Staff perceptions of Do Not Attempt Cardiopulmonary Resuscitation discussions in a palliative care setting – a qualitative study

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Background

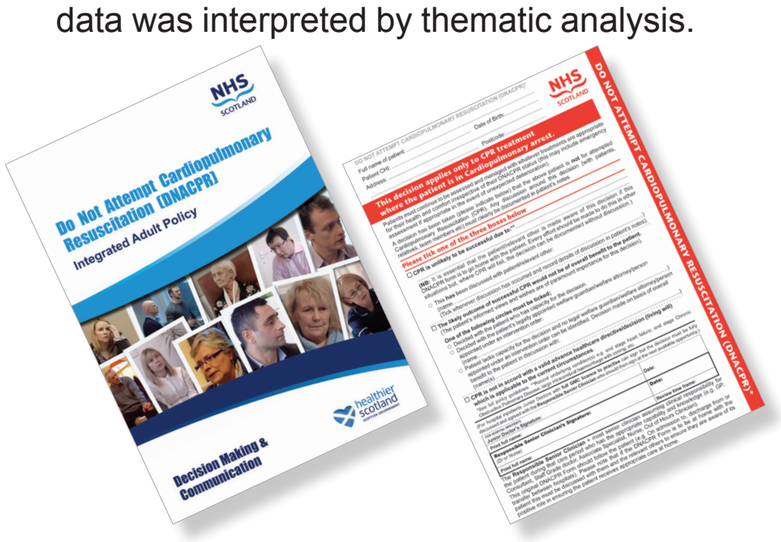
In 2010 a Scotland wide policy was established that allows patients to take their Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms home. This encourages health professionals to discuss resuscitation in the context of anticipatory care planning with patients if appropriate[1,2]. To allow the patient to take a DNACPR form home discussions must be had with either patients or their families – a responsibility which falls on healthcare staff.

Aim

To explore palliative care staff experiences and perceptions of discussing DNACPR decisions with patients; and to outline recommendations for good practice.

Methods

- A purposive sample consisting of eleven staff members of Marie Curie Hospice Edinburgh were recruited for this study.
- This included medical and nursing staff of various experience levels from inpatient and community settings.
- Semi structured interviews were conducted with staff in a private environment and were recorded with a digital voice recorder.
- Interviews were transcribed verbatim, then data was interpreted by thematic analysis.



Results

Four main themes emerged from our analysis:

1. Promoting and inhibiting factors

Staff found that certain situations made them more or less likely to initiate DNACPR discussions with patients. These included:

Promoting factors

- Patient's discharge
- A change in the patient's clinical condition
- Patient initiated discussions
- The context of end of life planning and discussing the future

Inhibiting factors

- Worry of causing distress
- Patient characteristics (young patients, patients with unrealistic views)
- The staff patient relationship (both feeling close to a patient and having no relationship with a patient make the discussion more difficult)

"…when I have an emotional engagement with a patient that leaves me wanting to be over optimistic then it ... em I can tell that I'm trying to talk myself round to not needing to have a DNACPR discussion."

- Personal emotions

"there have been times where people have given cues to that and I've not taken them up on that and probably purposely and so I think that is something that every practitioner has probably done at some point because I think sometimes you just can't go there at that particular time... sometimes there's an element of self preservation."

2. Patient and family responses

- Discussions are emotional for patients
- Patients' individual reactions vary and can be difficult to predict
- Negative reactions are rare
- Discussions can be a relief for patients/families

"I think she feels relieved to have...you know having spoken about it, having put forward what she would like to happen. I think on one level she feels relief having done it, but on the other level it kind of brings home what has happened."

- Discussions can give patients a better understanding of their disease and prognosis

3. Staff experience of discussions

- Staff find discussions challenging – mainly due to the worry of causing patient distress
- Many staff members experience anxiety before discussions
- Discussions can affect staffs' personal emotions – this is usually dependent on the patients reaction

"you don't go in there as a disembodied brain, you go in there as a person with emotions and other people's emotions affect yours. And it can become quite difficult...it may be emotionally difficult."

- Staff find discussions rewarding or satisfying if they have gone successfully

"Yes … because ye… you get caught up in... it's very humbling to be in somebody's house at this period."

4. Staff opinion of DNACPR issues

- All staff saw the benefit in preventing inappropriate CPR attempts/acute admissions

"It's not something I particularly enjoy doing but I know it's for long term benefit, which makes it okay."

- Despite this one participant mentioned that DNACPR forms are very rarely actually needed

"someone goes on to have an arrest at home, and they have a form, and therefore are managed in the correct way, then that's great. But that happens so rarely compared to the number of discussions we have."

- General consensus is that forms are worthwhile and allow patients to die peacefully and with dignity

"No I just think you see the people that have got the forms, and they're not dying in A and E on a trolley anymore. And that's a massive benefit for me."

Recommendations for good practice

- It should be acknowledged that DNACPR discussions are difficult and can be distressing even for specialist staff.
- Staff should be aware of triggers to initiate DNACPR discussions: discharge/changes in a patient's condition.
- DNACPR discussions are best conducted in the context of wider end of life discussion and anticipatory care planning.
- Discussions are easier with patients who have realistic views of their prognosis – therefore effective communication with patients prior to end of life discussions is important.
- Staff should be aware that few negative reactions from patients are reported after a DNACPR discussion and some staff believe discussions allow patients more clarity on their situation.

Conclusions

Staff find DNACPR discussions to be challenging and in some cases find that they cause personal anxiety or distress. Despite this staff believe that discussions about resuscitation are in their patients best interests and most staff members view discussions to be a worthwhile aspect of end of life care. Staff should be reassured that few negative patient reactions in response to a DNACPR discussion were reported.

It is helpful to discuss DNACPR in the context of a broader end of life discussion. This made the discussion easier for staff and also allowed the potential reaction of patients to be gauged. Some staff believe this discussion can even be therapeutic for patients.

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