SOMERSET TREATMENT ESCALATION PLAN (STEP) & RESUSCITATION DECISION POLICY

Policy

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Applies to:	Adult In-patients in Acute Trusts **and** appropriate adult patients in community settings.	**Exclusions:**	Maternity and Day Case Patients		

CONTENTS

KEY POINTS QUICK REFERENCE SUMMARY

- The Somerset Treatment Escalation Plan is often referred to as a TEP or STEP and these are used within this document as abbreviations for this form.

- The STEP form is a clinical record of agreed recommendations made in advance. The STEP form is not a legally binding form.

- The STEP is valid in colour and in black and white/photocopy.

- Appendix C outlines who can fill out a STEP form and the process for Acute, Mental Health and Community sites.

- If a patient already has a clinically relevant STEP, then there is no need to write a new STEP on admission or change of care setting.

- Only change a STEP when there has been a clinical change, or if the patient has asked to discuss their STEP decisions with you and a change is required.

- People can refuse a treatment which is on offer but cannot demand a treatment that is not suitable for them or considered futile. Where dispute arises in decision making a second opinion from an experienced clinician should be sought.

- The Mental Capacity Act should be used where applicable, further support and resources can be viewed from the QR codes on the form itself.

- Resuscitation decision and treatments on offer to an individual should be based upon discussion within a multidisciplinary team which includes the senior clinicians (such as advanced clinical practitioners and medical staff) able to best inform the individual's suitability for resuscitation and/or specific treatments e.g., the patients usual GP, ACP or medical consultant/senior doctor.

- A completed STEP form must be uploaded to the patient's digital record (e.g. SIDeR/EPRO/RiO/trackcare/patient centre) and also emailed to: tep.somerset@nhs.net to ensure the STEP can be reflected in the patient's GP record.

1.0 INTRODUCTION

1.1 Cardiac and respiratory arrest are an inevitable part of dying, and it is necessary to identify, on an individualised basis, those in whom cardiopulmonary resuscitation (CPR) is unlikely to be successful, when it would be against their wishes or when attempts to resuscitate would merely prolong their natural death in an invasive and distressing manner. Helping patients to make clear decisions is regarded as good practice and should be carried out in a sensitive, realistic, and honest manner.

1.2 The SFT policy has been reviewed and updated and has been shared and developed with other health care providers across the Somerset System. It recognises the integral links to other providers and provides the details of how SFT will implement this policy. It is recognised that system partners may wish to adhere to the same principles and practice and a local adoption of the principles set out are recommended but cannot be enforced. Somerset Integrated Care Board would support other providers who wish to adopt and adapt this policy for their own local organisational use as appropriate.

1.3 This policy takes regard of the current guidelines published in joint statements from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (October 2017, March 2020) and the Mental Capacity Act (2005) and takes into consideration the 2014 judgement from the Royal Courts of Justice relating to Tracey v Cambridge University Hospitals NHS Trust ('Tracey') and Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust (2015) ('Winspear').

1.4 This policy applies the principles of the Human Rights Act 1998. This Act incorporates the majority of rights set out in the European Convention on Human Rights into UK law. In order to meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention. Provisions particularly relevant to decisions about attempting CPR include the right to life (Article 2), the right to be free from inhuman or degrading treatment (Article 3), the right to respect for privacy and family life (Article 8), the right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and the right to be free from discriminatory practice in respect of these rights (Article 14) (Resuscitation Council, 2016).

2.0 DEFINITIONS

2.1 **Cardiopulmonary Resuscitation (CPR)** is an initial basic emergency procedure for life support, consisting of artificial respiration and manual external cardiac massage. It is used in cases of cardiac arrest to establish effective circulation and ventilation in order to prevent irreversible cerebral damage resulting from anoxia. In addition to basic life support it leads into advanced life support to attempt to correct the causes of cardiopulmonary arrest.

2.2 **Allow Natural Death (AND)** indicates that in the event of cardiopulmonary arrest, neither basic or advanced resuscitation will be instigated. The focus in a situation as death approaches will be comfort and palliative care.

2.3 **Somerset Treatment Escalation Plan & Resuscitation Decision Form (STEP)** is a document designed to facilitate communication between healthcare professionals outlining an individualised treatment plan, focusing on which treatments may or may not be the most helpful for a particular patient should they deteriorate. Most deteriorations will be foreseeable and based on the patient's existing health conditions. A variety of treatments can be considered such as antibiotic therapy or mechanical ventilation, and the plan must include a resuscitation decision. The form allows consideration of additional treatments for the individual and should not be seen as a 'tick box' exercise.

3.0 MAKING A DECISION

3.1 Making a clinical decision regarding application of AND or considering that the patient is not for treatment escalation can be a difficult process. Involvement of the senior clinical team is therefore paramount. In all cases, wherever possible and appropriate, patients and their families should be involved in the discussions around the inherently medical decision of resuscitation and escalation. As a guide consideration should include:

3.1.1 Futility of any resuscitation attempt to successful return of spontaneous circulation (ROSC) and prolonged survivability to an acceptable state of health in case of ROSC. (The proportion of people who survive cardiorespiratory arrest following CPR is relatively low. In hospital, the chance of surviving cardiorespiratory arrest to discharge varies considerably and depends on many factors, including comorbidities and the cause and circumstances of the arrest. In most hospitals the average survival to discharge is in the range of 15-20% - [Resus Council, 2016].)

3.1.2 Likeliness of significant and prolonged post resuscitation/escalation morbidity or disability. (Success at restarting the heart is almost always followed by a significant period in intensive care and is often associated with significantly reduced mental and physical function. [Fritz et al, 2014].) (Of those who need ICU care, most will require a period of artificial ventilation, and some will require renal replacement therapy, and/or circulatory support with inotropic drugs and/or an aortic balloon pump. Resus Council, 2016).

3.1.3 Quality of life prior to deterioration and post interventions.

3.1.4 Quality of health prior to deterioration and interventions.

3.1.5 The wishes of the patient if the treatment of CPR is on offer.

3.1.6 See appendix D for further data on survival to discharge.

3.2 For the majority of patients, a decision in favour of attempting CPR and all interventions is assumed. However, this may not be the case with all patients and consideration of withholding some treatments, including CPR, may be appropriate. Even if all treatment is on offer it is important to share such decisions, as a person may want to express their right to refuse them.

3.3 It is appropriate to consider allowing a natural death and/or implementing a 'ceiling of care' for a patient in the following instances:

3.3.1 It is the decision of a patient with mental capacity chosen from options available and specific to them and their needs.

3.3.2 The clinician/s considers that CPR will not restart the patient's heart and breathing.

3.3.3 The clinician/s considers that CPR will not restart the patient's heart and breathing with prolonged viable cognitive and/or physical functionality which would be acceptable to the patient.

3.3.4 The clinician/s considers that the application of invasive therapies will not restore independent viable functionality to a degree of independence, similar to condition prior to current illness or injury.

