Draft 21

DNAR
(Do Not Attempt Resuscitation)
Policy

for Northgate and Prudhoe NHS Trust

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Contributors

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Policy structure

Supplementary documentation:
DNAR form and pathway
Patient and family advice leaflet
Policy summary for staff
CliP (Current Learning in Palliative Care) worksheet on 'Issues on Resuscitation'

1. Background

There is much confusion and uncertainty about resuscitation:
- what is meant by resuscitation
- when a decision is needed
- when to ask a patient and/or relative
- what to do when the patient is not competent
- what to do if there is uncertainty

2. Guidelines

These exist in several key publications which were updated in 2001.[1 – 11] These guidelines now take account of the Human Rights Act.

2.1 Summary of BMA/RCN/RC guidelines [1]

Principles

- Timely support for patients and people close to them, and effective communication are essential.
- Decisions must be based on the individual patient's circumstances and reviewed regularly.
- Sensitive discussion in advance should always be encouraged, but not forced.
- The chances of a success for cardiopulmonary resuscitation (CPR) need to be realistic.

2.1a Practical matters

- Information about CPR should be displayed for patients and staff.
- Leaflets should be available for patients and people close to them explaining about CPR, how decisions are made and their involvement in decisions.
- Decisions about attempting CPR must be communicated effectively to relevant health professionals.

2.1b In emergencies

- If no advance decision has been made, CPR should be attempted unless 1) the patient has refused CPR, 2) the patient is clearly in the terminal phase, or 3) the burdens of the treatment outweigh the benefits.

2.1c Advance decision making

- Competent patients should be involved in discussions about attempting CPR unless they indicate that they do not want to be.
- Where patients lack competence to participate, people close to them can be helpful in reflecting their views.

2.1d Legal issues

- Patients' rights under the Human Rights Act must be taken into account in decision making.
- Neither patients nor relatives can demand treatment which the health care team judges to be inappropriate, but all efforts will be made to accommodate wishes and preferences.
- Patients (or their allocated advocate) do have the right to a second opinion.
- In England, relatives and people close to the patient are not entitled in law to take health care decisions for the patient.
- Health professionals need to be aware of the law in relation to decision making for children and young people.

2.2 Resuscitation: what it is and what it is not

- *These are resuscitation measures:* cardiac massage, artificial respiration. These CPR measures will be instituted by local staff, but would precipitate calling emergency services and admission to an acute hospital. CPR is instituted immediately and in full following an *unexpected* collapse if success was likely.
- *These are comfort and palliative treatment measures:* analgesia, antibiotics, drugs for symptom control, feeding, (any route), hydration (any route), oxygen, hospital admission for investigation and treatment of a reversible condition, seizure/status control, suction, and treatment for choking. Comfort and treatment measures are instituted after assessment, consultation with patient and family, and on the basis of clinical need.

2.3 Problems with the current guidelines

The BMA/RCN/RC guidelines are often misinterpreted in three key areas:

a) a belief that all patients must be asked.
b) a requirement to ask dying patients about CPR
c) a belief that CPR is the 'default' in the absence of an advanced decision

2.4 The principles underlying this policy

This policy is based on the following five principles:

1. *Circumstances of an arrest:* if the circumstances of a future arrest cannot be anticipated, it is not possible to make decision that can have any validity in guiding the clinical team at the time of an unexpected arrest. It is an unnecessary and cruel burden to ask patient, partners or families about CPR when its circumstances cannot be anticipated. This should never prevent discussions about progress being communicated to the patient, including discussions about CPR if they wish.
2. *When CPR would fail:* in the situation where a death is *expected* as an inevitable result of the underlying disease, and the clinical team is 'as certain as it can be' that resuscitation would fail,[1] it is *not right* to offer the patient this option.[3] It is an unnecessary and cruel burden to ask patient, partners or families about CPR when CPR is not an option. This should never prevent discussions about progress being communicated to the patient.
3. *Communication:* throughout their care the patient must be given as much information as they wish about their situation.[3] Families can be told if the

patient agrees. It is not the professionals responsibility to decide how much information they can 'take'- their task is to find out how much the patient wishes to know or can understand. If a patient is not competent for this decision, then the clinical team must decide the best option taking into account the knowledge of the partner and family about the patient's previous wishes.

