCEPOD Advisors reviewed the case notes and care of 526 patients, who had suffered a cardiac arrest in hospital, and underwent a resuscitation attempt.
- For further information about NCEPOD visit our website on www.ncepod.org.uk
- Copies of *Time to Intervene?* can be downloaded from the website as a PDF from 1 June 2012, or ring NCEPOD on 020 7600 1893.