3.3.5 Where the benefits of CPR or interventional invasive procedures required for organ support are outweighed by the risks.

3.3.6 The clinical team should make these decisions in discussion with the patient or their family/carer/significant others. Where a decision has not been discussed with the family/carer, then it must be documented onto the STEP for with a valid reason as to why they were not informed.

3.3.7 When attempting CPR or interventional invasive procedures providing organ support is contrary to the recorded and sustained wishes of an adult who was mentally competent and aware of the implications at the time of making the decision and who now lacks the capacity to decide.

3.4 In addition, any decision not to perform CPR or any other treatment should only be made after appropriate discussion and consideration of all aspects of the patient's condition. Decisions must be informed by the likely clinical outcome and the patient's known or ascertainable wishes. Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision (Resus Council, 2016).

3.5 When discussing supportive care at home, with transfer to hospital only for unmanageable/emergency reasons, it is important to note certain situations maybe difficult to manage in the community and may result in a transfer to hospital. Examples include: head injuries (especially patients on anticoagulants), fractures, and hyperglycaemic events. Discussions around minor treatments with limited hospital time should be noted as requiring transfer, such as simple fractures e.g. wrist fracture or wound closure, where it cannot be done in the community. If a patient wishes to stay at home and is not to be transferred for conditions that are treatable in hospital, as they maybe at the very end of life, then these details should be outlined in the "what matters to you" box. Where unforeseen circumstances can be managed at home, other interventions might need to be put in place and discussed with specialist teams. Please also discuss this as necessary with a senior clinician if there is a need for further clinical expertise or a second opinion.

3.6 The clinician has a duty to discuss with a patient with capacity unless they think the patient will be harmed by the discussion. There should be convincing reasons that it would likely cause the patient to suffer physical or psychological harm (it is not sufficient to purely cite patient distress as a reason for not involving a patient with capacity in any decision to withhold treatment). The rationale for not involving the patient in this decision should be clearly documented in the patient's record and in

cases where the circumstances change and an opportunity to discuss with the patient arises it should be taken. This is a key outcome of the Tracey case and the practice of this point ensures compliance with human rights law. Where significant harm maybe caused, then a second opinion must be sought to discuss the degree of harm to the patient, and it must be noted that both agree this is the reason NOT to discuss the decisions with the patient. (This is not to discuss the actual decision, but the impact on the discussion of decision to the patient.)

3.7 Where the patient has capacity then discussion with family/carer/significant others will need to be with the patient's consent. Where the patient lacks capacity then discussion should occur following the Best Interests provisions. It should be emphasised however that the family/carer/significant others are informing the process rather than making the final decision. It may be appropriate to involve the spiritual and/or palliative care team to support the patient and their family/carer/significant others through this.

3.8 It is important to document these discussions in contemporaneous notes using the appropriate box on the STEP and/or in the patient's paper or electronic record.

4.0 THE MENTAL CAPACITY ACT (MCA)

4.1 The STEP document is formed from two elements. The MCA applies in a different manner to each.

i) The Treatment Escalation element
ii) The Resuscitation Decision element

4.2 Treatment Escalation and Resuscitation Decisions comprise both clinical and patient decision making. Aintree University Hospitals NHS Foundation Trust v James {2013} UKSC 67 clarifies that "...no patient can demand particular medical treatment which clinicians do not consider appropriate to offer". Put another way patient choices are limited by clinical decision making in regard to the appropriateness of treatments. A futile treatment cannot be demanded. An appropriate treatment can be refused.

5.0 THE MENTAL CAPACITY ACT AND TREATMENT ESCALATION

5.1 The treatment escalation element records the wishes and preferences of patients in regard to issues such as hospital admissions, health care treatments, and ceilings of care.

5.2 It is important to note that the Treatment Escalation element relates to future treatments and is hypothetical in nature. Treatment Escalation is a part of advance care planning and gathers general information to be used in future specific decisions related to medical care. The form itself cannot be considered a 'decision' as defined under the MCA as it may relate to a number of decisions and the concrete nature of these is not yet known. The Treatment Escalation element gathers information to inform future decisions (including MCA based ones) at the time they need to be made. It is not a record of a legally binding decision.

5.3 At the point of making the specific decision (with the concrete information at hand) the information detailed in the Treatment Escalation element can be used as an aide memoire for the health care professional and patient should the patient HAVE Mental Capacity. In this situation the individual may change their mind and not follow what they have detailed in the Treatment Escalation element of their STEP if that is their wish.

5.4 The information in the Treatment Escalation element may also be used to inform a Best Interests decision at the time the decision needs to be made where the person is deemed to LACK capacity.

5.5 The Treatment Escalation element therefore does not ask for an explicit statement regarding the person's capacity when writing, as there is no concrete decision to assess capacity against. However, the person's views and wishes must remain central to the Treatment Escalation element of the STEP and considered in the context of clinical views in regard to available or indicated treatment.

5.6 Rather than assessing capacity to determine an on/off position in regard to their capacity healthcare professionals should simply start with the person themselves in order to gather the necessary information. If the person is unable or unwilling to discuss the Treatment Escalation element of the STEP then the healthcare professional may move onto other interested parties (family, friends, IMCA - Independent Mental Capacity Advocate) to gather the information. There is space to document those discussions during these conversations on the form.

5.7 The source of the gathered information should be clearly recorded In the Treatment Escalation element of the STEP. Was it from the person directly or indirectly via other interested parties? What was the standing of those other people e.g. family, friend, lasting power of attorney for health?

6.0 THE MENTAL CAPACITY ACT AND THE RESUSCITATION DECISION

6.1 Decisions in regard to resuscitation are informed by case law (Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB) & R (Tracey) v Cambridge University Hospitals NHS Foundation Trust Ors [2014] EWCA Civ 822) and national policy (Decisions relating to cardiopulmonary resuscitation, joint guidance from the BMA, RCN, & Resus Council). This policy cannot replicate the case law and guidance in full and offers a pertinent brief summary.

6.2 The starting assumption in regard to resuscitation is that a person is for CPR.

6.3 Where a decision is made not to resuscitate or Allow a Natural Death (AND) it will fall into one of three categories;

i. There is no prospect of CPR being effective in respect of extending a person's life.

An appropriately qualified health care professional may make a clinical decision as to if CPR is an available treatment option. The professional may

decide that due to other factors (e.g. frailty, multiple co-morbidities) that CPR would be ineffective in restoring life. In this situation the professional's role is to inform the person and/or their family of this decision and the existence of the AND decision. Capacity is not a 'live' issue here as the decision as to the clinical availability of treatments is not dependent upon the person's capacity. If the person and / or their family do not agree however they should be supported to obtain a 2nd opinion.

ii. There is some prospect that CPR will be effective but the burdens on the person post CPR outweigh the benefits.

