

POLICY FOR MAKING “DO NOT ATTEMPT RESUSCITATION” (DNAR) DECISIONS

Controls Assurance Statement

This policy outlines the legal and ethical standards for planning patient care and decision making in relation to cardiopulmonary resuscitation. It is the Trust's intention that this policy ensures that all healthcare professionals are aware of the legal and ethical issues regarding cardiopulmonary resuscitation and are enabled to adopt practices which aim to ensure the understanding and support of the patient and thus minimise the risk of legal challenge. *This policy should be applied to all patients regardless of age, and on the basis of clinical need alone.*

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POLICY FOR MAKING “DO NOT ATTEMPT RESUSCITATION” (DNAR) DECISIONS

1.0 Introduction

This policy is based on the ethical guidelines issued in “Decisions Relating to Cardiopulmonary Resuscitation - A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing”, March 2001.

- 1.1 **Do Not Attempt Resuscitation (DNAR):** in the event of cardiac or respiratory arrest, the cardiac arrest team is not called and neither basic life support (BLS) nor advanced life support (ALS) as defined by the UK Resuscitation Council, will be given.
- 1.2 Cardiopulmonary resuscitation (CPR) refers to resuscitation of a patient including cardiac compression and artificial ventilation following a sudden collapse, cardiac or respiratory arrest.
- 1.3 Cardiopulmonary resuscitation (CPR) can be attempted on any person in whom cardiac or respiratory function ceases. Failure of these functions is inevitable as part of the normal process of dying and thus CPR can theoretically be attempted 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 attempted CPR would be inappropriate (i.e. a futile act).
- 1.4 **It is also essential to identify those patients who do not want CPR to be attempted and who competently refuse it. It is vital to encourage the involvement of patients, the health care team and significant others close to the patient in decision-making, and to ensure the communication of decisions to all relevant health professionals.**
- 1.5 In order to meet our obligations under the Human Rights Act 1998 this policy has been written to reflect the spirit of the Human Rights Act, which aims to promote human dignity and transparent decision-making.
- 1.6 Provisions particularly relevant to decisions about attempted CPR include the right to life (Article 2), to be free from inhuman or degrading treatment (Article 3), to respect for privacy and family life (Article 8), to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and to be free from discriminatory practices in respect of these rights (Article 14).

2.0 Scope of the policy

- 2.1 This policy applies to all healthcare professionals employed by the Trust.
- 2.2 Do not attempt resuscitation indicates that no CPR, BLS nor ALS is attempted on a patient with an up to date documented DNAR order for that patient.
- 2.3 **A DNAR order must never imply withdrawal of medical and nursing care.**
- 2.4 It should be made clear to the patient, people close to the patient and members of the health care team that **this order does not preclude all other treatments and care which are appropriate for the patient and that all other treatment and care that are appropriate for the patient will continue to be considered and offered.**
- 2.5 To avoid all confusion, the expression "do not attempt resuscitation" must be used and included in the patient's notes.

3.0 Making decisions to resuscitate

- 3.1 No person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision-making capacity.
- 3.2 Where no explicit advance decision has been made about the appropriateness or otherwise of attempting resuscitation prior to a patient suffering cardiac or respiratory arrest, and the express wishes of the patient are unknown and cannot be ascertained, there should be presumption that health professionals will make all reasonable efforts to attempt to revive the patient.
- 3.3 Although this is the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of illness or for whom the burdens of the treatment clearly outweigh the potential benefits.

4.0 Making a "Do Not Attempt Resuscitation" (DNAR) decision

- 4.1 The overall responsibility rests with the Consultant in charge of the patient's care. If not available then a deputy of at least Registrar status may act on his or her behalf in the decision of a DNAR order.
- 4.2 Decisions must be taken in the best interests of the patient and ideally should be made in advance as part of overall care planning for that patient.

- 4.3 An advance decision that CPR will not be attempted (a "do not attempt resuscitation", or "DNAR" order) should be made only after the appropriate consultation and consideration of all relevant aspects of the patient's condition.

