

## **Do Not Attempt Resuscitation (DNAR) Policy Document** **Withholding cardiopulmonary resuscitation**

The St. Mary's Resuscitation Committee has produced this policy. Our policy is based on the Joint Statement from The British Medical Association, the Resuscitation Council (UK) and The Royal College of Nursing on Decisions Relating to Cardiopulmonary Resuscitation published in June 1999. The Joint Statement is reproduced as background information to this policy and is also available at [www.resus.org.uk/pages/dnr3](http://www.resus.org.uk/pages/dnr3).

The policy acknowledges the Health Service Circular on Resuscitation Policy (HSC 2000/028) stressing the need for patient's rights to be respected and to be central to decision making on resuscitation.

### **Decisions Relating to Cardiopulmonary Resuscitation** **A Joint Statement from the British Medical Association,** **the Resuscitation Council (UK)** **and the Royal College of Nursing** **June 1999**

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#### **Introduction**

Cardiopulmonary Resuscitation (CPR) can be attempted on any individual in whom cardiac or respiratory function ceases. Failure of these functions is inevitable as part of dying and thus CPR can theoretically be used on every individual prior to death. It is therefore essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom CPR is inappropriate. It is also vital to encourage the involvement of patients, the health care team and people close to the patient in decision making, and to ensure the communication of decisions to all relevant health professionals.

#### **Background**

"Do-not-resuscitate" (DNR) decisions may be a potent source of misunderstanding and dissent amongst doctors, nurses and others involved in care of patients. Many of the problems in this difficult area would be avoided if communication and explanation of the decision were improved, both to relevant health professionals and people close to the patient. A letter from the Chief Medical Officer (PL/CMO (91) 22) following a case brought to the attention of the Health Service Commissioner clarified where responsibility lies. The Chief Medical Officer makes it clear that the responsibility for resuscitation policy lies with the consultant concerned and that each consultant should ensure that this policy is understood by all staff who may be involved. This is of particular importance for temporary or locum staff. Unfortunately, in many cases discussion and consultation about the resuscitation of a patient is carried out by staff least experienced or equipped to undertake such sensitive tasks.

The factors surrounding a decision whether or not to initiate CPR involve complex clinical considerations and emotional issues. The decision arrived at in the care of one patient may be inappropriate in a superficially similar case. These guidelines therefore should be viewed as a framework providing basic principles within which decisions regarding local policies on CPR may be formulated. Individual Trusts and hospitals are advised to produce their own protocols which may encompass more detailed guidance than we can provide here. Further assistance for doctors and nurses where individual problems arise can be obtained from their respective professional organisations. Some additional published guidance is listed below.

## Guidelines

**1.** It is appropriate to consider a Do Not Resuscitation (DNR) decision in the following circumstances:

- a) Where the patient's condition indicates that effective cardiopulmonary resuscitation (CPR) is unlikely to be successful.
- b) Where CPR is not in accord with the recorded, sustained wishes of the patient who is mentally competent.
- c) Where CPR is not in accord with a valid applicable advance directive (anticipatory refusal or living will). A patient's informed and competently made refusal which relates to the circumstances which have arisen is legally binding upon doctors.
- d) Where successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain.

**2.** Where a DNR decision has not been made and the express wishes of the patient are unknown, resuscitation should be initiated if cardiac or respiratory arrest occurs. Anyone initiating CPR in such circumstances should be supported by their senior medical and nursing colleagues.

**3.** The overall responsibility for a DNR decision rests with the consultant or general practitioner in charge of the patient's care. This should be made after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interests of the patient, an assessment of which should include likely clinical outcome and the patient's known, or ascertainable, wishes. The perspectives of other members of the medical and nursing team, including the GP, the patient, and with due regard to patient confidentiality, the patient's relatives or close friends, may all be valuable in forming the decision. People close to the patient (who may not be relatives) frequently report feeling excluded from decision making. Where possible, patients should be asked in advance whom they want, or do not want, to be involved in decision making if they become incapacitated.

**4.** Where competent patients are at risk of cardiac or respiratory failure, or have a terminal illness, there should be sensitive exploration of their wishes regarding resuscitation. Ideally this should be carried out by the responsible doctor concerned. Such discussions, and any anticipatory decisions, should be documented, signed and dated, in the patient's record.

**5.** Although responsibility for CPR decisions for in-patients rests with consultants, they should be prepared always to discuss the decision for an individual patient with other health professionals involved in the patient's care. The importance of teamwork cannot be over-emphasised.

**6.** Proper understanding of the DNR decision is impossible without knowing the rationale behind it. The entry in the medical records of the decision and reasons for it should be made by the most senior member of the medical team available who should ensure that the decision is effectively communicated to other members of staff, including GPs, deputising or GP co-operative services, and ambulance staff for patients in the community.

**7.** Recording in the nursing notes should be made by the primary nurse or the most senior member of the nursing team whose responsibility it is to inform other members of the nursing team.

**8.** The decision reached following admission of the patient should be reviewed by the consultant in charge at the soonest available opportunity. Such decisions will, of necessity, need to be reviewed regularly in the light of changes in the patient's condition.

**9.** When the basis for a DNR decision is the absence of any likely medical benefit, discussion with the patient, or others close to the patient, should aim at securing an understanding and acceptance of the clinical decision that has been reached. If a DNR decision is based on quality of life considerations, the views of the patient where these can be ascertained are particularly important. If the patient cannot express a view, the views of family or others close to the patient may be sought regarding what would be in the patient's best interests. Their role is to reflect the patient's views, not to take decisions on behalf of the patient. Relatives and others close to the patient should be assured that their views on what the patient would have wanted will be taken into account in decision making. However, they cannot determine a patient's best interests, nor give consent to or refuse treatment on a patient's behalf.

**10.** Discussions of the advisability or otherwise of CPR will be highly sensitive and complex and should be undertaken by senior and experienced members of the medical team supported by senior nursing colleagues. A DNR decision applies solely to CPR. It should be made clear that all other treatment and care which are appropriate for the patient are not precluded and should not be influenced by a DNR decision. To avoid all confusion, the expression "not for cardiopulmonary resuscitation" should be used and included in the patient's notes.

**11.** Experience with DNR decisions is an appropriate subject for clinical audit.

**12.** This statement gives only general guidance. In addition, all acute hospital trusts should establish local guidelines to deal with decisions relating to CPR.



# Decisions Relating to Cardiopulmonary Resuscitation

## Local Guidelines for St Mary's

1. **Definitions.** Resuscitation in this context refers to the process of attempting to re-establish cardiac output and/or independent breathing. A Do Not Attempt Resuscitation (DNAR) order is a declaration that such resuscitation is not to be attempted.
2. **Scope.** A DNAR decision applies solely to CPR. It should be made clear that all other treatment and care which are appropriate for the patient are not precluded and should not be influenced by a DNAR decision. To avoid all confusion, the expression "not for cardiopulmonary resuscitation" should be used and included in the patient's notes.
3. **The status quo without a DNAR order.** Where a DNAR Order has not been made and the wishes of the patient are not known, resuscitation should be initiated if cardiac or respiratory arrest occurs. Responsibility for resuscitation policy lies with the consultant concerned and each consultant should ensure that this policy is understood by all staff who may be involved.
4. **Reasons for a DNAR Order** These are summarised overleaf and on the DNAR Order documentation for the patient's clinical records and discussed more fully below:
  - a) **Where the patient's condition indicates that effective cardiopulmonary resuscitation (CPR) is unlikely to be successful.** *This is ultimately a medical decision.*
    - When the basis for a DNAR decision is the absence of any likely medical benefit, discussion with the patient, or others close to the patient, should aim at securing an understanding and acceptance of the clinical decision that has been reached.
    - Discussions of the advisability or otherwise of CPR will be highly sensitive and complex and should be undertaken by senior and experienced members of the medical team supported by senior nursing colleagues.
    - Although responsibility for CPR decisions for in-patients rests with consultants, they should be prepared always to discuss the decision for an individual patient with other health professionals involved in the patient's care. The importance of team work cannot be over-emphasised.
    - Proper understanding of the DNR decision is impossible without knowing the rationale behind it. The entry in the medical records of the decision and reasons for it should be made by the most senior member of the medical team available who should ensure that the decision is effectively communicated to other members of staff.
  - b) **Where CPR is not in accord with the recorded, sustained wishes of the patient who is mentally competent.**

Where competent patients are at risk of cardiac or respiratory failure, or have a terminal illness, there should be sensitive exploration of their wishes regarding resuscitation. Ideally this should be carried out by the responsible doctor concerned. Such discussions, and any anticipatory decisions, should be documented, signed and dated, in the patient's record.
  - c) **Where CPR is not in accord with a valid applicable advance directive (anticipatory refusal or living will). A patient's informed and competently made refusal which relates to the circumstances which have arisen is legally binding upon doctors.**

**d) Where successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain.**

- If a DNR decision is based on quality of life considerations, the views of the patient where these can be ascertained are particularly important. If the patient cannot express a view, the views of family or others close to the patient may be sought regarding what would be in the patient's best interests. Their role is to reflect the patient's views, not to take decisions on behalf of the patient. Relatives and others close to the patient should be assured that their views on what the patient would have wanted will be taken into account in decision making. However, they cannot determine a patient's best interests, nor give consent to or refuse treatment on a patient's behalf.
- This decision should be made after appropriate consultation and consideration of all aspects of the patient's condition. Decisions must be taken in the best interests of the patient, an assessment of which should include likely clinical outcome and the patient's known, or ascertainable, wishes. The perspectives of other members of the medical and nursing team, including the GP, the patient, and with due regard to patient confidentiality, the patient's relatives or close friends, may all be valuable in forming the decision. People close to the patient (who may not be relatives) frequently report feeling excluded from decision making. Where possible, patients should be asked in advance who they want, or do not want, to be involved in decision making if they become incapacitated.

5. **Completing the DNAR Order, communication** The entry in the medical records of the decision and reasons for it should be made by the most senior member of the medical team available who should ensure that the decision is effectively communicated to other members of staff. The Trust's DNAR Order should be completed by the senior doctor and entered into the clinical notes. Recording in the nursing notes should be made by the primary nurse or the most senior member of the nursing team whose responsibility it is to inform other members of the nursing team.

6. **Regular review of DNAR decisions** The decision reached following admission of the patient should be reviewed by the consultant in charge at the soonest available opportunity. Such decisions will, of necessity, need to be reviewed regularly in the light of changes in the patient's condition.