If CPR has been identified as an available treatment option (That is to say that there is a clinical view that it could be successful) then a decision regarding resuscitation should be made through considering the benefits and burdens of CPR. A benefits and burdens decision is more than a narrow clinical judgement. It is an ethical decision which must consider the wishes, feelings, beliefs, and values of the person involved. Whilst not strictly speaking an MCA based patient decision case law suggests that the framework of the MCA should be used to structure the consideration of the issue. In this context the person and / or the family involvement is through a **discussion**.

iii. The person has capacity to refuse an offer of CPR or a valid and applicable Advance Decision to Refuse Treatment (ADRT) is present and does not wish to have CPR.

The person has capacity or a has a valid and applicable Advance Decision to Refuse Treatment (ADRT) and does not wish to have CPR. If CPR is an appropriate treatment option, then a person may **decline** it should they a) possess the relevant mental capacity or b) lack capacity and have an ADRT in regard to this decision. Should the person express this wish and there are doubts about their ability to make this decision then a formal capacity assessment should be completed alongside the STEP form. In this context the patient involvement is through having a **discussion** and then **declining** the offer of CPR.

6.4 Case Law and national guidance detailed in 6.1 details that patients and / or their families should be involved in resuscitation decisions. The nature of the involvement depends on the grounds for the decision and the abilities of the person. It is **essential that a rationale for the resuscitation decision is recorded**. Responsibilities in regard to the Mental Capacity Act will not be clear unless the rationale for the decision is made explicit.

6.5 Discussions about CPR can be difficult for the professional and distressing for the person. However, case law has made clear that this cannot be a reason for failing to have this discussion. There may be situations where discussion would cause actual physical or emotional harm to the person. Of note here is that 'distress' as a reason on its own would be insufficient. In these cases, professionals need to detail their rationale as to how and why the person will come to harm. Otherwise, case law articulates a strong presumption in regard to patient & interested party involvement.

6.6 AND decisions are not legally binding but are used to guide and inform professional's decision making at the time the treatment needs to be given. Within the context of CPR decisions these will need to be made in urgent circumstances and the information readily at hand. Professionals are able to divert from AND documents if there is a justified clinical reason to do so e.g., reversible choking witnessed in a dining room. ADRT decisions around CPR however are legally binding and have the same status as a capacitated person's refusal of treatment. In order to carry this weight then an ADRT must be valid and applicable. As AND decisions relate to life sustaining treatment they must also be in writing, signed & witnessed. Further advice may be found regarding ADRT's here: Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk) Alternatively contact the Trust's MCA lead.

7.0 CIRCUMSTANCES WHEN A CPR DECISION MAY NOT BE FOLLOWED

7.1 There are circumstances in which a CPR decision has been documented in advance, but when the patient suffers cardiorespiratory arrest the attending healthcare professionals assess the situation and decide to act contrary to the previously documented decision. The below outlines further details on the types of scenarios where the need to deviate from a DNACPR may be required (BMA et al, 2016).

They are –

i. Contemporaneous clinical assessment
ii. Not the envisaged circumstances
iii. DNACPR during the peri-operative period.

Taken from the Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (previously known as the 'Joint Statement') (2016),

7.2 **Contemporaneous clinical assessment:** Unless there is a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, then the STEP form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's death or cardiorespiratory arrest. The final decision regarding the application or not of the CPR decision in an emergency rest with the healthcare professionals responsible for managing the patient's immediate situation. These healthcare professionals may, on attending an arrest, make a clinical assessment resulting in a different decision from the one on the CPR decision form. As with any clinical decisions, healthcare professionals must be able to justify their decision. In particular, clinicians should be cautious of overriding a DNACPR decision where the CPR decision form records that the patient has expressed a clear wish not to receive attempted CPR (BMA et al, 2016).

7.3 **Not the envisaged circumstances:** The decision around Resuscitation attempts is made based upon the projection of expected deterioration, or current futility, or frailty where the success of resuscitation is balanced against likeliness of being able to return a patient back to a quality of life that is deemed to be appropriate to the patient and health care teams providing care. Based upon this there may be circumstances where a sudden unexpected event, outside of projected deterioration, may occur which can

be imminently reversible, without futility and could return to a state similar to prior to the resuscitation phase. Examples of this may be an acute injury causing bleeding, a post operative event, an anaphylactic reaction to a medication, a choking episode or dislodged airway support device etc. In these circumstances it may be appropriate for the treating medical team to undertake resuscitative interventions despite a STEP DNACPR being in place.

To avoid misunderstandings it may be helpful, whenever possible, to make clear to patients and those close to patients that DNACPR decisions usually apply only in the context of an expected death or a sudden cardiorespiratory arrest and not to an unforeseen event such as a blocked airway (BMA et al, 2016).

7.4 **DNACPR during the peri-operative period (elective and emergency):** Taking time pre-operatively to understand and document the patient's wishes will mean that clinicians can act confidently and ethically and ensure the best outcomes for the individual patient.

Management of patients with a DNACPR decision during the peri-operative period should be considered by both surgical and anaesthetic teams and/or the doctor in charge of the patient's care prior to surgery and anaesthesia. This should be discussed with the patient and/or their representative (if lacking capacity) prior to surgery, as part of the process of seeking informed consent for the procedure (Meek et al, 2022).

Anaesthesia presents some very specific challenges in patients who have a DNACPR order in place. Anaesthesia may be required for palliative operative procedures or some cardiac interventions. Due to the overlap of what represents safe anaesthetic practice and resuscitation due to the drugs and techniques involved and the risk precipitating cardiac arrests in this frail group it is often appropriate and recommended to temporally suspend or at least modify a DNACPR order during such procedures if it is thought that they are of benefit to the patient, but risk causing a reversible cardiac arrest (Meek et al, 2022).

The decision to suspend (or modify) the order must be discussed with the patient or their proxy in advance of the procedure, clearly establishing what the patient would accept or refuse and what outcomes they would be most anxious to avoid (e.g. brief use of the defibrillator while under anaesthesia versus a protracted course in ICU post operatively) (Meek et al, 2022).

For example, cardiac catheterisation, pacemaker insertion, or surgical operations may trigger cardiorespiratory arrest occasionally. General or regional anaesthesia may cause cardiovascular or respiratory instability that requires supportive treatment, which may include CPR. Many routine interventions used during anaesthesia (for example tracheal intubation, mechanical ventilation or injection of vasoactive drugs) may also be regarded as resuscitative measures. Under these circumstances, where a cardiorespiratory arrest and its cause can be treated promptly, survival rates are much higher than those following many other causes of in-hospital cardiac arrest.

If DNACPR to remain in place throughout operation some patients may wish a DNACPR decision to remain valid despite the risk of a cardiorespiratory arrest from a reversible cause; others will request that the DNACPR decision is suspended

temporarily. The time at which the DNACPR decision will be reinstated should also be discussed, agreed in advance and documented.

