Completion of Do Not Attempt Resuscitation (DNAR) Forms

The Trust DNAR Policy includes the DNAR form. Please take time to read the Policy.

It is essential that when a DNAR decision has been made, the DNAR form is correctly and concisely completed and placed at the front of the Patient's notes.

A new form must be completed for each admission.

Overall responsibility lies with the Consultant to ensure that the DNAR form has been correctly completed.

Audit is required on a monthly basis and is undertaken by the Clinical Leaders and Junior Medical staff. This data is submitted to the Resuscitation Training Department and collated on behalf of the Trust. This data may be required by the NHS Litigation Authority and the Care Quality Commission.

Particular attention should be given to the following sections of the DNAR form where poor compliance has been demonstrated:

Section 2: Summary of the reason the decision has been made – there must be a brief explanation of the reason(s) e.g. “serious co-morbidities” “very poor prognosis”. Single words alone i.e. “futile”, “elderly”, “frailty”, “sleepy” are not sufficient. A more extensive explanation can be documented inside the patient's notes in addition if necessary.

Section 3: Communication with the patient (or Welfare Attorney) – If the patient has not been consulted there must be a clearly stated explanation for this e.g. “would cause patient distress”.

Section 4: Communication with relatives/friends – If discussion has taken place, state names and relationships with whom the decision has been discussed. If not discussed state “not discussed”.

Section 5: Members of the Multidisciplinary Team contributing to the decision – Names and positions must be stated and ensure the decision has been communicated to all relevant members of the healthcare team.

Section 7: Endorsement – the form must be signed or endorsed by a senior health care professional. (DNAR Policy, 2.2 for authorised health care professionals). Endorsement of the form must be in a timely manner e.g. within 48 hours.

Key points on correct form completion are located on the reverse of the DNAR form. More details can be found in the DNAR Policy.
RESUSCITATION/DO NOT ATTEMPT RESUSCITATION (DNAR) POLICY

<table>
<thead>
<tr>
<th>Approval Committee</th>
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<th>Document Author</th>
</tr>
</thead>
<tbody>
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<td>Resuscitation Committee</td>
</tr>
</tbody>
</table>
## Contents

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2.0 How the Decision is made</td>
<td>3</td>
</tr>
<tr>
<td>2.1 Patients for CPR</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Patients not for CPR</td>
<td>3</td>
</tr>
<tr>
<td>2.3 Decisions about CPR that are based on the balance of benefits and burdens</td>
<td>4</td>
</tr>
<tr>
<td>2.4 Communications and discussion with patients who lack capacity or those close to patients</td>
<td>4</td>
</tr>
<tr>
<td>2.5 Advance decisions refusing CPR</td>
<td>5</td>
</tr>
<tr>
<td>2.6 Lasting Power of Attorney</td>
<td>5</td>
</tr>
<tr>
<td>2.7 Adults who lack capacity and have no family, friends or other advocate whom it is appropriate to consult</td>
<td>6</td>
</tr>
<tr>
<td>3.0 Date for Review</td>
<td>6</td>
</tr>
<tr>
<td>4.0 References</td>
<td>6</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>7</td>
</tr>
<tr>
<td>Appendix 2</td>
<td>8</td>
</tr>
</tbody>
</table>
1.0 Introduction

This policy has been formulated by the Resuscitation Committee of the Trust and agreed by the Trust Management Board. This policy must be adhered to by the medical and nursing staff of the Trust. It has been written for adult patients and is based on the joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing published in October 2007. In the case of patients under the age of 18 a refusal of a CPR (Cardio Pulmonary Resuscitation) attempt should be taken into account, but could be overruled by a court or a person with parental responsibility. DNAR (Do Not Attempt Resuscitation) decisions apply only to CPR and not to any other aspects of treatment.

2.0 How the Decision is Made

Refer to the Decision-Making Framework (Appendix 1, DNAR policy)

2.1 Patients for CPR

All patients admitted to the Trust will be for attempted resuscitation unless an active decision is made to the contrary. Decisions about CPR must be made on the basis of an individual assessment of each patient's case. When a DNAR decision has not been made or there is uncertainty regarding DNAR status, then resuscitation should be attempted. If appropriate, enquiry should be made at the time of in-patient admission as to whether a valid and applicable advance decision exists.

It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe the patient is likely to suffer a cardio-respiratory arrest. There may be situations in which CPR is commenced, but during attempted resuscitation further information comes to light that makes continued CPR inappropriate (for example, a DNAR order, a valid and applicable advance decision, or important clinical information). In such circumstances, continued attempted resuscitation would not be appropriate.

2.2 Patients not for CPR

If the clinical team believes that CPR would not restart the heart and breathing, it should not be attempted. The patient's individual circumstances and the most up-to-date guidance must be carefully considered before such a decision is made.