These include:

- The likely clinical outcome, including the likelihood of successfully restarting the patient's heart and breathing, and the overall benefit achieved from a successful resuscitation;
 - The patient's known, or ascertainable, wishes (in consultation with relatives and/or carers); and
 - The patient's human rights, including the right to life and the right to be free from degrading treatment.
- 4.4 The views of all members of the medical and nursing team, including those involved in the patient's primary and secondary care and, with due regard to patient confidentiality, people close to the patient, should be included in forming the decision.
- 4.5 If a DNAR decision has been made with a patient, the order **must** be indicated using a "**Do not attempt resuscitation order form**" (Appendix 1). All parts of the form must be completed before filing it in the front of the patient's notes.
- 4.6 If a DNAR order is reversed or a patient is discharged, the doctor **must cancel the form in black ink**, by drawing a line diagonally across the form and writing "cancelled" with a date, the doctor's name and signature.
- 4.7 Once made, the DNAR decision **must** be recorded in the medical notes by the Responsible Medical Officer. The instruction "**DO NOT ATTEMPT RESUSCITATION**" must be **written in block capital letters and in black ink**.
- 4.8 It is the responsibility of the Doctor writing the instruction to make certain that this order and its meaning are discussed with other medical personnel involved in the care of the patient and the registered nurse in charge.
- 4.9 The registered nurse in charge must inform nursing and other health care staff caring for the patient immediately. The registered nurse in charge should clearly document the order in the nursing notes in black ink.
- 4.10 All decisions must be communicated effectively to the relevant healthcare professionals through hand-overs during shift changes and patient transfers. Under no circumstances should "DNAR" be written against

patient names on nominal boards or lists.

5.0 Making decisions with competent adults

- 5.1 Decisions about whether the likely benefits from successful CPR outweigh the burdens should be discussed with competent patients.
- 5.2 Where competent patients are at foreseeable risk of cardiopulmonary arrest, or have a terminal illness, there should be sensitive exploration of their wishes regarding resuscitation.
- 5.3 If patients indicate that they do not wish to discuss resuscitation this should be respected. Competent patients should understand that there are opportunities to talk about attempting CPR, but should not be forced to discuss the issue if they do not want to.
- 5.4 Where a DNAR order is made and there has been no discussion with the patient because he or she has indicated a clear desire to avoid such discussion, this must be documented in the health records and the reasons given. As with any other aspect of care, health professionals must be able to justify their actions.
- 5.5 For the vast majority of patients receiving care in hospital the likelihood of cardiopulmonary arrest is small and no advance decision is made. If cardiopulmonary arrest does occur, resuscitation is attempted in accordance with Section 3 of this policy.
- 5.6 Any discussions about whether to attempt CPR, and any anticipatory decisions, should be documented, signed and dated in the patient's record.

6.0 Refusal of a “DNAR Order” and patient request for attempted CPR

- 6.1 There may be some circumstances where a patient may ask for CPR to be attempted, even if the clinical evidence suggests that CPR will not effectively restart the heart and breathing or that it cannot provide any overall benefit. In these cases, sensitive efforts should be made without alarming the patient to convey a realistic view of the procedure and its likely success.
- 6.2 Discussion should aim at securing an understanding and acceptance of the clinical judgement. If the patient still asks that no DNAR order be made, this should be respected.

- 6.3 If a situation in which CPR is a practical option for such patients then arises, the decision must be made in accordance with Section 3 of this policy.
- 6.4 Doctors cannot be required to give treatment contrary to their clinical judgement, but should, whenever possible, respect patients' wishes to receive treatment which carries only a very small chance of success or benefit.

7.0 Making decisions with incapacitated adults

- 7.1 No person is legally entitled to give consent to medical treatment on behalf of an adult who lacks decision-making capacity.
- 7.2 Doctors have authority to act in their patients' best interests where consent is unavailable.
- 7.3 If the doctor's decision is contrary to the patient's interest, people close to the patient should be kept informed about the patient's health and be involved in decision making in order to reflect the patient's views and preferences.
- 7.4 It should be made clear that the role of people close to the patient is 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 want will be taken into account in decision making but they cannot insist on treatment or non-treatment (see also Section 9 below - Involving people close to the patient).

8.0 Children and young people

- 8.1 Medical decisions relating to children and young people ideally should be taken within a supportive partnership involving patients, their families and the health care team.
- 8.2 The views of children and young people must be taken into consideration in decisions about attempting CPR.
- 8.3 Competent young people are entitled to give consent to medical treatment, and where they lack competence it is generally their parents who make decisions on their behalf.
- 8.4 Refusal of treatment by competent young people is not necessarily binding upon doctors since the courts have ruled that consent from people with parental responsibility, or the court, still allows doctors to provide treatment.

- 8.5 Where a competent young person refuses treatment, the harm caused by violating the young person's choice must be balanced against the harm caused by failing to treat.
- 8.6 Usually agreement will be reached about whether CPR should be attempted if the patient suffers respiratory or cardiac failure.
- 8.7 If disagreement persists despite attempts to reach agreement, legal advice should be sought.
- 8.8 Parents cannot require doctors to provide treatment contrary to their professional judgement, but doctors will try to accommodate parents' wishes as far as is compatible with protecting the child's interests.