If a patient wants a DNACPR decision to remain valid during a procedure or treatment that carries some risk of cardiorespiratory arrest this may increase the mortality risk of the procedure or treatment. As an extreme example, some cardiac surgical procedures require induction of cardiac arrest as a necessary part of the procedure, so treatment could not be completed successfully without reversal of that arrest by defibrillation. If a clinician believes that a procedure or treatment would not be successful or would be unacceptably hazardous with the DNACPR decision still in place, it would be reasonable not to proceed. The Association of Anaesthetists of Great Britain and Ireland (Nolan et al 2023) has published specific guidance on management of DNACPR decisions in the perioperative period. In the event of disagreement, the patient should be offered a second opinion (BMA et al, 2016).

The agreed DNACPR management option should be clearly documented in the patient's notes and communicated amongst the healthcare team taking care of the patient in the operating theatre & recovery areas.

The reviewed DNACPR decision should remain in place for the period while the patient is in the theatre & recovery areas with clear demarcation of when in force and when rescinded alongside clear information of what will and what will not be enacted with regard to life saving treatments.

8.0 DOCUMENTING A DECISION

8.1 The general principle holds that any decision will be documented using the Somerset Treatment Escalation Plan and Resuscitation Decision form with the option of adding explanatory text in the patient's record if required.

8.2 Further details on the role/environment (community, ward based etc) documentation process can be found within Appendix C.

8.3 The decision will be documented using the terminology:

8.3.1 For CPR - In the event of cardio-respiratory arrest, CPR will be undertaken.

8.3.2 To Be Allowed A Natural Death (AND) - This definition is limited to CPR in the event of a cardio-respiratory arrest and does not alter the medical or nursing care of the patient. All other appropriate treatment and care must continue including appropriate observations. 'Appropriate' will vary by individuals' needs and is guided by them, their family, and the multidisciplinary team. All we do in healthcare should be individualised and help the patient whilst not harming them. An AND decision does NOT override clinical judgement in the unlikely event of a reversible cause of a person's respiratory or cardiac arrest that does not match the circumstances envisaged when the decision was made and recorded as outlined in section 7 above.

8.4 It is essential that the professional completing the form provides a rationale if choosing the Allow a Natural Death (AND) option. This will always fall into one of 3 domains:

8.4.1 CPR is unlikely to work and is not clinically indicated.
8.4.2 CPR may work but the burdens to the person outweigh the benefits.
8.4.3 The person HAS capacity or a valid and applicable Advance Decision to Refuse Treatment (ADRT) and does not want CPR.

8.5 One of the above options must be detailed as a minimum. Best practice would dictate the inclusion of additional contextual information (e.g. co-morbidities that clarify why CPR would be unlikely to work, rationale as to why burdens outweigh benefits and where this discussion has been recorded, details of capacity assessment in regard to any refusal).

8.6 A clearly recorded rationale is essential to provide evidence that AND decisions have been made;
8.6.1 On a sound clinical basis,
8.6.2 Are person-centred in their approach,
8.6.3 Are not discriminatory in nature.

8.7 If a patient is for resuscitation/escalation STEP forms must not be completed purely to facilitate discharge via transport. However, if a patient is not for resuscitation or escalation then a STEP form must be completed, and a copy provided to the transport facilitator. If no STEP is provided then the assumption, as in law, is that resuscitation and escalation is to be assumed. Great care must be taken so the correct information about the right person is available in an emergency.

8.8 If a patient has a recorded Advanced Decision to Refuse Treatment (ADRT) then this decision should be documented on a STEP form to highlight the specific decision laid out within the ADRT. Other aspects of the STEP can be filled out in accordance with this policy.

8.9 Once completed the STEP form must be uploaded to the patient's digital record (e.g. **SIDeR/**EPRO/RiO/trakcare/patient centre) and also emailed to: tep.somerset@nhs.net to ensure the STEP can be reflected in the patients GP record.

9.0 COMMUNICATING THE DECISION

9.1 Patients with capacity must be involved in discussions about their resuscitation status and/or treatment options and a sensitive exploration of the patient's thoughts must occur unless the clinician thinks the patient will be distressed by being involved and that this distress might cause the patient physical or psychological harm; or they indicate that they do not wish to participate in the discussion. In these cases, a decision will be made in their 'best interest'. Information concerning resuscitation and CPR is available for patients and relatives and can be found on the Somerset End of Life Care website – Supporting Conversations.

9.2 Patients who lack the capacity to make their own decisions may have appointed someone who has Lasting Power of Attorney for health and welfare decisions or have a nominated IMCA and they must (where practicable) be involved in the process.

9.3 As outlined in 3.6 where the patient has capacity then discussion with family/carer/significant others will need to be with the person's consent. Where the

patient lacks capacity then discussion should occur following the Best Interests provisions. It should be emphasised however that the family/carer/significant others are informing the process rather than making the final decision. It may be appropriate to involve the spiritual and/or palliative care team to support the patient and their family/carer/significant others through this.

9.4 The original STEP form should accompany the patient on discharge home or to another care setting. For patients being transferred or discharged from acute trust settings this is only required if an AND decision has been made or a 'ceiling of care' is in place i.e. the patient is not for re-admission to an acute hospital. The presence of an AND decision or ceiling of care does not necessarily mean that the patient will not be readmitted to an acute hospital.

9.5 Where a patient with an AND decision is being discharged home, it is the medical and nursing team's responsibility to ensure that the patient's significant others are aware of the decision and know what to do in the event of the patient's death.

9.6 If a patient requires transportation by the ambulance service, ambulance control must be made aware of the existence of an AND decision at the time of booking.

9.7 The clinician making the decision must inform the senior nurse on duty of the content of the current STEP. The nurse informed of the decision should then cascade the information throughout the remainder of the team, updating nurse handover sheets (using the terminology 'for CPR' or 'AND' as appropriate) and informing allied health professionals involved in the patient's care. It is not appropriate for resuscitation status to be recorded on ward bed state boards.

9.8 It is important that the resuscitation status is communicated when the patient is transferred within the hospital including when attending other departments such as Diagnostic Imaging. It is the responsibility of the designated nurse caring for the patient to ensure that this information is communicated. The receiving department must routinely seek clarification of resuscitation status in the event that this information is not provided.

9.9 There is **no requirement** to supply documentation for a patient who is for resuscitation and all aspects of escalation, UNLESS there are specific needs of the patient or senior doctor/senior clinician or specialist nurse where it may be necessary to document the discussion around STEP that have occurred.

10.0 CHANGING/AMENDING A STEP FORM OF A PATIENT

10.1 The STEP form should be crossed through with a diagonal line on both sides and the lines signed and dated by the person changing the escalation/resuscitation status. Involving the patient in the revision or reversal of a decision relating to resuscitation and other treatments is required. However, if they lack capacity, it may be necessary to involve a person with lasting power of attorney or an IMCA.