The overall responsibility for a DNAR decision rests with the consultant in charge of the patient's care. In the absence of the consultant a senior member of the team possessing the MRCP, MRCS or FRCA or its equivalent, may make a DNAR decision. Out of hours, in the absence of a senior doctor, the doctor on call may undertake the decision in consultation with the consultant on call and nursing staff. In all cases where the consultant in charge has not been involved in the DNAR decision, then his/her agreement should be obtained at the earliest opportunity. The decision of DNAR status should not preclude undertaking other aspects of care.
The date and time of giving a DNAR decision should be clear and fully documented using the Resuscitation Order Form (Appendix 2, DNAR policy) together with the clinical justification and when applicable, the documented discussion with the patient. The reasons and circumstances of any DNAR decision must be reviewed regularly on the junior staff and consultant ward rounds. This is essential if there is a material change in the patient’s clinical condition. Any changes must be fully documented. The nursing staff are encouraged and expected to raise the issue of resuscitation status of a patient with the medical team at these rounds or at other times when appropriate. The resuscitation status must be communicated at each patient handover. Importance is placed on communication of the resuscitation status to any personnel involved with the clinical management of the patient, e.g. radiographers, physiotherapists etc.

When a clinical decision is made that CPR should not be attempted, because it will not be successful, and the patient has not expressed a wish to discuss CPR, it is not necessary or appropriate to initiate discussion with the patient to explore their wishes regarding CPR. However, this decision must be the right one for the patient. In some circumstances it may be best to explain such a decision to a patient rather than them finding out by chance that a decision has been made without them being involved or being informed of it.

Uncommonly, some patients for whom a DNAR decision has been established may develop cardiac or respiratory arrest from a readily reversible cause such as choking, induction of anaesthesia, anaphylaxis or blocked tracheostomy tube. In such situations CPR would be appropriate, whilst the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances. In addition to reversible causes, it may be appropriate to temporarily suspend a decision not to attempt CPR during some procedures if the procedure itself could precipitate a cardiopulmonary arrest – for example, cardiac catheterisation, pacemaker insertion or surgical procedure.

2.3 Decisions about CPR that are based on the balance of benefits and burdens

Some patients do not fall easily into the categories 2.1 and 2.2 above even though CPR may be successful in re-starting the patient’s heart and breathing. Then the benefits of possible prolongation of life must be weighed against the potential burdens to the patient. This is not solely a clinical decision and in this situation the patient’s informed views are of paramount importance. The views of members of the medical and nursing team involved in the patient’s care are also valuable in forming a decision.

2.4 Communication and discussion with patients who lack capacity or those close to patients

If a patient lacks capacity, any previously expressed wishes must be taken into account when making a CPR decision.

Consideration of whether the benefits of attempting CPR would outweigh the risks and burdens for the patient should be discussed by the healthcare team, and those close to or representing the patient. Such considerations should always be
undertaken on the basis of the patient’s best interests, following the process laid down in the Mental Capacity Act including:

- The likely clinical outcome, including the likelihood of successfully re-starting the patient’s heart and breathing for a sustained period, and the level of recovery that can realistically be expected after successful CPR
- The patient’s known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values
- The patient’s human rights, including the right to life and the right to be free from degrading treatment
- The likelihood of the patient experiencing severe unmanageable pain or suffering
- The level of awareness the patient has of their experience and surroundings.

2.5 Advance Decisions refusing CPR

An Advance Decision specifically refusing CPR will be legally binding if:

- The patient was 18 years or older and had capacity when the Decision was made
- The Decision is in writing, signed, and witnessed and has not been withdrawn by the patient
- It states that the Advance Decision applies even if the patient’s life is at risk
- The patient has not, since the Advance Decision was made, appointed a welfare attorney to make Decisions about CPR on their behalf
- The patient has not acted in a manner that clearly goes against the Advance Decision which suggests that they have changed their mind
- The circumstances that have arisen are the same as those envisaged in the Advance Decision.
- There are no reasonable grounds for believing that there have been changes in circumstance, which would have affected the Decision if the patient had known about them at the time they made the Advance Decision.
- The patient now lacks capacity to make a decision about CPR

2.6 Lasting Power of Attorney (LPA)

The Mental Capacity Act allows adults over 18 years of age who have capacity to give another person authority to make a decision on their behalf. A Lasting Power of Attorney (LPA) is the legal document that allows them to do so. Under LPA the appointed person (Attorney) can make health and personal decisions on the patient’s behalf once capacity is lost. The healthcare team must be satisfied that:

- The patient now lacks capacity to make a decision about CPR
- A statement has been included in the LPA specifically authorising the welfare attorney to make decisions about life-prolonging treatment
- The LPA is registered with the Office of the Public Guardian
Therefore if CPR may be able to restart the heart and breathing, and a decision on whether or not to attempt CPR is based on the balance of benefits and burdens, the Attorney’s decision must be sought.

