# APPENDIX H

# DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNAR) POLICY FOR ADULTS

# EXECUTIVE SUMMARY

Cardiopulmonary resuscitation (CPR) is the act of attempting to revive someone in cardiac arrest. There may be situations when CPR is inappropriate. It is important to note that a DNAR decision relates only to the act of CPR (e.g. chest compressions, ventilations, defibrillation) and does not in itself place any limitations on other aspects of a patients care. This document outlines the Heart of England Foundation Trust Do Not Attempt Cardiopulmonary Resuscitation (DNAR) policy for adults (aged over 18). The policy aims to protect patients and support staff in making these complex decisions.

## Key points

**WHEN**

A DNAR decision may be appropriate in the following scenarios

1. Clinical team believe resuscitation attempt will fail to restart the heart / breathing
2. Where the burdens of a resuscitation attempt outweigh the benefits
3. Where CPR is against the express wishes of a competent patient or where it is not in accordance with a valid and applicable advance decision to refuse life sustaining treatment

DNAR decisions will remain active for the duration of the hospital admission unless they are clearly cancelled.

DNAR decisions should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home

**WHO**

The consultant in charge of the patients care carries responsibility for DNAR decisions.

Authority may be delegated to a registered medical practitioner of a registrar grade or equivalent (staff grade; associate specialist; ST 3+). When responsibility has been delegated the responsible consultant should be informed and this should be documented in the patients clinical record.  When the consultant next reviews the patient they should sign to endorse the DNAR form.

Discussions within the healthcare team should aim to achieve consensus about a DNAR decision

Careful consideration should be given to involving the patient and relatives in discussions over resuscitation status – especially when the decision is based on a balance of benefits, risks and burdens

**HOW**

A DNAR decision must be recorded on the Trust DNAR form and the form filed in the front of the patient’s notes. Complete all relevant boxes. Where there is insufficient space on the form to document adequately the term “see patients notes” or equivalent may be used, additional information may then be documented in the patient’s notes

The person making the DNAR decision must inform the nurse in charge of the patients care.

Nursing staff must ensure a robust system is in place for ensuring DNAR decisions are communicated accurately between nursing teams involved in the patients care.

**EXCEPTIONS**

If doubt exists over resuscitation status –resuscitation should be commenced

Clinical judgement can override a DNAR decision if a readily reversible cause of a patient’s cardiac arrest occurs e.g. choking, blocked tracheostomy tube, induction of anaesthesia etc unless the patient has specifically refused intervention in these circumstances

1. **THE AIM OF THE POLICY**

1.1To set out the principles which govern the use of Do Not Attempt Cardiopulmonary Resuscitation (DNAR) decisions within the Trust. The policy is an appendix to the main Trust Resuscitation policy and should be read in conjunction with the main policy.1.2 The policy has been written with reference to the latest guidance issued by the BMA / RCN / Resuscitation Council and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK) (<http://www.resus.org.uk/pages/dnar.htm> ).

1. **THE SCOPE OF THE POLICY**

2.1 The policy applies to all clinical staff in relation to adult patients (age >18) in whom making a DNAR decision is considered

**3.0 GENERAL PRINCIPLES**

3.1 Where no explicit decision has been made in advance (or there is uncertainty over the validity of a DNAR decision) in the event of a cardiac arrest resuscitation should be commenced

3.2 Decisions about CPR must be made on the basis of an individual patient assessment

3.3 Decisions about CPR must be reviewed regularly and especially whenever changes occur in the

patient’s condition or in the patient’s expressed wishes or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home . The frequency of review should be determined by the health professional in charge and will be influenced by the clinical circumstances of the patient Prior to cancelling a DNAR decision a discussion should take place amongst the multidisciplinary team including the consultant responsible for the patients care.

3.4 Unless cancelled, DNAR decisions remain effective for the duration of the hospital admission. This includes inter-site transfers between hospitals / facilities managed by Heart of England Foundation Trust

3.5 A DNAR decision does not override clinical judgment in the unlikely event of a reversible cause of the patient’s respiratory or cardiac arrest that does not match the circumstances envisaged when the decision was made provided that there is not a valid and applicable advance decision expressly refusing such intervention in those circumstances. In an emergency where there is no time to investigate further, the presumption should be in favour of CPR if this has a realistic chance of prolonging life.

3.6 DNAR decisions should be reviewed in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) in the event that a patient needs to undergo general anaesthesia <http://www.aagbi.org/publications/guidelines/docs/dnar_09.pdf>

3.7 DNAR decisions should be made in accordance with requirements contained in the Human Rights Act 1998 and Mental Capacity Act 2005 and Professional regulatory bodies e.g. General Medical Council.

3.8 DNAR decision relates only to the act of CPR (e.g. chest compressions, ventilations, defibrillation) and does not in itself place any limitations on other aspects of a patients care.

3.9 At the time of making a DNAR decision staff should consider if any other limitations of treatment are to be applied (e.g. not for referral to ITU, not for antibiotic, not for MEWS scoring etc)

3.10 Decisions limiting other aspects of care must be clearly and explicitly recorded in the medical record and communicated to the multi-disciplinary team. In addition, the decision to stop MEWS scoring must be clearly recorded on the MEWS Chart (MEWS Policy V2 June 09).

**4.0 THE USE OF DNAR DECISIONS**

4.1 DNAR decisions are usually only appropriate in three settings:

**Where attempting CPR will not restart the patient’s heart and breathing**. The healthcare team must be as certain as it can that attempting CPR would not restart the patient’s heart and breathing, this decision should be based on clinical assessment of the patient and relevant guidelines

**Burdens outweigh benefits -** Where the expected benefit is outweighed by the burdens e.g. terminal illness. This assessment can only be made following discussion with the patient (or relatives if the patient lacks capacity). Further details are provided in the joint BMA/RC(UK)/RCN guidance (section 7.2) <http://www.resus.org.uk/pages/dnar.htm>

**Patient refusal -** where CPR is againstthewishes of a patient with mental capacity. This may be expressed verbally or in accord with a valid and applicable advance decision. (A valid advanced directive must be made by someone over the age of 18, be in writing, signed, witnessed and state that it is to apply to life sustaining treatment even if life is at risk). Further details on advance directives can be found in the Trust consent policy and at <http://www.adrtnhs.co.uk/>)

**5.0 COMMUNICATION AND RECORDING BY THE HEALTHCARE TEAM**

5.1 Communication and good record keeping are central to the safe and effective use of the DNAR policy

5.2 Discussions around DNAR status should be undertaken sensitively. Clinicians should be responsive to verbal and non-verbal communication signals from the patient which may indicate the extent to which they wish to be involved in these discussions

5.3 The Resuscitation Council (UK) / RCN / BMA Guidance Decision-making framework provides guidance on when and how approaches to patients and relatives should be made (Page 5).

5.4 Discussion within the healthcare team (doctors, nurses, allied health professionals) should aim to achieve consensus about a DNAR decision

5.5 A DNAR decision must be recorded on the Trust DNAR form and the form filed in the front of the patient’s notes. Complete all relevant boxes. Where there is insufficient space on the form to document adequately the term “see patients notes” or equivalent may be used, additional information may then be documented in the patient’s notes Details providing the rationale and any discussions with others should be recorded

5.6 When a DNAR decision is cancelled it should be marked through with two parallel lines and the word cancelled written clearly along. The date, time, name and grade of person revoking the DNAR decision should be recorded on the form. The form should be immediately removed and filed in the correspondence section of the medical notes by the person cancelling the DNAR decision.

5.7 Medical staff must inform the nurse in charge of a patients care whenever a change in DNAR status is made. This should also be recorded on the DNAR form.

5.8 Nursing staff have a duty to record and maintain up to date records of DNAR decisions. Robust systems must be in place to ensure effective communication between shifts and whenever a patient is moved between clinical areas. The Trust electronic nurse hand-over system provides a reliable route for recording DNAR status.

5.9 When a patient is discharged or transfered form must be removed from the front of the notes and filed in the correspondence section of the medical notes.

**Figure 1 : Decision making framework (modified from Decisions relating to CPR statement RC UK)**

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6.0 **DISCUSSIONS WITH PATIENTS AND THEIR FAMILY**

6.1 All patients should be assessed for mental capacity with the starting point of presumption of capacity

6.2 Certain patients may be unable to be involved in a DNAR decision because they lack mental capacity.

6.3 A person is unable to make a decision if as a result of an impairment of the mind or brain, or disturbance in the functioning of the mind or brain they are unable to:

* 1. understand the information relevant to the decision; and
	2. retain that information; and
	3. use or weigh that information as part of the process of making the decision; or
	4. communicate his/her wishes (whether by talking, using sign language or any other means).

6.4 The outcome of the assessment of mental capacity should be recorded in box 1 on the DNAR form

6.4 *The patient who has mental capacity*

Where the patient is deemed to have mental capacity and are at risk of cardiac arrest, CPR should be sensitively discussed with them, if deemed appropriate by the treating clinician as one part of their overall care. This discussion should be documented on the DNAR form as well as in the patient’s notes.

When a decision not to attempt CPR is made on the grounds of futility, it is not appropriate to ask the patient’s wishes about CPR but a sensitive explanation for the rationale behind this decision should be provided (as part of the discussion of their overall treatment plan).

Decision making where the focus is around balancing risks, burdens and benefits of CPR must involve the patient (and ideally the relatives provided the patient agrees to this) as judgements in this setting will be driven by the patients (rather than clinicians) assessment of these factors.

If patients indicate they do not wish to discuss resuscitation this should be respected. Where a DNAR decision is made and there has been no discussion with the patient because he/she has indicated a desire to avoid such a discussion this must be documented on the form and in the health records with reasons given.

Rarely, it may be considered inappropriate to discuss the decision with the patient. If it is deemed inappropriate to discuss a DNAR decision with either the patient and/or relatives, this must be documented, with reasons why. Health professionals must be prepared to justify their actions. Staff reluctance to discuss DNAR issues is NOT a sufficient reason.

If a patient has the mental capacity to refuse CPR you must comply with their decision and document it in the medical records (see page 24 of the Consent Policy), including details of the discussion & advice given.

In the event of a disagreement over a DNAR decision between clinicians, patients and/or their relatives all attempts at resolving these differences should be made. This can often be achieved through sensitive discussions which address the fears or worries and misconceptions the patient may have, often they are worried that DNAR means no treatment.

Whilst clinicians cannot be required to give medical treatment contrary to their clinical judgment, and a patient cannot demand treatment, it is unwise to make a DNAR decision before these conflicts are resolved.

In the event that the clinical team are unable to resolve these conflicts a second opinion from a consultant colleague should be sought. If this fails to lead to resolution then advice from the Governance team, Trust solicitors, Clinical Ethics Committee or Resuscitation Committee should be sought.

It is good practice to engage the patient’s relatives / next of kin in discussions on CPR status. If a DNAR decision has been made the patient may wish their family to be informed of this but may not be able or willing to do this themselves. The relatives will need to be informed at the earliest opportunity, in a sensitive manner when they next visit the ward / department.

Refusal by a patient with mental capacity, to allow information to be disclosed to the family and friends should be clearly documented and must be respected.

6.5 *The patient who lacks capacity:*

 The Trust Consent Policy provides guidance on decision making in patients that lack capacity. The Mental Capacity Act establishes legal obligations for staff caring for patient that lack capacity. These policies must be followed when making DNAR decisions in patients that lack capacity. The policy emphasises the importance of consulting with those close to the patient when weighing up the risks, benefits and burdens of resuscitation. The policy covers (i) duty to consult (ii) lasting power of attorney (iii) advance directives and the role of IMCA’s. Further details on the Mental Capacity Act and how it applies to decisions about life sustaining treatment can be found at <http://www.publicguardian.gov.uk/mca/mca.htm>

**7.0 RESPONSIBILITY FOR DNAR DECISIONS**

7.1 The consultant in charge of the patients care at the time the DNAR decision is made carries responsibility for DNAR decision until the patient is formally transferred to the care of another consultant at which point that consultant will assume responsibility for the on-going DNAR decision.

7.2 Authority may be delegated to a registered medical practitioner of a registrar grade or equivalent (staff grade; associate specialist; ST 3+). When responsibility has been delegated the responsible consultant should be informed and this should be documented in the patients clinical record.  When the consultant next reviews the patient they should sign to endorse the DNAR form.

7.3 At Sir Robert Peel Hospital the decision can be made by the duty doctor. This decision must be discussed with and agreed by the Consultant responsible for the patients care at the time. It must be clearly documented in the patients notes that this discussion has taken place.

7.4 The consultant should sign the DNAR at the earliest opportunity

7.5 DNAR decisions must be made by consensus within the clinical team. This includes as a minimum nursing and medical staff.

8.0 **DNAR DECISION IN PATIENTS REQUIRING OFF SITE TRANSFER**

8.1 DNAR decisions remain active for the duration of hospital admission

8.2 The Ambulance Service DNAR policies apply during inter hospital transfers or transfer from hospital to home / hospice etc. These policies usually dictate that the patient will be transported in a vehicle by themselves rather than with other patients which can lead to delays in the patients transfer.

8.2 Prior to transfer the circumstances behind the DNAR decision should be reviewed and an assessment made of the likelihood of the patient sustaining a cardiac arrest during transfer. If the reasons for the DNAR decision remain valid and the patient is considered at risk of sustaining a cardiac arrest en route then the DNAR decision should remain active during the transfer

8.3 In the event that the DNAR order has been made on the basis of patient refusal this should be discussed with the patient. The patient’s wishes following this discussion should be recorded and must be respected.

8.4 When arranging an ambulance to transfer a patient with a DNAR decision:

* + Ensure that the DNAR order is valid and reasons for DNAR are clearly documented in the medical notes
	+ Contact the respective ambulance control and state that a DNAR decision is in place and that resuscitation should not be attempted by the ambulance crew in the event of a cardiac arrest. Advice the patient (and relatives) (if appropriate) that the DNAR will remain in place during the transfer. Record this in the patient’s medical record
	+ Present the ambulance crew with a copy the valid DNAR order and any documentation confirming why the DNAR is in place

DNAR Documentation standards for audit

Appropriately communicated with patient and/or relative, non-compliant documentation

No communication or documentation

Appropriately communicated and documented with patient and/or relative

No communication or documentation

Appropriately communicated with relative/IMCA, non-compliant documentation

Appropriately communicated and documented with relative/IMCA or documented that not available in reasonable time

NO

YES

**‘Appropriately communication and documented’** where documentation is on the DNAR form or where there is insufficient space ‘see patients notes’ is written on the DNAR form

**‘Appropriately communicated but non-compliant documentation’** is where the DNAR form is blank but there is documentation within the medical notes

Patient has Capacity

If not documented capacity assumed