10.2 If a patient has just moved address, it acceptable to use the form until the amended address change be undertaken; providing the patient can be directly linked to this form

(Date of Birth/NHS number). If the address can be written, legibly, on the current form, then do so. If the address cannot be changed legibly, the form will need to be rewritten, reflecting the current clinical position or using the current STEP form.

10.3 The updated form MUST also be emailed to tep.somerset@nhs.net on DISCHARGE of the patient and the original of the new document provided to the patient. This ensures the STEP can be reflected in the GP record system. The patients digital record (e.g. **SIDeR**/EPRO/RiO/trakcare/patient centre) must also be updated.

11.0 RESUSCITATION STATUS IN CHILDREN AND YOUNG PEOPLE

11.1 All children including neonates and young people up to their 18th birthday experiencing respiratory or cardiorespiratory arrest will normally have CPR attempted, unless their condition is such that this not in the child's best interest. In this situation the consultant paediatrician in charge of the child's care will discuss this with the child where possible and their parent or legal guardian. If made, the decision to allow a natural death will be documented in a Child and Young Person's Family Wishes Advance Care Plan.

12.0 MATERNITY AND DAY SURGERY PATIENTS

12.1 Due to the fact that these patients are often not seen by a senior doctor/senior clinician during their admission, it is not necessary to document a 'For CPR' decision for any maternity patients as an assumption for all interventions including CPR will be made universally. In the unlikely event that a decision to Allow a Natural Death is made for a pregnant woman it should be documented in the method described above using the STEP form.

12.2 Similarly, a decision in favour of all treatments including CPR, is made for all day-case patients universally unless a pre-existing decision regarding treatment options including CPR is in place. In the event that a decision to Allow a Natural Death is made for a day-case patient it should be documented in the method described above using the STEP form. People should be given the opportunity to refuse a treatment or escalation they do not want.

13.0 MENTAL HEALTH PATIENTS

13.1 All inpatients in Pyrland wards should have a STEP form completed; and all older/frail patients and patients with complex life limiting health conditions in general adult and CAMHS wards should have a STEP completed as part of an advance care conversation. These conversations should be documented in the method described above using a STEP form.

14.0 PEOPLE WITH LEARNING DISABILITIES AND AUTISTIC PEOPLE

14.1 DNACPR decisions for people with a learning disability and autistic people should be made on an individual basis, be appropriate and based on conversations that are reasonably adjusted, where possible involving the person themselves. NHS England and Baroness Campbell (2020) highlighted that it is unacceptable for people to have a

DNACPR decision on their record purely because they have a learning disability, autism or both.

14.2 The same principles should apply to the development of Treatment Escalation Plans and Advance Care Planning whereby reasonable adjustments should be made to enable people to have person-centred conversations about their wishes and preferences related to future care.

15.0 TRAINING / COMPETENCE REQUIREMENTS

15.1 Training is provided via an e-learning package available on LEAP to all SFT staff, and on completion of this training there is the opportunity to complete a face to face "conversation skills" training, also available via the LEAP platform.

16.0 MONITORING

16.1 This policy will be maintained by the author to reflect the most up to date national guidance as applicable, and/or the current research literature. The authors are responsible for ensuring appropriate discussion with all relevant and involved organisations on the review of this document.

16.2 In order to maintain compliance with the policy, a STEP in-patient audit is completed across the following Somerset Foundation Trust sites: Musgrove Park Hospital, Yeovil Hospital, all Community Hospital sites and Pyrland (older persons' mental health) wards. The audit is completed yearly, with half of the wards in each area being audited each year on rotation

16.3 This policy is ratified through Somerset FT governance process and will be shared for information at the ICB End of Life Programme Board.

16.4 Annual reporting on STEP to the trust Quality Assurance Group (QAG).

Element of policy for monitoring	Section	Monitoring method - Information source (e.g. audit)/ Measure / performance standard	Item Lead	Monitoring frequency /reporting frequency and route	Arrangements for responding to shortcomings and tracking delivery of planned actions
Documentation and making and communicating the decision	8.0 and 9.0	Trustwide audit	Treatment Escalation Plan Lead	Yearly	Action plan produced following audit which is monitored through the Education Working Group, End of Life Programme Board

Training	15.1	Training attendance figures monitored	Treatment Escalation Plan Lead	Yearly	Reported and discussed at the STEP education group

17.0 REFERENCES

Aintree University Hospitals NHS Foundation Trust v James { 2013 } UKSC 67

British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). Decisions Relating to Cardiopulmonary Resuscitation (previously known as the Joint Statement). 3rd Edn (1st revision).

Fritz, Z., Cork, N., Dodd, A. and Malyon, A. (2014). 'DNACPR decisions: challenging and changing practice in the wake of the Tracey judgment' Clinical Medicine, 14 (6) 571-576; DOI: 10.7861/clinmedicine.14-6-571

GMC (2010) Treatment and Care Towards End of Life: Good Practice in Decision Making.

Meek, T., Clyburn, R., Fritz, Z., Pitcher, D., RuckKeene, A. and Young, P.J. (2022) Implementing advance care plans in the peri- operative period, including plans for cardiopulmonary resuscitation: Association of Anaesthetists clinical practice guideline. Vol: 77, pp: 456–462

Mental Capacity Act (2005) Department of Health.

NHS England and Baroness Campbell (2020). Joint statement on personalised approaches to care and treatment

Recommended Standards of Recording – Do Not Attempt Resuscitation (DNAR) Decisions (2009) Resuscitation Council (UK)

Tracey v Cambridge University Hospitals NHS Trust. (2014) Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust [2015]

18.0 APPENDIX A – SOMERSET TREATMENT ESCALATION PLAN & RESUSCITATION (STEP) FORM

The most up to date form can be found on:

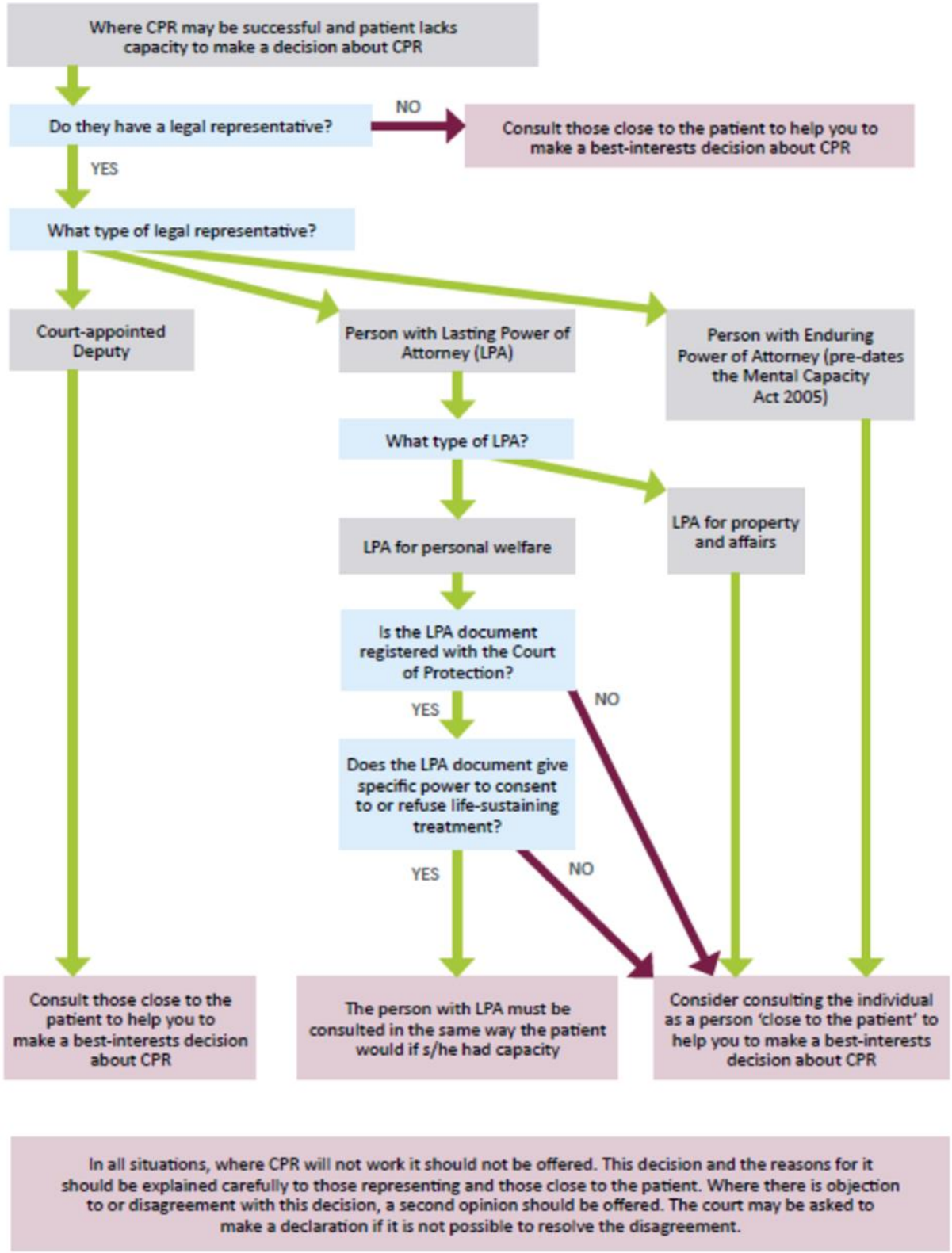
Somerset - End Of Life Care & Bereavement Support (eolcare.uk)

Or:

Somerset treatment escalation plan - NHS Somerset ICB

(The form can also be ordered via INTEGRA or printed out from either website)

19.0 APPENDIX B – FLOW DIAGRAM OF HOW TO UNDERTAKE A STEP DISCUSSION WHEN A PATIENT LACKS CAPACITY



20.0 APPENDIX C – COMPLETING THE STEP FORM AND DOCUMENTING THE DECISION

Where no CPR Status is documented, or evident, at the time of admission, an assumption in favour of conducting CPR is made universally.

1) The resuscitation status of all in-patients (except paediatric, obstetric and day-case patients) must be documented using a STEP proforma (see Appendix A) at or around the time of admission. **If a patient already has a clinically relevant STEP, then there is no need to write a new STEP on admission or change of care setting.**

2) In addition to this, it may be appropriate to detail which treatment interventions in the event of deterioration in a patient's clinical condition should be considered appropriate up to and including CPR and admission to critical care.

3) The Joint Statement (Resuscitation Council, 2016) asserts that 'The overall clinical responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician responsible for the person's care *as defined by local policy*.

4) Whereas a broad variety of professionals can ***contribute*** to the completion of the STEP document, the senior health clinician in charge of the patients care at the time as outlined in 5 and 6 below, must take overall ***clinical responsibility*** for the document. A health care professional working as part of a clinical team providing care for the patient whilst not taking overall responsibility for the documented decisions may be delegated with completing the STEP document prior to sign off from the senior health clinician (See section 9).

5) **Inpatient settings**: Clinical responsibility - A suitably experienced and capable registered health care professional who work within the following professional bodies: GMC (all), NMC or HCPC (with the following titles - ECP, ACP, specialist nurse job roles only).

6) **Community settings:** Clinical responsibility - A suitably experienced and capable registered health care professional who work within the following professional bodies: GMC (all), NMC/HCPC – (Clinical responsibility for health care professionals in community settings is not limited to specific job roles due to the wider variety of roles and environments that they work within.) (Please refer to local governance processes to ensure monitoring of community STEPs)

7) The degree to which a clinician is deemed experienced and capable will be determined by; i) individual support and supervision arrangements, ii) individual CPD undertaken & iii) professional responsibilities in regard to self-reflection and monitoring. (i.e. GMC: Good Medical Practice 'Provide a good standard of

practice and care, and *work within your competence*.'(GMC, 2024), NMC: The Code 'Recognise and *work within the limits of your competence' (NMC, 2024)*

8) Any clinician taking clinical responsibility must be sufficiently capable and experienced to determine if CPR would be effective or not decide if CPR is appropriate and likely to achieve a successful outcome or not.

9) Contribution to the STEP form from other professionals may take different forms and should be encouraged to gather valuable information pertinent to the patient's overall health status and individual care preferences.

   This could involve a devolved arrangement where the contributing professional completes the form and then shares this with the clinician responsible for sign off. Health professionals who may undertake a devolved approach include HCPs with the following registrations: GMC, NMC, ACPs, PAs (listed on the voluntary register (PAMVR) or HCPC), HCPC (with titles of: OT, ODP, Paramedic, Physiotherapist). This list is relevant to both inpatient and community settings.

10) Other professionals (e.g. social workers / SaLT) and support staff (e.g. HCA's) may also contribute to the STEP document, in fact their input may be of central importance. They however may not take on devolved responsibility for the document. They cannot take sole responsibility for the document.

11) The clinician should always be prepared to discuss a CPR decision with other healthcare professionals involved in the person's care. Wherever possible and appropriate, a decision about CPR should be agreed with the whole healthcare team. Teamwork and good communication are of crucial importance in the delivery of high-quality care. If there is doubt or disagreement about the most appropriate decision, a second opinion should be sought. Accurate documentation of conversations should also be held within the patients notes. (BMA, Resuscitation Council and the RCN, 2016)

12) Transcribing from DIGITAL to paper:
    In cases where a decision to resuscitate has already been made and this is documented clearly on the patient's digital record (such as SIDeR/EPRO) then it is acceptable that any Registered Health Care Professional may transcribe the decision onto a STEP form on behalf of the originating Consultant or Deputy. It must be clearly documented the location of this original decision and any discussions that have taken place with the patient, family and senior clinical decision maker as determined in paragraph 5 or 6. In cases where only a decision to resuscitate has been made, and no documented decisions around escalation then this must take place as a matter of urgency by those determined in paragraph 5 or 6 but the decision to resuscitate can be documented on the STEP as an interim.

13) Transcribing from PAPER to digital:
    Where a completed TEP form just needs to be transcribed onto a digital format (e.g. SIDeR) then it is acceptable for admin staff to complete this task. If there

were any issues with transcribing, the staff member would be expected to discuss with the clinician who wrote the TEP form.

14) A decision in favour of all interventions, including CPR, can be recognised, and documented by ANY grade of doctor or appropriately trained registered (NMC, GMC, PA's (listed on the voluntary register (PAMVR) or HCPC) healthcare professional by completing the 'For CPR' box only. A ceiling of care need not be completed for these patients unless there are circumstances that require clarification (i.e. a decision has been made in favour of CPR in spite of medical concerns) however, the rationale for the decision must be documented.

15) The completed STEP form must be filed at the front of the patient's paper record. If a paper record is not available but a patient or relative is aware of a decision, then check any digital records such as SIDeR to see if the decision has been made on a digital platform rather than paper.

16) Patients who are thought to be at the end of their lives should be cared for under an appropriate end of life care plan and a STEP must be completed recording the decision.

17) Upon discharge from the acute site, if the STEP is no longer valid then it must be cancelled in accordance with paragraph 7.0 of the policy. If it remains valid then a copy must be emailed to tep.somerset@nhs.net and the original provided to the patient or their carers for ongoing communication. Transport services only require a STEP if the patient is AND and/or not for hospital transfer or escalation.

References

British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). Decisions Relating to Cardiopulmonary Resuscitation (previously known as the Joint Statement). 3rd Edn (1st revision).

General Medical Council, (2024) Available online at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/leadership-and-management-for-all-doctors/employment#:~:text=You%20must%20recognise%20and%20work,support%20from%20colleagues%20when%20necessary.

Nursing and Midwifery Council (2024) Available online at: https://www.nmc.org.uk/standards/code/read-the-code-online/#fifth

21.0 APPENDIX D – DATA AND STATISTICS ON IN-HOSPITAL CARDIAC ARRESTS

The association between time of in hospital cardiac arrest and mortality; a retrospective analysis of two UK databases (McGuigan, 2023), this data shows patient demographics on the type of patient that goes into cardiac arrest, history and cardiac arrest rhythms.

Table 1 – Patient demographics.

Patient characteristics	NCAA cohort (n = 115,690)	ICU linked cohort (n = 13,858)
Age (years), Median (IQR)	76 (66–84)	69 (58–78)
Male sex, n (%)	67,984 (58.8)	8,248 (59.5)
Ethnic group, n (%)		
White	95,197 (82.3)	11,134 (80.3)
Not stated	11,030 (9.5)	1191 (8.6)
Asian/Asian British	5,373 (4.6)	880 (6.4)
Black/African/Caribbean/Black British	1,955 (1.7)	325 (2.3)
All other	1,492 (1.3)	221 (1.6)
Mixed/multiple ethnic group	642 (0.6)	107 (0.8)
Pre-admission dependency, n (%)		
Able to live without assistance in daily activities	NA	8,854 (64.3)
Minor assistance with some daily activities	NA	3,684 (26.8)
Major assistance with majority of/all daily activities	NA	1,082 (7.9)
Total assistance with all daily activities	NA	150 (1.1)
Presence of severe comorbidity*, n (%)	NA	2,661 (19.2)
Diagnosis resulting in ICU admission, n (%)		
Acute coronary syndrome	NA	5,370 (38.8)
Cardiac arrhythmia	NA	3,683 (26.6)
Other	NA	2,798 (20.2)
Sepsis	NA	2,007 (14.5)
APACHE-II physiology score, median (IQR)	NA	15 (11–21)
Length of hospital stay prior to arrest (days), median (IQR)	2 (0–6)	1 (0–5)
Reason for admission to/attendance at/visit to your hospital, n (%)‡		
In-patient - medical	99,809 (86.3)	11,245 (81.2)
In-patient - surgical	13,945 (12.1)	2,334 (16.8)
Outpatient	1,490 (1.3)	217 (1.6)
Staff or visitor	371 (0.3)	60 (0.4)
Location of cardiac arrest, n (%)		
In-patient location	69,607 (60.2)	7,697 (55.5)
At the point of presentation to hospital	22,727 (19.7)	3,180 (23.0)
High dependency/coronary care unit	13,160 (11.4)	1,064 (7.7)
Treatment area	10,159 (8.8)	1,915 (13.8)
Status at team arrival, n (%)		
Resuscitation ongoing	97,853 (84.6)	11,814 (85.3)
ROSC achieved before team arrival	10,201 (8.8)	961 (6.9)
Deteriorating (not yet arrested)	6,706 (5.8)	1,080 (7.8)
Dead - resuscitation stopped	809 (0.7)	0 (0.0)
Presenting rhythm, n (%)		
Shockable	18,885 (16.3)	2,524 (18.2)
VF	12,883 (11.1)	1,839 (13.3)
VT	5,412 (4.7)	608 (4.4)
Unknown (shockable)	590 (0.5)	77 (0.6)
PEA	63,387 (54.8)	8,642 (62.4)
Asystole	25,110 (21.7)	1,868 (13.5)
Rhythm never determined	8,308 (7.2)	824 (5.9)

*Using APACHE II definition of severe co-morbidity.

‡ **Reason for admission to/attendance at/visit to your hospital, n (%).**

In-patient include all patients from the point of triage in the emergency department to discharge from hospital.

Outpatients include all those who attended the hospital for clinic or appointment.

In-patient location: In-patient ward, obstetric clinical areas or other inpatient intermediate care area.

At the point of presentation to hospital: Emergency department, emergency admissions unit (or equivalent), outpatient clinic, non-clinical area.

Treatment area: Theatre and recovery, imaging department, cardiac catheter laboratory or other specialist treatment area.

High dependency/coronary care unit: HDU, CCU.

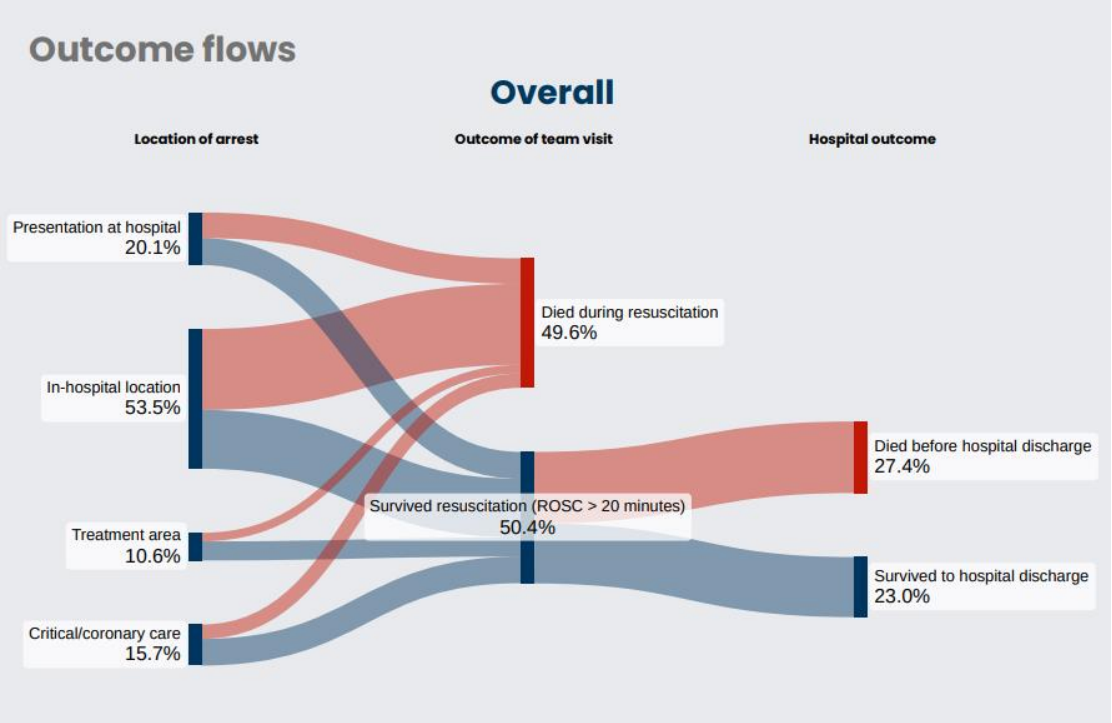
McGuigan, P, J., Edwards,J., Blackwood, B., Dark, P., Doidge,J. C., Harrison, D. A., Kitchen, G., Lawson, I,. Nichol, A. D., Rowan, K. M., Shankar-Hari, M. and McAuley, D. F. (2023) Clinical paper: The association between time of in hospital cardiac arrest and mortality; a retrospective analysis of two UK databases {online} Available at: Resuscitation (resuscitationjournal.com)

National Cardiac Arrest Audit 2022/2023 Key statistics:

	Sustained ROSC > 20 mins			Survived to hospital discharge †		
	Acute general hospitals	Cardiothoracic hospitals	Overall	Acute general hospitals	Cardiothoracic hospitals	Overall
Shockable – VF/VT						
0 – 15	5/8 (62.5)	2/2 (100.0)	7/10 (70.0)	3/7 (42.9)	2/2 (100.0)	5/9 (55.6)
16 – 64	578/740 (78.1)	113/129 (87.6)	691/869 (79.5)	401/667 (60.1)	64/101 (63.4)	465/768 (60.5)
65 – 74	419/542 (77.3)	62/74 (83.8)	481/616 (78.1)	227/480 (47.3)	34/59 (57.6)	261/539 (48.4)
75 – 84	466/630 (74.0)	47/53 (88.7)	515/685 (75.2)	241/566 (42.6)	26/43 (60.5)	267/611 (43.7)
85+	164/233 (70.4)	7/10 (70.0)	171/243 (70.4)	76/221 (34.4)	2/9 (22.2)	78/230 (33.9)
Overall	1632/2153 (75.8)	231/268 (86.2)	1865/2423 (77.0)	948/1941 (48.8)	128/214 (59.8)	1076/2157 (49.9)
Non-shockable – PEA						
0 – 15	47/84 (56.0)	7/8 (87.5)	54/92 (58.7)	27/77 (35.1)	1/8 (12.5)	28/85 (32.9)
16 – 64	1062/1970 (53.9)	67/108 (62.0)	1132/2084 (54.3)	389/1890 (20.6)	41/99 (41.4)	431/1994 (21.6)
65 – 74	803/1670 (48.1)	57/91 (62.6)	862/1765 (48.8)	225/1610 (14.0)	24/82 (29.3)	249/1695 (14.7)
75 – 84	934/2096 (44.6)	62/102 (60.8)	997/2199 (45.3)	211/2034 (10.4)	40/96 (41.7)	252/2131 (11.8)
85+	307/854 (35.9)	12/26 (46.2)	319/880 (36.2)	69/836 (8.3)	6/25 (24.0)	75/861 (8.7)
Overall	3153/6674 (47.2)	205/335 (61.2)	3364/7020 (47.9)	921/6447 (14.3)	112/310 (36.1)	1035/6766 (15.3)
Non-shockable – Asystole						
0 – 15	18/42 (42.9)	0/0 (0.0)	18/42 (42.9)	11/40 (27.5)	0/0 (0.0)	11/40 (27.5)
16 – 64	258/719 (35.9)	22/28 (78.6)	282/749 (37.7)	79/686 (11.5)	14/23 (60.9)	94/711 (13.2)
65 – 74	212/697 (30.4)	10/17 (58.8)	222/715 (31.0)	51/679 (7.5)	6/13 (46.2)	57/693 (8.2)
75 – 84	201/787 (25.5)	11/22 (50.0)	212/809 (26.2)	40/774 (5.2)	7/19 (36.8)	47/793 (5.9)
85+	94/479 (19.6)	3/4 (75.0)	97/483 (20.1)	22/472 (4.7)	3/4 (75.0)	25/476 (5.3)
Overall	783/2724 (28.7)	46/71 (64.8)	831/2798 (29.7)	203/2651 (7.7)	30/59 (50.8)	234/2713 (8.6)

† Excludes subsequent team visits to the same patient within the same hospital stay and patients with unknown outcomes

National Cardiac Arrest Audit 2022/2023 Key statistics – Outcome Flow:



National Audit Project – Anaesthesiology

- The Seventh National Audit Project (NAP7) Activity Survey showed that among 20,717 adults (> 18 years) undergoing surgery, 595 (2.9%) had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) recommendation preoperatively.
- The preoperative DNACPR recommendation was suspended in less than one-third of these cases.
- Eight patients (1.4%) with a DNACPR recommendation had a cardiac arrest in their perioperative period and four were resuscitated successfully.
- Of the 881 perioperative cardiac arrest reports to NAP7 that included a resuscitation attempt, 54 (6.1%) had a DNACPR recommendation made preoperatively.
- Of these case reports, 70% had a Clinical Frailty Scale (CFS) score of 5 or greater (mild to very severely frail).
- Just under 50% of these DNACPR recommendations were formally suspended at the time of anaesthesia and surgery.
- One in five of those with a DNACPR recommendation and who had a cardiac arrest survived to leave hospital.