9.0 Involving people close to the patient

- 9.1 People close to patients must be involved in decisions even where their views have no legal status in terms of actual decision making.
- 9.2 The agreement of all competent patients must be sought.
- 9.3 Competent patients must be asked who they want, or do not want, to be generally involved in decision making if they become incapacitated.
- 9.4 Refusal by a competent patient to allow information to be disclosed to family or friends should be respected.
- 9.5 Where an incompetent patient's views on involving family and friends are not known, doctors may disclose confidential information to people close to the patient or the "Nearest Relative", where this is necessary to discuss the patient's care and not contrary to the patient's interests.
- 9.6 The information sought from people close to patients is to help ascertain what the patient would have wanted in these circumstances, as opposed to what those consulted would like for the patient or what they would want for themselves if they were in the same situation.
- 9.7 Health professionals should be aware that the requirement to respect family life and impart information is important human rights considerations.
- 9.8 Where patients have become incapacitated, relatives can provide important information to help ascertain the patient's prior views about treatment. These need to be factored into any decision but may not ultimately be determinative.

- 9.9 The European Court of Human Rights has taken the view that parents have the right under Article 8 of the European Convention to be involved in important decisions concerning their children. By analogy, it is arguable that excluding the family of incompetent patients also breaches this right unless the patient previously instructed it.

10.0 Refusal of treatment

- 10.1 Resuscitation must not be attempted if CPR is contrary to the recorded, sustained wishes of an adult who was mentally competent and aware of the implications at the time of making that advance decision. Refusal of treatment by children and young people is dealt with in Section 8 above.
- 10.2 Competent adults have the right to refuse any medical treatment, even if that refusal results in their death. Such a patient's informed and competently made refusal which relates to the circumstances which have arisen is legally binding upon doctors.
- 10.3 Patients who choose to express their wishes in a written document; an advance directive or "living will" will have their wishes respected although it is not necessary for refusal to be in writing in order to be valid. People often discuss their wishes with a GP or another health professional who records the discussion in the patient's notes.
- 10.4 Where patients express a clear and consistent refusal, this is likely to have the same status as a written advance directive.
- 10.5 Patients are not obliged to justify their decisions, but need to ensure that the health team is aware of them if they are to be implemented.
- 10.6 Health professionals should request to discuss the implications of the refusal with patients in order to ensure that the decision is based on accurate information and not on a misunderstanding, but must take care not to pressure patients into accepting treatment they do not want.

11.0 Appropriate factors to consider when making "DNAR" decisions

- 11.1 Where attempting CPR will not restart the patient's heart and breathing.**
CPR attempts should not be made if the health care team is as certain as it can be that attempting CPR would not restart the patient's heart and breathing and that the patient cannot gain any clinical benefit from an attempt. Consensus within the team about likely clinical outcome should be the aim, and decision making must be based on clinical assessment of the patient's condition and up-to-date clinical guidelines.

11.2 Where there is no benefit in restarting the patient's heart and breathing
CPR attempts should not be made where:

- No benefit is gained if only a very brief extension of life can be achieved and the patient's co-morbidity is such that imminent death cannot be averted.
- No benefit is gained by the patient if he or she will never have awareness or the ability to interact and is therefore unable to experience benefit.

11.3 Where the expected benefit is outweighed by the burdens

Where CPR may be successful in restarting the patient's heart and breathing, and thus prolong the patient's life, the benefits to be gained from the prolongation of life must be weighed against the burdens to the patient of the treatment.

12.0 Responsibility for decision making

12.1 The overall responsibility for decisions about CPR and DNAR orders rests with the Responsible Medical Officer (RMO) or GP in charge of the patient's care.

12.2 The RMO or GP should be prepared always to discuss the decision for an individual patient with other health professionals involved in the patient's care.

12.3 Where care is shared, for example between hospital and general practice, or between general practice and a residential facility, the doctors involved should discuss the issue with each other, with other members of the health care team and with the patient and people close to the patient as appropriate.

12.4 While responsibility for achieving agreement is a shared task, one individual should take charge of ensuring that the decision is properly recorded and conveyed to all those who need to know it, including locum staff.

12.5 Decisions must be based on reliable, up-to-date clinical guidelines and must always be made on an individual basis.

12.6 Blanket decisions, which deny attempts at resuscitation to groups of patients, for example to all patients in a nursing home or to patients above a certain age, are unethical and probably unlawful under provisions of the Human Rights Act which prohibit discrimination in the enjoyment of Convention rights.

13.0 Recording and communicating decisions

- 13.1 Any decision about the provision of attempted CPR must be readily accessible to all health professionals who may need to know it, including hospital staff, GPs, deputising or GP co-operative services, and ambulance staff for patients in the community. The patient's known wishes and decisions relating to attempting CPR should be communicated between health professionals when a patient is referred or discharged.
- 13.2 The entry in the medical records should clearly document and date the decision and the reasons for it, and should be made by the RMO.
- 13.3 The RMO should ensure that the decision is communicated effectively to other relevant health professionals in both primary and secondary care. The RMO may delegate the task of disseminating information to another member of the health care team. Where the GP takes the professional lead, he or she has responsibility for these tasks.
- 13.4 The decision should be recorded in the nursing notes 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.
- 13.5 Communication of decisions to the patient and people close to the patient is also a part of this process. Patients who want to be involved in decision making will be aware what decision has been reached and should be told how this will be communicated to the health care team.
- 13.6 Unless the patient refuses, decisions should also be communicated to the patient's family and others close to the patient. The usual rules of confidentiality apply.

14.0 Disagreement

- 14.1 Where no advance decision can be reached, a note should be made of the reasons.
- 14.2 The health care team should be prepared to attempt CPR unless other factors intervene (such as unavoidable delay in starting the procedure, or if there has been severe deterioration in the patient's condition since the discussion).
- 14.3 Where the clinical decision is seriously challenged and agreement cannot be reached, some form of legal review may be necessary. Legal advice should be sought from the Trust's Legal Services Manager.

15.0 Review of decisions

15.1 Decisions about resuscitation must be reviewed regularly and in the light of changes in the patient's condition and wishes.

15.2 The frequency of review should be determined by the health professional in charge and will be influenced by the clinical circumstances of the patient. The decision reached following admission of the patient to hospital should be reviewed by the consultant in charge at the soonest available opportunity.

15.0 Implementation

15.1 All clinical directorates are responsible for implementing this policy.

15.2 Decisions about whether to attempt to resuscitate a particular patient should be part of the overall care planning for that patient.

16.0 Monitoring and review

16.1 The Medical Director is responsible for the overall monitoring and review of this policy

17.0 References

"Decisions Relating to Cardiopulmonary Resuscitation - A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing", March 2001.

NHS Executive. Resuscitation policy (HSC 2000/028). London: Department of Health, September 2000.

The impact of the Human Rights Act 1998 on medical decision making. London: BMA, October 2000.

Consent, rights and choices in health care for children and young people. London: BMJ Books, 2001.

British Medical Association. Advance statements about medical treatment. London: BMA, 1995.

Resuscitation Council (UK). CPR guidance for clinical practice and training in hospitals. London: Resuscitation Council, February 2000.

ORDER FORM - DO NOT ATTEMPT RESUSCITATION
(in the event of a respiratory or cardiac arrest)

Guidelines for using a DNAR order form

*N.B. This form should be used in conjunction with the current Suffolk Mental Health Partnership NHS Trust Policy: Do Not Attempt Resuscitation **AND COMPLETED IN BLACK INK***

If a decision **Do Not Attempt Resuscitation** has been made, this form must be completed and filed in the front of the patients notes. Any discussion with the patient or relatives should be documented and dated within the medical notes. The doctor making the DNAR decision (Consultant or Registrar) **must ensure** that all staff involved in the patient’s care are aware of the decision. When a decision is made it **must** be reviewed at least every **seven** days (or more frequently if the patient’s condition dictates, according to the DNAR policy) Any changes to the resuscitation decision must be clearly documented and fully communicated.

Addressograph	Date of admission
	Ward/Department
	Consultant

1. Date of DNR commencement _____ Time _____
2. Senior Doctor implementing DNAR order: Consultant / Registrar (delete as appropriate)
 Name: (PRINT) _____ Signature: _____
3. Reviewing DNAR order (according to DNAR policy & patient requirements)

Date	Date
Name	Name
Signature	Signature
Designation	Designation
Date	Date
Name	Name
Signature	Signature
Designation	Designation

N.B. On discharge from hospital or if a DNAR order is reversed, this document must be made invalid by a doctor involved in the patients care, by crossing through diagonally and stating ‘CANCELLED’ with date, name and signature, **in black ink**. The ward clerk must file this document in the miscellaneous section of the patient’s medical notes.

Resuscitation status