Healthcare professionals should take all practical and appropriate steps to ascertain whether a patient:

- Has made an advance decision to refuse treatment, or,
- Has appointed a welfare attorney under a Lasting Power of Attorney.

If the decision being made by the Attorney does not appear to be in the patient’s best interests, then it may be necessary to apply to the Court of Protection for declaration as to the patient’s best interests.

### 2.7 Adults who lack capacity and have no family, friends or other advocate whom it is appropriate to consult

An Independent Mental Capacity Advocate (IMCA) needs to be consulted about decisions concerning ‘serious medical treatment’ where patients have nobody to speak on their behalf, if ‘what is proposed would be likely to involve serious medical consequences for the patient’. Therefore an IMCA does not need to be called if it is clear to the medical team that CPR would not restart the patient’s heart and breathing.

However, if there is genuine doubt about whether or not CPR would have a realistic chance of success, or if a DNAR decision is being considered on the balance of benefits and burdens, an IMCA must be involved. If an urgent decision is needed (e.g. at night or at a weekend) the decision should be made and recorded in the health record, and the decision discussed with an IMCA at the first available opportunity.

### 3.0 Date for Review

The policy will be reviewed on an annual basis or in response to new national guidance.

### 4.0 References

- Decisions relating to cardiopulmonary resuscitation
  A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing
  October 2007

If there is no reason to believe that the patient is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with the patient (or those close to patients who lack capacity) about CPR. If, however, the patient wishes to discuss CPR this should be respected.

When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient’s wishes about CPR, but careful consideration should be given as to whether to inform the patient of the DNAR decision (see section 6.)

Where the patient lacks capacity and has a welfare attorney or court-appointed deputy or guardian, this person should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussion about the patient’s care (see section 6).

If a second opinion is requested, this request should be respected, whenever possible.

If a patient has made an advance decision refusing CPR, and the criteria for applicability and validity are met, and the advance decision meets the documentation requirements stipulated in the Mental Capacity Act, this must be respected. If an attorney, deputy or guardian has been appointed they should be consulted (see sections 8 and 9).

When there is only a very small chance of success, and there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial. When the patient is a child or young person, those with parental responsibility should be involved in the decision where appropriate. When adult patients have mental capacity their own view should guide decision-making (see section 7).

CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.

- Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully.
- Decisions should be reviewed regularly and when circumstances change.
- Advice should be sought if there is uncertainty.
- Flow chart adapted from the Decision-Making Framework published by the BMA.
In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the patient have capacity to make and communicate decisions about CPR?
   If “YES” go to box 2

   If “NO”, are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If “YES” go to box 6

   If “NO”, has the patient appointed a Welfare Attorney to make decisions on their behalf?
   If “YES” they must be consulted.

   All other decisions must be made in the patient’s best interests and comply with current law.
   Go to box 2

2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:

3. Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:

4. Summary of communication with patient’s relatives or friends:

5. Names of members of multidisciplinary team contributing to this decision:

6. Healthcare professional completing this DNAR order:
   Name
   Position
   Signature
   Date
   Time

7. Review and endorsement by most senior health professional:
   Signature
   Name
   Date
   Review date (if appropriate)

   Signature
   Name
   Date

   Signature
   Name
   Date
This form should be completed legibly in black ball point ink

All sections should be completed

- The patient’s full name, date of birth and address should be written clearly.
- The date of writing the order should be entered.
- This order will be regarded as “INDEFINITE” unless it is clearly cancelled or a definite review date is specified.
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball-point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare professional cancelling the order.

1. **Capacity / advance decisions**
   Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient’s current circumstances.
   
   **16 and 17-year-olds:** Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.

2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests**
   Be as specific as possible.

3. **Summary of communication with patient…**
   State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate.

4. **Summary of communication with patient’s relatives or friends**
   If the patient does not have capacity their relatives or friends must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original Lasting Power of Attorney.

   If the patient has capacity ensure that discussion with others does not breach confidentiality.

   State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5. **Members of multidisciplinary team…**
   State names and positions. Ensure that the DNAR order has been communicated to all relevant members of the healthcare team.

6. **Healthcare professional completing this DNAR order**
   This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7. **Endorsement / review…**
   The decision must be endorsed by the most senior healthcare professional responsible for the patient’s care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended. Review should occur whenever circumstances change.

**REINSTATEMENT OF A DNAR:** if this situation were to arise then a new form should be used.

Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust.