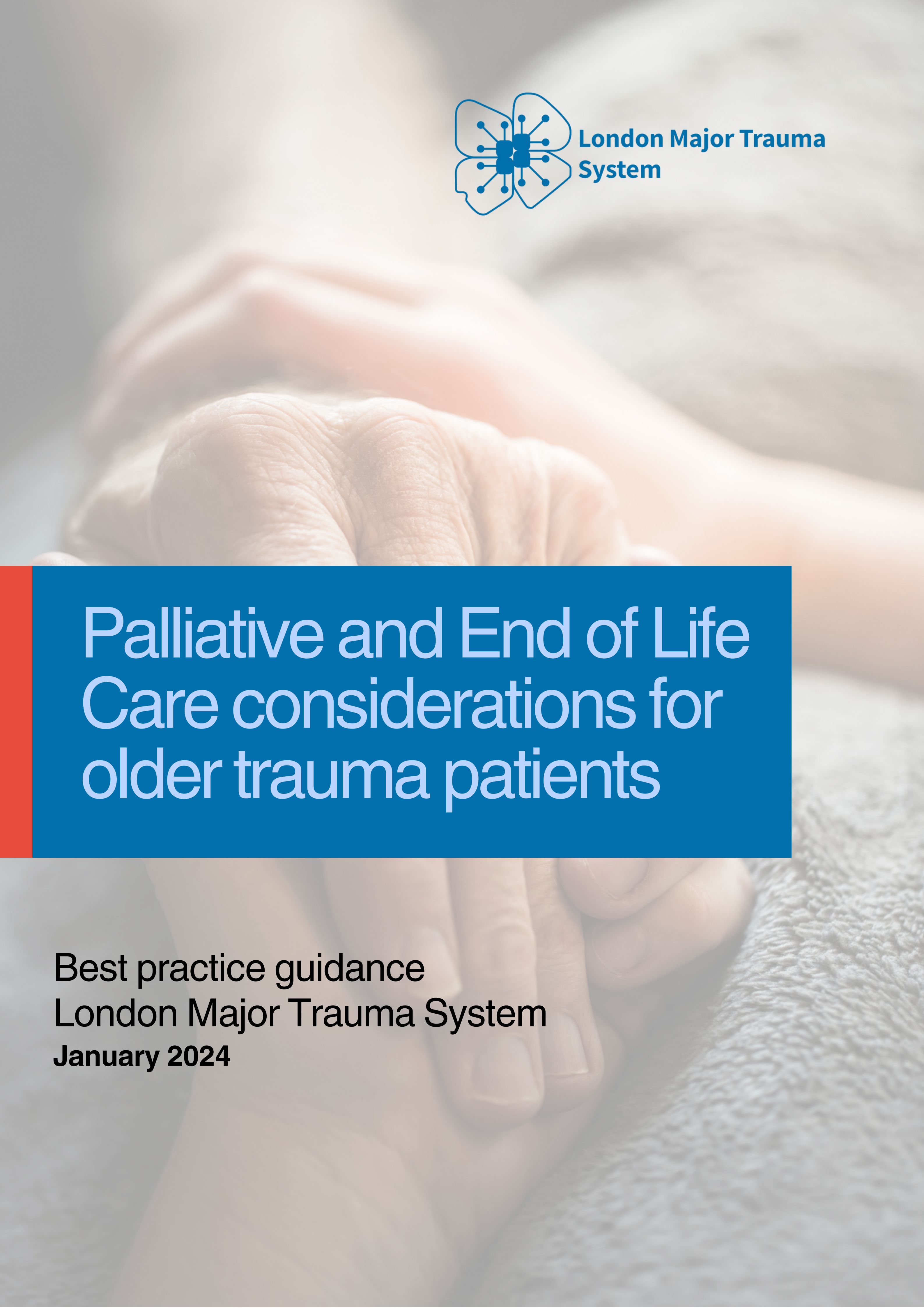

London Major Trauma System

Palliative and End of Life Care considerations for older trauma patients

Best practice guidance
London Major Trauma System
January 2024

Key Principles

All healthcare professionals involved in the care of older trauma patients have a responsibility towards the identification and management of an individual's palliative and end of life care needs

Palliative support for older trauma patients should be provided in conjunction with, and not separate to, best available curative/life-prolonging interventions

All older trauma patients should be looked up on local health records to see if they have an advance care pathway, e.g. on the Universal Care Plan (https://ucp.onelondon.online/about/)

Prognostication at the outset can be difficult. Where the appropriateness of clinical interventions is uncertain, 'time limited trial of treatments' should be considered, alongside patients wishes and preferences.

Effective communication between TUs and MTCs is essential and palliative care referral pathways should be in place within trauma networks to facilitate individualised decision-making.

Where specialist services at MTCs are requested to guide treatment options, senior TU clinicians managing the patient should factor in and convey relevant information about a patient's medical background and personal values, to enable shared decision-making on prognosis, treatment intentions and the best location of ongoing care.

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Appendix

Aims of this guidance

This guidance aims to provide best practice recommendations when considering palliative and end of life care for older trauma patients by:

- Improving recognition of older patients who are at risk of dying following a traumatic injury
- Integrating principles of palliative care into routine comprehensive assessment of older trauma patients to enhance wellbeing, irrespective of prognosis or curability
- Providing clinicians with a framework to support decision-making when dealing with clinical uncertainty
- Informing and empowering non-palliative-specialist clinicians working with older trauma patients to ensure collaborative decision-making for their patients.

This document is not intended to replace any local or national guidelines, but provides a trauma-focused resource for non-palliative care specialists caring for older trauma patients.

1. What is palliative care?

The focus of palliative assessment is to enhance wellbeing and quality of life through holistic, integrated multi-disciplinary care at any stage of a life-threatening, disabling or advancing disease, not just when death is imminent.

Core aspects of palliative care should be routinely implemented through all stages of an older trauma patient's journey.

Find out what matters most

Early identification of patient's wishes to ensure treatment aligns with patient's values

Communication and shared decision-making

Involve relevant specialties, the patient and patient's representatives in decision-making where possible

Holistic symptom management

Manage pain, dyspnoea, agitation, or any other symptoms using pharmacological and non-pharmacological methods

Psychospiritual and socioeconomic support

Identify emotional, psychological, spiritual, religious and socioeconomic needs of patients and those important to the patient, to support their journey through life-altering illness or injury

What is palliative care? continued...

Consider appropriateness of interventions

Establish and regularly review decisions around cardio-pulmonary resuscitation and treatment escalation decisions including clinically assisted feeding and hydration, and invasive organ support

Identifying an appropriate place of care

For example, if risk of dying is significant transfer from a local trauma unit to a major trauma centre may be less preferable to patients/relatives due to accessibility

Advance care planning

Access any existing advance care plans and document future treatment plans, patient's preferences and wishes

Continuity of care

Ensure effective handover and continued support of patients' needs upon transfer to another ward or hospital or return to community setting (for example, referral to community palliative care team or district nurses). Document decisions on the Universal Care Plan

2. Screening for palliative care needs

Screening of patient's palliative care needs should be carried out at the earliest opportunity.

2.1 Frailty screening

All older patients with trauma should be screened for frailty using the **Clinical Frailty Scale (CFS)** [1]. CFS Is a validated tool to measure frailty in older trauma patients aged 65 years and above [2,3].
Patients with a CFS of ≥5 are at higher risk of poor outcomes and death after traumatic injury. **However CFS should not be used in isolation to set limits on treatment.**

2.2 Identifying those at risk of dying

On admission, the responsible clinical team should identify those who are either at risk of dying or are expected to survive but with poor outcomes (Appendix 1). These may include patients with:

- Catastrophic injury e.g. traumatic brain injury with cerebral herniation
- Disabling injury where health and quality of life outcomes are anticipated to be poor e.g. high spinal cord injury
- Significant pre-morbid frailty or co-existing conditions where the patient may die within 12 months. The **SPICT tool** can be used to aid identification of these patients (https://www.spict.org.uk/) [4].
- Other underlying terminal or life-limiting illness e.g. metastatic malignancy, end stage organ failure

Assessments should be reviewed regularly during the patient's admission as clinical trajectory becomes clearer and clinical challenges and treatment decisions change.

2.3 Comprehensive Geriatric Assessment

Early collateral history and initiation of comprehensive geriatric assessment within 72 hours, or earlier if possible, is essential to guide decision-making regarding treatment escalation.

2.4 Universal Care Plans and LPA

It is essential to investigate if the patient has any previously expressed wishes.
Universal Care Plans (UCP) and Electronic Palliative Care Coordination systems (EPaCCS) are digital personalised care and support planning tools. These hold advanced care planning decisions, wishes and preferences for future care and can be used to guide decision making in a situation **where a person lacks capacity or cannot speak for themselves**.
All patients should be looked up on these systems or local health records to see if they have an advance care pathway.

Records should also be checked to determine if the patient has a Lasting Power of Attorney (LPA), legally appointed to make health and care decisions on their behalf (https://www.nhs.uk/conditions/end-of-life-care/planning-ahead/lasting-power-of-attorney/)

2.5 Advance Decision to Refuse Treatment

An Advance Decision to Refuse Treatment (ADRT) is a written statement of a patients wishes to refuse certain treatments in specific situations.
All patients/representatives should be asked about ADRT or do not attempt cardiopulmonary resuscitation (DNACPR) that may be in place (https://www.nhs.uk/conditions/end-of-life-care/planning-ahead/advance-decision-to-refuse-treatment/)

3. Five priorities of care at end of life

- Recognising that someone is dying
- Communicating sensitively with them and others important to them
- Involving them and others important to them in decisions
- Providing support
- Creating an individualised plan of care and delivering it with compassion

4. Palliative and end of life care

TUs and MTCs should have protocols in place for how to contact local specialist palliative care teams, including out of hours.

4.1 When death is expected

Scenario

Mrs CD was admitted after a fall down the stairs. On assessment, her GCS was 4, her right pupil was dilated and she had a self-terminating tonic-clonic seizure. She was intubated on arrival. A CT scan showed a large subdural haemorrhage with compression of the right lateral ventricle and uncal herniation.

The emergency medicine team in the TU liaised with the MTC neurosurgical team. The injury was considered to be not survivable. The probability of imminent death was discussed with her family and the focus of care was an individualised “palliative” approach. Mrs CD did not have an advance care plan in place prior to the fall.

Key considerations to provide good quality end of life care for patients like Mrs CD would include the role of seizure prophylaxis, compassionate delivery of palliative extubation and preferred place of care.

- Where death is expected or inevitable, focus should be on the ***5 priorities of care at end of life*** **(see previous page),** together with withdrawal of life sustaining interventions that are likely to prolong dying rather than leading to any meaningful chance of recovery.

- **The person's preferred place of care should be considered.** Patients transferred to or admitted directly to an MTC may be long distances away from their families and friends. Therefore if time critical/specialist surgery, invasive procedures or critical care are deemed to be not in the patient’s best interests, for some patients transfer to a MTC may not be appropriate. In such cases, shared decision making between the TU and MTC should be considered (see Appendix 2 for a suggested framework). Decisions must be documented in the patients notes.

- NICE provide national guidance for the care of adults in the last days of life (https://www.nice.org.uk/guidance/ng31)[5]

- Patients and/or families may want to support end of life care in the patient's own home or other community setting, eg hospice. This option should be offered where possible, although this may not always be feasible (e.g. complex palliative care needs). Systems should be in place to prioritise organisation of the required services to support end of life care in the home /hospice setting.
- If a person is at a location at a distance from family and friends, repatriation to a local hospital should be considered.
- Repatriation decisions need to be weighed up against possible deterioration and death during transfer.
- All hospitals should have access to palliative care team input, including out of hours telephone support, to help clinicians provide these patients with a comfortable and dignified death.

4.2 Trials of treatment

Scenario

Mr JD was an 86 year old gentleman admitted after an unwitnessed fall. Previously, he walked with a frame, but needed assistance with washing and dressing. On assessment, he had a GCS of 12/15 and was requiring 8l/min of oxygen. Head CT confirmed a small right cerebral contusion, right sided rib fractures and a right basal pneumonia. In view of his pre-morbid frailty (CFS 6) and acute critical illness, expectancy of adequate clinical recovery was uncertain. A trial of antibiotics, pain management and chest physiotherapy was thought reasonable, especially as it would also provide symptomatic benefit. At once, it is paramount to establish within the MDT and with Mr JD's family:

- Establish patients wishes and preferences as soon as possible
- What treatment interventions would remain inappropriate? e.g. CPR, invasive organ support
- What time-frame to expect clinical improvement in?
- What parameters would indicate clinical improvement? e.g reduced oxygen requirement, GCS >14
- Expected management if treatment is deemed ineffective. e.g. stopping antibiotics, palliative care input

Decision-making regarding benefits of treatment are often centred around mortality benefit and probability of clinical effectiveness. **However, survival benefit should be weighed against patient-centred outcomes of comfort, disability, dignity and personal beliefs.**

When there is uncertainty or conflict concerning prognostic benefits or outcomes of treatment interventions, decisions should start from presumption in favour of prolonging life.

In such cases, time-limited trials of treatment can be initiated. The proposed treatment can be medical or procedural and must:

- Align with what patient's wishes would be
- Have evidence of clinical effectiveness
- Be acceptable to the patient's quality of life and not cause disproportionate harm
- Not prevent the patient from experiencing good end of life care

Time limited trials should be agreed with the multi-disciplinary team, the patient/patient representative and relatives. It is important to convey uncertainty and avoid firm predictions.

At the outset itself, it is important to establish:

- The duration of trial of treatment
- Acceptable parameters to gauge treatment efficacy
- Steps to be taken if trial of treatment is deemed unsuccessful
- The range of possibilities of outcomes

Where conflict or uncertainty continues in spite of time-limited trials, decision-making can be supported by:

- Second opinion within the department
- Second opinion from another specialty
- Palliative care team
- Local Ethics Committee within the NHS Trust
- Legal team within the NHS Trust

4.3 Shared decision-making

Shared decision making is a collaborative approach between healthcare professionals to support and empower a patient with capacity / legal authority to choose between treatment options or refuse treatments.

Scenario

Mr SD is an 82 year old gentleman who was admitted after a fall and presented with a GCS 12/15. CT Head confirmed a large acute subdural haemorrhage with mass effect. Neurosurgical advice suggested local admission for monitoring with interval imaging if any deterioration. They planned to arrange for transfer after a week to allow optimal timing of haematoma evacuation.

Mr SD was reviewed by a geriatrician. He was known to have end stage renal failure and had declined dialysis in renal clinic recently with a documented advanced directive. In recent months, there had been a marked decline in his cognitive and physical function. The geriatrician contacted the neurosurgical team to re-discuss fitness for general anaesthesia and other indicators of terminal illness. Both parent and neurosurgical teams, alongside his family, agreed that operative intervention was in fact, unlikely to provide "overall benefit" to health outcomes.

The geriatrician and parent team were best placed to appraise Mr SD's medical background, his/his family's expectations and anticipated treatment outcomes leading to an appropriate and collaborative best interests decision.

Who assesses "appropriateness" of treatments?

- Appropriateness of treatment should be determined by the clinical team with access to information to facilitate informed and shared decision making.
- In TUs, where transfer to an MTC is deemed inappropriate, the decision lies with the senior clinician of the admitting team.
- Where the patient is unable to express their wishes or lacks mental capacity, discussion with someone important to them MUST be a priority
- Specialty teams in MTCs should pro-actively collaborate with the responsible clinicians in TUs in guiding prognostic assessment early on and ensuring timely decision-making.
- Uncertainty regarding complex treatment decisions may not be adequately resolved over online portals and may require more regular and direct communication. MTCs should develop collaborative pathways with TUs for complex shared decision-making at a consultant level for such patients, e.g. using weekly virtual MDTs or direct hotlines.

Deciding on treatment

The clinical team should then discuss the available treatment options with the patient. For those with capacity or an appropriate legal authority, the individual has the right to accept, refuse or choose between treatment options made available.

It is the clinical team's role to ensure they have access to all information including treatment goals, benefits and risks to support their decision making.

If a patient lacks capacity and there is no legal directive or proxy, the lead clinician is responsible for assessment of decisions regarding "overall benefits" as long as principles of best interests decision have been applied.

Application for Independent Mental Capacity Advocate may also be appropriate.

If the patient/legal proxy asks for treatment that is not thought to be clinically appropriate, the responsible clinician should:

- Explore reasons why they feel this is appropriate for him/her and explore realistic expectations, personal goals and values.
- Re-consider whether this treatment may reasonably serve the patient's needs and there may be an argument in offering this as a "time limited trial".
- If the treatment is not thought to achieve any clinical benefit, then the healthcare team should not offer it. But their reasoning for why the treatment is not deemed beneficial should be communicated and documented.
- If unsure, seek a second opinion.

5. Clinical considerations and management

Common clinical considerations for palliative and end of life care needs after traumatic injury

5.1 Traumatic brain injury

- It is difficult to predict long term outcomes after a significant traumatic brain injury early in the patient's admission and it can take up to 1-2 years to reach the chronic stage of recovery.

- Caution must be exercised in implementing early treatment restrictions on the basis of severity of brain injury, especially in the absence of previous frailty.

- Neurosurgical and neurorehabilitation teams at MTCs should assist clinicians at TUs in prognostic assessment and decision-making, where local expertise may not be available.

5.2 Anticipatory medications

- Anticipatory medicines are used for end of life symptoms control and include the most important medicines which might be required to manage predictable and distressing symptoms:
    - Pain
    - Shortness of breath
    - Sickness/Nausea
    - Excessive respiratory secretions
    - Restlessness/agitation
- Local trust end of life care guidelines should be followed.

5.3 Seizure management

Seizures can occur at the end of life, especially in traumatic head injuries or those with previous epilepsy. They can be distressing for patients, relatives and healthcare professionals.

Whilst the evidence for seizure prophylaxis in traumatic head injuries is unclear, certain high-risk patients such as those with seizures at presentation or those with large contusions or cerebral oedema may benefit from anti-epileptic drug (AED) treatment. D*iscussion with the neurosurgical team on a case-by-case basis may be required.*

For patients who have been on longer-term AEDs, avoid any interruptions in these as best as possible, although dose adjustments may be needed in patients with derangement of renal or liver function. Liquid formulations of most AEDs are available and can be administered via NG. Liaise with the pharmacist where needed.

Where AEDs cannot be given orally/NG, some medications such as levetiracetam or lacosamide can be given intravenously at equivalent doses. For other medications, discuss with the palliative care team or where indicated, a neurologist.

Where intravenous or oral routes are not possible, midazolam is the most commonly used AED and can be given via buccal, intramuscular and subcutaneous routes.

Seek specialist palliative care advice to guide the use of AEDs or continuous subcutaneous infusions (CSCI). Midazolam, levetiracetam and phenobarbital can be given as CSCI, but the use of the latter two may be limited by availability.

Management plans for patients at risk of seizures should include recommendations for the prevention of seizures at the end of life.

5.4 Withdrawal of artificial feeding and hydration

- Continuation of artificial feeding and hydration (clinically assisted nutrition and hydration CANH) can prolong the dying process and contribute to risks such as electrolyte imbalance, re-feeding syndrome or oedema. Repeated intravenous cannulations or nasogastric tube insertion and placement monitoring can be distressing.
- Lack of treatment efficacy and potential risks associated with CANHs may still conflict with cultural, religious and personal values of patients and their representatives.
- Careful consideration is required for decisions to start/continue/withdraw CANH especially when a person is not felt likely to die within hours or days, a senior doctor must take all reasonable steps to obtain a second opinion.
- The GMC requires a second clinical opinion to be sought where it is proposed it is in the patient's best interests to stop or not start CANH and the patient is not within hours or days of death. The RCP and BMA have published guidelines to provide a framework to clinicians [6].

5.5 Extubation and withdrawal of ventilatory support

Decisions about extubation and withdrawal of ventilation require a multidisciplinary agreement. This must also include discussion with the patient's next of kin or LPA.

- **One-way extubation**:

One-way extubation refers to withdrawal of artificial ventilation with uncertain outcome. For example extubation may be successful and active treatments may be continued (eg. feeding, antibiotics, fluids) but if the patient deteriorates abruptly they will not be reintubated and end of life care provided.

It is important that relatives are counselled on uncertainty. In some cases of one way extubation where death is felt to be imminent by clinical teams, patients may not die immediately or may respond better than expected after extubation. This can be distressing for relatives who may be expecting death to occur quickly. It is important to emphasise uncertainty under these circumstances and a pragmatic approach to managing patients on an individual basis.

- **Palliative extubation**:

Airway and ventilatory management at the end of life should be at the discretion of the treating consultant. Immediate extubation can be considered and will often be preferred by relatives. However, in some cases, such as those where imminent airway occlusion might be reasonably anticipated, or ventilatory requirements are high, potentially leading to distressing air hunger on withdrawal of ventilation, it may be more appropriate to wean ventilation (FiO2, PEEP, and driving pressure) while providing opiates or benzodiazipines to manage dyspnoea.

Extubation in ED can be appropriate (e.g. if the family are in attendance, there is no possibility of getting the patient to critical care or if it has been established the patient is not a potential organ donor).

Every MTC and TU should have defined pathways for organ donation referral and patients should be assessed on an individual basis.

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4 University of Edinburgh. SPICT https://www.spict.org.uk/the-spict/

5 NICE Care of dying adults in the last days of life https://www.nhs.uk/conditions/end-of-life-care/what-to-expect-from-care/

6 BMA Clinically-assisted nutrition and hydration and the decision-making process https://www.bma.org.uk/advice-and-support/ethics/adults-who-lack-capacity/clinically-assisted-nutrition-and-hydration/the-decision-making-process

Resources

American College of Surgeons. Trauma Quality Improvement Program palliative care best practice guidelines. https://www.facs.org/media/g3rfegcn/palliative_guidelines.pdf

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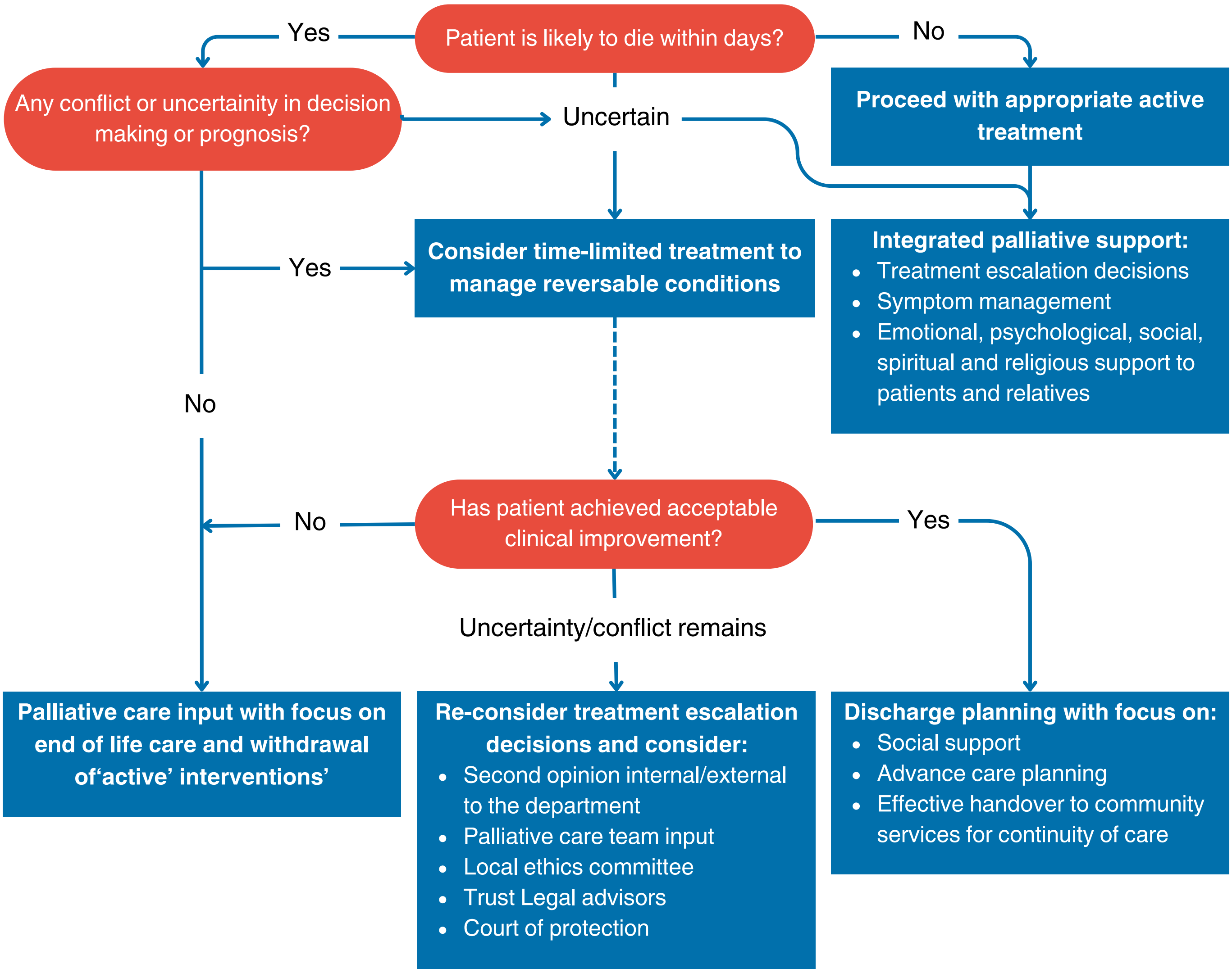
Appendix 1

Screening for palliative care needs

Screen the following patients for palliative care needs

- Those aged 65 or over with trauma:
- Those unlikely to survive this hospital admission
- Those predicted to have poor functional recovery
- Those with advanced frailty e.g. CFS 5 or above
- Those with long term conditions e.g. end stage renal failure, advanced malignancy, severe heart failure
- Those who you would not be surprised if they died within one year due to comorbidities
- Those where patient/representative wishes/have previously expressed wishes for palliative care



Patient is likely to die within days?

Yes

No

Proceed with appropriate active treatment

Any conflict or uncertainty in decision making or prognosis?

Uncertain

Yes

Consider time-limited treatment to manage reversable conditions

Integrated palliative support:

- Treatment escalation decisions
- Symptom management
- Emotional, psychological, social, spiritual and religious support to patients and relatives

No

Has patient achieved acceptable clinical improvement?

No

Yes

Uncertainty/conflict remains

Palliative care input with focus on end of life care and withdrawal of‘active’ interventions’

Re-consider treatment escalation decisions and consider:

- Second opinion internal/external to the department
- Palliative care team input
- Local ethics committee
- Trust Legal advisors
- Court of protection

Discharge planning with focus on:

- Social support
- Advance care planning
- Effective handover to community services for continuity of care

Appendix 2

Principles of shared decision making for Trauma Unit to MTC transfers

1. Shared information		
Handed over - current clinical condition and images	Yes	No
Pre-injury health assessment using SPICT and frailty score	Yes	No
2. Shared Trauma Unit team assessment:		
Would you be surprised if the patient was still alive in 12 months?	Yes	No
Is this patient likely to survive this admission?	Yes	No
Is this patient currently fit for a general anaesthetic?	Yes	No
3. Patient wishes/priorities:		
Does this patient have an Advance Care Plan / Universal Care Plan / ADRT / LPA Details:	Yes	No
4. Major Trauma team response - likely level of benefit to patient if transferred to MTC:		
Clear benefit	Yes	No
No benefit	Yes	No
Uncertain benefit	Yes	No
Potential benefits of transfer:		
Potential burdens of transfer:		
Potential risks of transfer:		
5. Transfer decision:		
Transfer patient now	Yes	No
Transfer patient at a later timepoint Details:	Yes	No
Do not transfer – all care at Trauma unit	Yes	No
6. Further MTC specialist advice and name/details of contact:		

Appendix 3

Principal ethical and legal determinants

Human rights act 1998:
Healthcare-related decisions must be governed by:

- Right to life (Article 2)
- Right to be free from inhuman or degrading treatment (Article 3)
- Right to freedom of expression including right to hold opinions and receive all information (Article 10)
- Right to be free from discriminatory practice (Article 14)

Capacity:
The Mental Health Act 2005 governs the principles of mental capacity. The main principles are:

- Always start in favour of presumption of capacity
- Capacity is task-specific
- Patients have the freedom to make unwise decisions
- Capacity assessment specific to a decision involves ability to:
    - (i)Understand relevant information, and
    - (ii)Retain relevant information, and
    - (iii)Weigh relevant information, and
    - (iv)Communicate their decision by any means.

Best interests decision:
If a patient is thought to lack capacity, all necessary steps must be taken to maximise capacity and incorporate patient values.

1.All reasonable measures have been taken to optimise capacity (e.g. optimising hearing, communication aids).

2.Where reasonable, the decision should be delayed if it is anticipated that the individual may regain capacity

3.If there is an advanced decision to refuse treatment, best interests principle will no longer apply as long as this is valid and applicable

4.Determine if there is appointed legal proxy (deputy or Power Of attorney) that would encompass the specific decision

5.If all above measures have been attempted, then the best interests decision lies with the lead health care professional and is based on clinical judgement, objective evidence and anticipated outcomes. This should:

- consider patient's preferences, values and previously expressed wishes
- cconsult (where appropriate) with those close to the patient
- consult with the multi-disciplinary team

Treatment escalation plan:
As outlined by the Mental Capacity Act 2005, a treatment escalation plan is a record that communicates personalised goals of treatment. It should reflect the values and preferences that are important to the person receiving care if their condition should deteriorate

Principal ethical and legal determinants

Decisions relating to cardiopulmonary resuscitation:
Where the healthcare team think that CPR will not restart the patients heart:

- CPR should not be offered or attempted
- It is a legal requirement that a CPR decision must be discussed with a patient who has capacity or with their NoK or LPA where mental capacity is absent or the patient has declined to be involved in the discussion
- However, it is not important to seek informed consent from the patient or those close to the patient as they do not have the right to demand treatment that is not clinically appropriate
- In the event where they disagree with the DNACPR order, a second opinion and endorsement of a multidisciplinary team should be sought. Patients do not have a legal right to treatment that is clinically inappropriate.

Where CPR may be successful in re-starting the heart and breathing for a sustained period but lead to poor/uncertain health outcomes or quality of life:

- It is not solely a clinical decision
- Patient's wishes and shared decision- making are paramount: patients should be given realistic expectations of chances of survival and expected length and quality of life after CPR
- Where CPR has a reasonable chance of being successful and the patient has accepted that the quality of life expected is reasonable to him/her, their wish for CPR should usually be respected.
    - However, doctors cannot be required to give treatment that is contrary to clinical judgment and if differences arise, a second opinion from another consultant should be considered

- A DNAR decision is not legally binding. It does not override clinical judgment in unforeseen circumstances that does not match the circumstances anticipated when the decision was made, e.g choking, blocked tracheostomy tube

Further reading: Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing (2016). Decisions relating to cardiopulmonary resuscitation. [3rd edition] Human rights act 1998:
Healthcare-related decisions must be governed by:
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Contributors

Julia Bichard, Consultant Palliative Care, West Hertfordshire Teaching Hospitals NHS Trust.
Liz Bunker, Lead Nurse for Palliative and End of Life Care, Hillingdon Hospital.
Katherine Buxton, Clinical Director, Palliative and End of Life Care Strategic Clinical Network, NHSE (London region).
Daniela Burlacu, Consultant in Emergency Medicine, West Hertfordshire Teaching Hospital.
Trish Burton, Patient and Family Liaison Nurse, Essex and Herts Air Ambulance.
Sharon Chardwick, Consultant Palliative Care, West Hertfordshire Teaching Hospitals NHS Trust.
Elaine Cole, Director of Research and Innovation, London Major Trauma System.
Sarah Cox, Palliative Care Consultant, Chelsea and Westminster Hospital.
Mireia Cuartero Sala, Consultant Intensivist, St Mary’s Hospital.
Aloysius Dsouza, Consultant Physician, Geriatric Medicine / Internal Medicine, Hillingdon Hospital.
Vanessa Elliot, Consultant in Intensive Care and Acute Medicine, St George's Hospital.
Derek Hicks, Emergency Medicine Consultant, Royal London Hospital.
Heather Jarman, Research Director for Nursing, Midwifery and AHPs, St George's Hospital.
Alice Kershberg, Centre for Excellence Patient & Family Liaison Lead, Essex and Herts Air Ambulance.
Hannah Kosuge, Trauma Network Manager, North East London and Essex Trauma Network.
Andrew Leitch, Consultant in Intensive Care Medicine and Anaesthesia, Royal London Hospital.
Nicola Lochrie, Consultant Physician, Geriatric and General Medicine, Kings College Hospital.
Jo Lockwood, Nurse Consultant in Trauma, St Mary’s Hospital.
Guy Lumley, Consultant Physician and Geriatrician, Royal London Hospital.
Cerys Morgan, Consultant Physician and Geriatrician, St Mary’s Hospital.
George Peck, Consultant Physician and Geriatrician, St Mary’s Hospital.
Jean Potter, Macmillan Consultant in Palliative Care, Hillingdon Hospital.
Alexandra Rogers, Consultant Palliative Care, West Hertfordshire Teaching Hospitals NHS Trust.
Faruq Siddiqi, Chaplain, Royal London Hospital.
Rhonda Sturley, Consultant Geriatrician, St George's University Hospitals NHS Foundation Trust.
Liz Sumner, Macmillan Palliative Care Deputy Lead Nurse, West Hertfordshire Teaching Hospitals NHS Trust.
Jane Tippett, Consultant Nurse ED, Kings College Hospital.
Harriett Tucker, Emergency Medicine and PHEM Consultant, St George's Hospital.
Surabhi Varma, Consultant Physician and Geriatrician, West Middlesex University Hospital.
Tara Whitburn, Consultant in Palliative Care, Royal London Hospital.

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