4. *Quality of life:* this policy adopts the view that medical decisions should be based on immediate health needs, and not on a professional's opinion on quality of life.[11] This is primarily because opinions on quality of life by health professionals are very subjective and often at variance to the view of the patient.[12]

5. *Default positions:* it is common for organisations to insist that CPR is given (or withheld) in the absence of a previous decision. This policy adopts the view that a default position for any treatment is unethical.
   This means that:
   a) In the absence of a decision on CPR, it is unacceptable to have policies that insist on doing CPR, or policies that insist on withholding CPR. Current clinical practice is that no other treatment has a default position, and CPR treatment should not be an exception.
   b) In the situation of an unexpected arrest, the clinical team must do what they have always done, make a rapid assessment of the clinical situation and weigh up the benefits and harm of CPR. DNAR decisions are not a shortcut to avoid such assessments.

2.6 The difficulties of deciding a DNAR order

Patients and relatives can surprise us with their decisions:

Some will wish to receive resuscitation despite marked disability with an advanced and irreversible condition. These are people who wish to continue fighting and could not conceive of giving up the option of resuscitation. *Offering resuscitation to these patients is our acknowledgement of their fighting spirit and makes the bereavement of families and partners less complicated since 'everything' that could be done was done.*

Some will wish to refuse resuscitation (in the absence of depression) despite an apparent good or reasonable quality of life. These are people who would not want to prolong their lives. *Withholding resuscitation from these patients is our acknowledgement of their wish not to suffer unnecessarily and makes the relative's bereavement less complicated since they feel the patient had their wishes respected.*

3. Review criteria
ie. the aims of this policy

3.1 To ensure that decisions regarding CPR are made according to
-whether CPR could succeed
–the clinical needs of the patient
–the patients wishes and best interests.
–current ethical principles
–current legal positions including the Human Rights Act.

3.2 To make DNAR decisions transparent and open to examination.

3.3 To clarify DNAR situations for clinical staff caring for people with learning disability and other vulnerable groups in this Trust.

3.4 To ensure patients, families and staff have information on making decisions about resuscitation and that they understand the process.

3.5 To avoid burdening patients, partners and relatives with a CPR decision when CPR would fail, or the circumstances cannot be anticipated.

4. Protocol
The process of deciding a 'DNAR' order

4.1 If the circumstances of an arrest *cannot* be anticipated, then it is not possible to make a decision that would help a clinical team decide whether to attempt CPR in an unexpected arrest

Consequences:

- Do not burden the patient, partner or family with a CPR decision
- The patient and family should be informed that they can have a discussion, or receive information, about any aspect of their treatment. If the patient wishes, this may include information about CPR and it's likely success in different circumstances.
- Continue to communicate progress to the patient (and to the partner/family if the patient agrees).
- Continue to elicit the patient, partner and family's concerns
- Review regularly to check if circumstances have changed
- In the event of an unexpected arrest, carry out CPR if there is a reasonable possibility of success.

4.2 If the arrest *can* be anticipated and is likely to occur because of a *reversible* condition (eg. previous life-threatening events or a condition where an arrest is likely), **then an advance directive on CPR is possible.**

Consequences:

- *If the patient is competent for this decision*:

-discuss the options of CPR v. DNAR with the patient.
-continue to communicate progress to the patient (and to the partner/family if the patient agrees)

- *If the patient is not competent for this decision:*

enquire about previous wishes from the partner and family to help the clinical team make the best decision.
- continue to communicate progress to the partner and/or family

- Document the decision.
- Continue to elicit the patient, partner and family's concerns
- Review regularly to check if circumstances have changed
- In the event of the expected arrest, act according to the patient's wishes (or if the patient was not competent follow the decision made by the clinical team)

4.3 When the patient is dying as a result of an irreversible condition CPR cannot be successful as the patient is dying naturally of their condition.

Consequences:

5 'AND' = Allow a Natural Death. Good palliative care should be in place to ensure a comfortable and peaceful time for the patient, with support for the relatives and partner

6 Do not burden the patient, partner or family with a CPR decision

7 Document the fact that CPR will not benefit the patient.

8 Continue to communicate progress to the patient (and to the partner/family if the patient agrees)

9 Continue to elicit the patient, partner and family's concerns.

10 Review regularly to check if circumstances have changed

4.4 Decide on the competency of the patient

Obtain verbal or written decision from the consultant and key worker responsible for the patient. Competent patients are able to understand their situation and the consequences of their decisions, are free from depression (a clinical diagnosis which is usually treatable), and are not under the influence of others (eg. pressure from a dominant person on a passive patient).

4.5 Keep the DNAR form and pathway in front of the notes.

Send a copy of the form to key clinical staff.

4.6 Document the anticipated circumstances for DNAR

This may be situations such as cardiac and respiratory failure as a natural part of dying due to advanced disease such as cancer. The DNAR decision *would not apply to any other cause*.

4.7 In the presence of an unexpected collapse the attending professionals must rapidly assess the need for CPR, weighing up the benefits and harm to the patient.

4.8 Reassess the need for resuscitation regularly.

While this does not mean burdening the patient and family with a DNAR decision each time, it does require staff to be sensitive in picking up any change of views during discussions with the patient, partner or family. The frequency will depend on the clinical situation. It can be based, for example, on the speed of deterioration eg. month-by-month deterioration could prompt a monthly review, whereas week-by-week deterioration could prompt a weekly review.

4.10 Any change in decision needs a new DNAR form.

5 When consensus is difficult to achieve

5.1 The senior doctor responsible for the patient has the authority to make the final decision, but it is wise to reach a consensus with the patient, staff and relatives.

5.2 On occasions a clear decision is difficult. When one or two members of the team hold a minority view, the rest of the team should respect their view and be prepared to review the situation after a time period agreed by the whole team.

5.3 Staff or family with continuing concerns should approach the consultant and senior nurse for discussion

5.4 Staff who still have concerns should approach their line manager.

5.5 Staff and family who still feel dissatisfied should contact the secretary of the Trust Board. The Chief Executive has responsibility for clinical governance within the Trust. The chair of the hospital ethics committee can offer advice on further action.

5.6 The courts may have to be approached for the final say. This is usually a last resort, although courts can be helpful in deciding complex cases.

See opposite for further advice

6 Ten key points

6.1 'Resuscitation' applies only to cardiac massage and artificial respiration (CPR).

6.2 It is not necessary to burden the patient with resuscitation decisions if the clinical team is as certain as it can be that CPR will not succeed or the circumstances cannot be anticipated. This must never prevent continuing communication with the patient and family about their illness, including information about CPR if they wish this.

6.3 It cases where the circumstances of an arrest can be anticipated, it is essential to obtain the patient's view. The only exceptions are:
- if the patient is not competent
– the patient does not want to discuss the matter

6.4 25% of resuscitations are successful, but only two thirds of these become well enough to return home. In at the end of an irreversible terminal disease (eg. cancer) CPR will not succeed.

6.5 It is unethical to have a default position on CPR in the absence of a previous decision.

6.6 Since circumstances can arise which were not envisioned when the decision process was completed, the anticipated circumstances for the DNAR must be documented.

6.7 The consultant responsible for the patient has the authority to make the final decision, but it is wise to reach a consensus with the patient, staff and relatives. The courts are a last resort.

6.8 Providing resuscitation can be less distressing than withholding it against the wishes of patient and relatives.

6.9 Asking patients and relatives is uncomfortable but is easier if:
- they have the information they want about the situation
– they are allowed time to make their decision

6.10 Advice from outside the clinical team can be invaluable especially the primary health care team, palliative care team, chaplain, and social worker. The local ethics committee can offer useful advice.

7. Key documentation

1. *Decisions relating to cardiopulmonary Resuscitation: a joint statement from the British medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.* Journal of Medical Ethics*, 2001; **27**: 310-6 (September 2001)*
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Saunders J. Perspectives on CPR: resuscitation or resurrection? *Clinical Medicine* 2001; **1**: 457- 60.

Scarborough and North East healthcare NHS Trust *Guidelines for withholding cardiopulmonary resuscitation*., August 1997.

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Further information resources

National Council for Hospice and Specialist Palliative Care Services. www.hospice-spc-council.org.uk/index.htm

Resuscitation Council www.resus.org.uk

Royal College of Paediatrics and Child Health www.rcpch.ac.uk/rcpch

8. Glossary

Policy headings:

Guidelines: systematically developed statement to *assist* decisions

Review criteria: systematically developed statement to *assess* decisions

Protocols: comprehensive set of criteria for a single situation

Standards: a percentage of events that should comply with the criteria. These are written by local teams, so are not included in this document.

Terms used in the document

Advanced directive: a written statement by a patient about their wishes regarding future treatment. It can be in the form of medical notes documenting a conversation between a health care professional and the patient. To be valid it must clearly state the circumstances under which treatment should or should not be applied. Teams attending an arrest may decide that an advanced directive does not apply eg. a patient with motor neurone disease writes a directive stating that in the event of respiratory arrest due to MND he does not wish to be ventilated. The next day he chokes on some meat and goes into respiratory arrest- the arrest team decide his advanced directive was not meant to cover this situation and carry out CPR.

Advocate: a person given the responsibility (usually in law) to make decisions on behalf of a person who is not competent to make decisions about their treatment.

AND (Allow Natural Death): an expression originating in New Zealand, describing the intention to neither hasten nor postpone death, ie. to allow a terminal disease to take its course naturally.

Artificial respiration: the repeated blowing of air into the lungs when the patient is unable to breathe for themselves.

Bereavement: the loss we feel following the death of a person.

BMA: British medical Association

Cardiac massage: the application of repeated external pressure to the front of the chest to pump blood around the body when the heart has stopped.

Comfort and health measures: care and treatment used to improve a patients health or comfort. They are not the same as resuscitation.

Competency: the ability of a person to make a rational decision about their treatment.

CPR: cardiopulmonary resuscitation

DNAR: Do Not Attempt Resuscitation

Expected death: the natural and inevitable end to a terminal illness.

Human Rights Act: European legislation on human rights that is now part of UK legislation.

Inappropriate treatment: care which has been judged on clinical grounds to offer no advantages to the patient, or whose disadvantages clearly outweigh any benefits. This decision should *not* be based on a clinical team's judgement of a patient's quality of life.[11] Patients, families and partners cannot demand treatment judged to be inappropriate, but patients can expect a second opinion as of right.

Keyworker: a professional who has responsibility for co-ordinating the care of a patient. This is not the same as an advocate.

Learning disability: a condition affecting the central nervous system developing in childhood or present at birth that causes difficulty in understanding new skills and concepts.

Life-limiting illness: a condition which is likely to result in a reduced life expectancy.

Life-threatening illness: a progressive condition which will result in the death of a person within months or a few years, eg. cancer.

Palliative care: the holistic care of people with advanced and progressing illness provided by clinicians with accredited training in palliative care.

Quality of life: an estimate by patients of the value they place on their everyday life. Estimates by clinicians can be very inaccurate and should not be used in decisions about treatment.[11]

RC: Resuscitation Council

RCN: Royal College of Nursing

Resuscitation: see CPR.

Second opinion: if patients (or their advocate) disagree with a clinical team's decision, they do have the right to seek other opinions.

Terminal illness: the end stage of a progressive disease that will end in the death of the patient within days, weeks or months.

Terminal phase: the last hours and days of a terminal illness.

Trust board: the governing body of an NHS Trust.

Unexpected collapse: a sudden stopping of the heart or breathing whose timing could not have been anticipated knowing the patient's current condition.

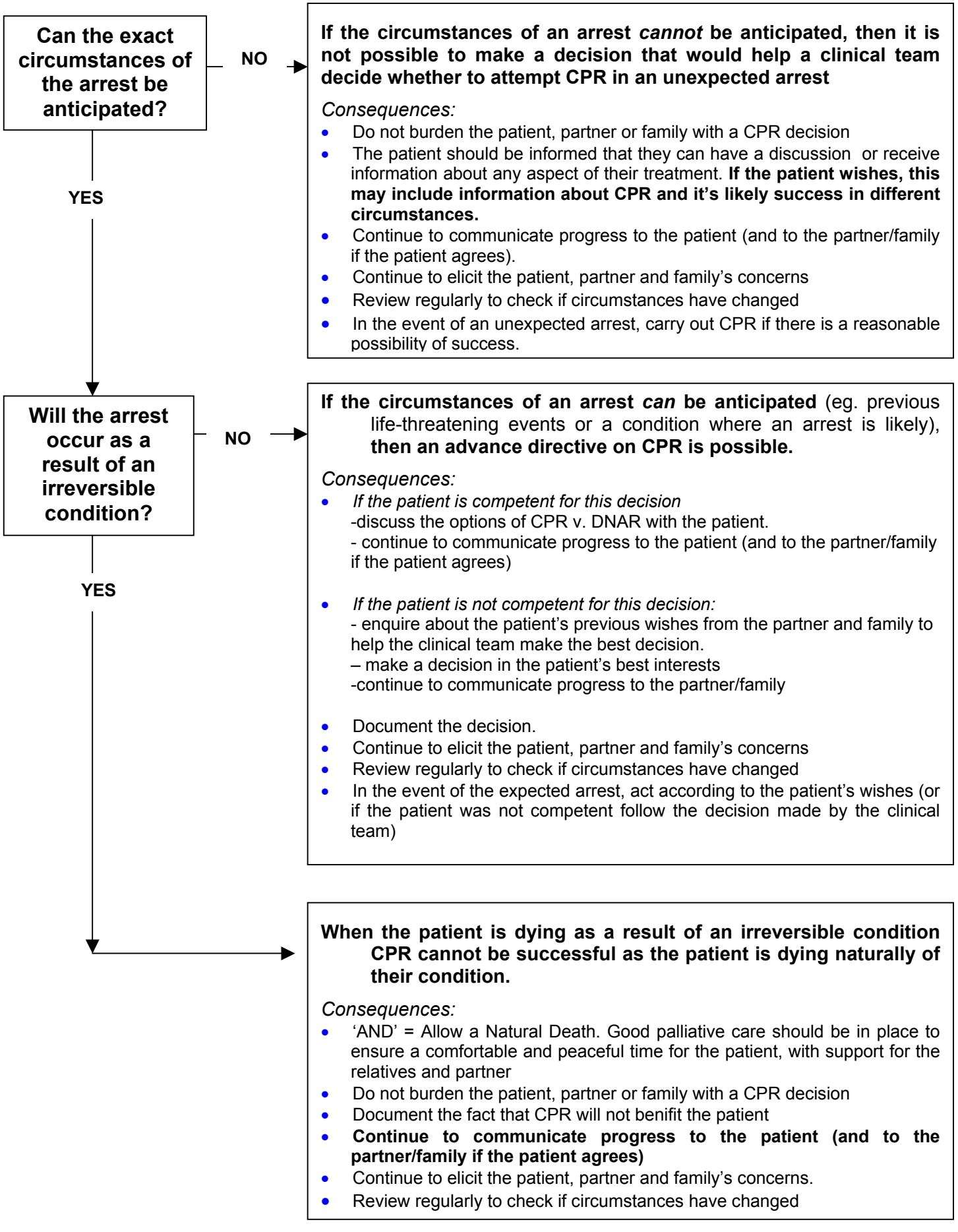
UKCC: United Kingdom Central Council for Nursing and Midwifery.

Withdrawal of treatment: the act of ending of treatment that is no longer of benefit to the patient.

Withholding of treatment: the act of not starting a treatment that will not be of benefit to the patient.

Witness: a fellow professional called to corroborate an action.

Deciding when to burden patients, partners and families with a CPR decision (summary)



DNAR form and pathway

Name	dob:
	Hosp no:

Date of assessment:…… / …… / ……

DNAR order Anticipated circumstances

R = resuscitate
DNAR =
do not attempt
resuscitation

Patient's competency and intent pathway (Ring Yes or NO, Cross out unused boxes)

Can the exact circumstances of the arrest be anticipated?

NO →

No decision can be made.

- **Continue to communicate** progress to the patient, partner and family, and continue to elicit their concerns. Provide whatever information they want.
- **In the event of an unexpected arrest:** carry out CPR if there is a reasonable possibility of success.

YES ↓

Will the arrest occur as a result of an irreversible condition?

NO →

Since the circumstances of an arrest *can* be anticipated an advance directive on CPR is possible

- **If the patient is competent for this decision:** discuss the options of CPR v. DNAR and continue to communicate progress to the patient if they want this.
- **If the patient is not competent for this decision:** enquire about the patient's previous wishes from the partner or family. The clinical team should then make a decision based on the patient's best interests.
- **Document the decision** above.
- **In the event of the expected arrest:** act according to the patient's wishes (or if the patient was not competent follow

YES ↓

- **Write** this fact above as DNAR and put details in the notes.
- **Explain** the decision to staff. Give the patient (and the partner or family with the patient's permission) as much information as they want.
- **When death occurs:** carry out 'AND' = Allow Natural Dying.

Doctor responsible for patient:	Witness name:
Designation	Designation
Signature:	Signature:

- Reassess decision daily
  While this does not mean burdening the patient and family with a decision every day, it does require staff to be sensitive in picking up any change of views during discussions with the patient, partner or family
- Send copy of form to key carers
- **Any change in decision needs a new DNAR form**

Next review dates

Date	Sign	Date	Sign

Deciding whether or not to receive heart and/or breathing resuscitation (CPR)

You have the right to make clear your preferences about treatment, especially if you can foresee situations when you may want to refuse treatment.

Thinking about such situations now can help your doctors to do the best for you if you were unable to tell them yourself.

What is CPR?

CPR stands for Cardio- Pulmonary Resuscitation.

If a person becomes unconscious because their heart or breathing stops, nurses and doctors can try to restart the heart or breathing by using ABC:

A **Airway**: the nurse or doctor check that there is nothing in the mouth or throat that is stopping the air from getting into the lungs. They may place a small tube or special longer tube into the mouth and airway.

B **Breathing:** to make sure that oxygen gets to the blood, the nurse or doctor will breathe for the person either using their own lungs ('mouth to mouth') or using oxygen through a rubber bag.

C **Cardiac (heart):** to make sure the blood is getting from the lungs to the rest of the body the heart needs to pump blood around. If the heart has stopped the nurse or doctor do this by pressing repeatedly on the chest to squeeze blood out through the heart and into the blood vessels. Sometimes the heart restarts itself, but otherwise special drugs may be needed or an electrical current is passed across the chest using a 'defibrillator'.

What resuscitation isn't

Resuscitation has nothing to do with giving food, fluids, antibiotics, pain-relieving drugs, or any treatment needed for health and comfort. The need for these will depend on your problems at the time, and, of course, you can talk to your nurses and doctors to let them know what treatments you wish to receive.

Information for patients

In the unlikely event of your heart or breathing stopping unexpectedly, doctors will normally make every effort to restart the heart and breathing. They would then work to correct the cause of the problem if possible, while monitoring you closely.

If you have been told there is a risk of this happening, you may wish to decide whether you want to receive CPR.

If you do *not* want to receive CPR:

- Discuss this with your doctors.
- Spend time thinking about your decision.
- If you still do not want CPR, then tell your doctors who will write your wish in the notes.
- Decide whether you want to tell your partner or family.

If you *do* want to receive CPR:

- Discuss the advantages and disadvantages of resuscitation with your doctors.
- In the event of an unexpected collapse, your nurses and doctors will do CPR and work hard to restart your heart or breathing.

How successful is CPR?

About one quarter of CPR is successful, and about two-thirds of these become well enough to go home. In some conditions the success rate is less – you need to discuss the likelihood of success with your team.

Information for family and partner

You may have clear views about whether or not CPR should be done on your relative or partner.

If your views are the same as your relative or partner, then discuss together this with the nurses and doctors.

If your views are different to your partner or relative, then do discuss this with the nurses and doctors, but remember they must give first choice to the patient.

Your partner or relative may be unable to choose what they want because they are too young, too ill or unable to make their wish known. If you know what choices the patient has made in the past, it is important to let the nurses and doctors know. The nurses and doctors will always act in the patient's best interests.

What if you feel your views are not being heard?

- Speak to the senior nurse or doctor in charge.
- If this is not helpful, then speak to secretary of the Health Trust Board in the Trust who manages the clinical team- the local ethics committee may be able to help advise you in how to do this.
- The courts are a last resort when discussion has not resolved the issue. However, the Courts can be helpful in deciding complex cases.

Advice for clinical staff on using this leaflet

This leaflet has been written for patients in whom there is a reasonable possibility that CPR could succeed, *and* in whom the circumstances of an arrest can be anticipated.

It is not intended for patients with a terminal condition whose death is a natural and expected part of their illness. In such patients, CPR is not expected to succeed and good palliative care should be in place to ensure a comfortable and peaceful time for the patient, and adequate support for the relatives and partner.

It does not apply to patients in whom the circumstances of an arrest cannot be anticipated.

See the DNAR Guidelines for detailed guidance.

Deciding whether or not to receive heart and/or breathing resuscitation (CPR)

This leaflet is for:
People at risk of sudden heart or breathing problems AND who wish to make their wishes clear about treatment

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DNAR Policy summary for staff

- Clinical decision and action checklist
- Is it impossible to anticipate the exact circumstances of the arrest?
- Is the patient dying because of an irreversible condition?
- Can the circumstances of the arrest be anticipated?
- Regularly reassess the need for resuscitation
- Have the circumstances changed?

Key points

- An advanced decision can only be made if the circumstances of the arrest can be anticipated.
- Patients and relatives should not be burdened with a decision when resuscitation is not an option.
- In the case of unexpected arrests the attending professional and team must rapidly assess the need for CPR.

Introduction

In the UK, several key publications give advice on resuscitation decisions and now take account of the Human Rights Act.[1 - 5] In addition, several papers have commented on the application of resuscitation guidelines in clinical practice.[6-12]

Resuscitation: what it is and what it is not

These are resuscitation measures: cardiac massage, artificial respiration (cardiopulmonary resuscitation- CPR). These CPR measures will be instituted by local staff, but would precipitate calling emergency services and admission to an acute hospital. CPR is instituted immediately and in full following an unexpected collapse, and in the absence of a 'Do Not Attempt Resuscitation' (DNAR) order.

These are comfort and palliative treatment measures: analgesia, antibiotics, drugs for symptom control, feeding, (any route), hydration (any route), oxygen, hospital admission for investigation and treatment of a reversible condition, seizure/status control, suction, and treatment for choking. Comfort and treatment measures are instituted after assessment, consultation with patient and family, and on the basis of clinical need.

Principles of resuscitation decisions

Clinical decision	If YES ⇨ Action
1. Is it impossible to anticipate the exact circumstances of the arrest?	It is not possible to make a decision that would help a clinical team decide whether to attempt CPR in an unexpected arrest • Do not burden the patient, partner or family with a CPR decision • The patient should be informed that they can have a discussion, or receive information, about any aspect of their treatment. If the patients wishes, this may include information about CPR and it's likely success in different circumstances. • Continue to communicate progress to the patient (and to the partner/family if the patient agrees). • Continue to elicit the concerns of the patient, partner and family. • Review the situation regularly to check if circumstances have changed • In the event of an unexpected arrest, carry out CPR if there is a reasonable possibility of success.
2. Will the arrest occur as a result of an irreversible condition?	eg. previous life-threatening events or a condition where an arrest is likely. An advanced directive on CPR is possible. • *Decide on the competency of the patient.* Competent patients are able to understand their situation and the consequences of their decisions, are free from depression and are not under the influence of others (eg. pressure from a dominant person on a passive patient. • *Consider the consequences of discussion of CPR with patient and family:* some will already have made clear their wish to discuss such issues. Others will have made clear that they do not want to discuss this, while some will be uncertain. • *If the patient is competent for this decision:* -discuss the options of CPR v. DNAR with the patient. - continue to communicate progress to the patient (and to the partner and family if the patient agrees) • *If the patient is not competent for this decision:* -exclude and treat reversible causes (eg. confusional state, depression). -enquire about previous wishes from the partner and family to help the clinical team make the best decision continue to communicate progress to the partner/family • Document the decision *and* the anticipated circumstances of the arrest. • Continue to elicit the concerns of the patient, partner and family. • Review regularly to check if circumstances have changed • In the event of the expected arrest, act according to the patient's wishes (or if the patient was not competent, follow the decision made by the clinical team).
3. Is the patient dying because of an irreversible condition?	CPR cannot be successful as the patient is dying naturally of their condition. • 'AND' = Allow a Natural Death. Effective palliative care should be in place to ensure a comfortable and peaceful time for the patient, and adequate support for the partner and family. • Do not burden the patient, partner or family with a CPR decision • Document the fact that CPR will not benefit the patient • Continue to communicate progress to the patient (and to the partner/family if the patient agrees) • Continue to elicit the patient, partner and family's concerns. • Review regularly to check if circumstances have changed
4. Regularly reassess the need for resuscitation While this does not mean burdening the patient and family with a CPR decision each time, it does require staff to be sensitive in picking up any change of views during discussions with the patient, partner or family.	
5. Have the circumstances changed? Start again at clinical decision 1.	

- If the circumstances of a future arrest cannot be anticipated, it is not possible to make a decision that can have any validity in guiding the clinical team at the time of an unexpected arrest.
- In the situation where a death is expected as an inevitable result of the underlying disease, and the clinical team is 'as certain as it can be' that resuscitation would fail, [1] it is not right to offer the patient this option. [6]
- It is an unnecessary and cruel burden to ask the patient, partners or families about CPR when CPR is not an option, or its circumstances cannot be anticipated.
- It cases where the circumstances of an arrest can be anticipated, it is essential to obtain the patient's view. The only exceptions are if the patient is not competent or the patient does not want to discuss the matter. Depression must be identified as its treatment increases the likelihood of acceptance of CPR. [13]
- The patient must be given as much information as they wish about their situation. [6] Medical decisions should be based on immediate health needs, and not on an opinion on quality of life.[14] This is primarily because opinions on quality of life by health professionals are very subjective and often at variance to the view of the patient.[15] 'Futility' is an unhelpful term with a tendency for subjective interpretation. Treatments should be decided in terms of acceptance to the patient, feasibility, likely success, risks and availability. [16]
- At best, 60% of resuscitations are successful, and up to half of these become well enough to return home, [17] but the discharge rate is lower in other series, [18] and reduces to 1% in non-witnessed arrests. [19] Some patients will choose CPR even if the success is as low as 10%.[20] However, at the end of an irreversible terminal disease (eg. cancer) CPR will not succeed and is not a treatment option.
- Since circumstances can arise which were not envisioned when the decision process was completed, the anticipated circumstances for the DNAR must be documented.

Asking patients and relatives is uncomfortable but is easier if they have the information they want about the situation and they are allowed time to make their decision.