Do Not Attempt Resuscitation (DNAR) Guidelines

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- ***Aim of CPR – achieve sustainable life***
- ***CPR = total opposite of traditional idea of a "good death" (peaceful, dignified, comfortable, family presence etc)***

- ***What is a DNAR decision?***
  - ***CPR is not to be attempted when patient dies***
    - ***CPR won't achieve sustainable life (Clinical)***
    - ***The burden of CPR Rx and likely outcome is such that the patient doesn't want CPR attempted (overall benefit)***
  - ***Protection for patients from aggressive, undignified, unnatural death – not a possible Rx being withheld***

- ***What is a DNAR form?***
  - ***Communication tool for that decision***

National background

- ***2000 NHS HDL 22*** - NHS Trusts are requested to ensure appropriate resuscitation policies are in place which
  - respect patients' rights
  - are understood by all staff
  - are accessible to those who need them
  - are subject to appropriate audit and monitoring

- ***2002 Good practice guidance***
  - ***BMA, RC(UK), RCN – revised 2007***
  - ***GMC – revised guidance out for consultation***

NHS Lothian road to DNAR integration

- *Initial thought to standardise DNAR form across 3 acute hospitals*
- Request from Scottish Ambulance Service to extend to transport
- Request by GPs and OOH to extend to patients at home / care homes

The NHS Lothian DNAR Policy:

- *Consistent policy, decision-making framework and documentation across all settings*
- First fully integrated policy in UK (including ambulance, police and procurator fiscal)
- Implemented May 2006, revised Dec 2007
- In line with national good practice guidance (*revised Joint Statement BMA/RCN/RC(UK) 2007 and GMC EoL guidance (consultation*)
- Adopted by other Health Boards in Scotland and England and Marie Curie Cancer Care

National background

- ***2008 Scottish Government Action Plan for Palliative and supportive care "Living and Dying Well"***
  - Action 8: NHS Boards should implement consistent DNAR and associated documentation such as the example developed by NHS Lothian across all care settings and provide education to support the effective and appropriate application of the documentation and procedures. NHS Boards should enter into discussion with the Scottish Ambulance Service regarding adoption of DNAR policies which are consistent with the SAS End of Life Care Plan.

- ***2009 Scottish Government Public Audit committee report***
  - ***"The Committee recommends that the Scottish Government ensure that the DNAR policy which is developed and adopted by boards is a consistent, national policy."***

Why all the fuss about integrated DNAR?

- Adam, 72yrs old with advanced lung cancer and bone mets
- Admitted to oncology with deterioration, jaundice and pain – extensive liver mets
- DNAR on oncology ward, EoL discussions – patient wanting to be at home so D/C arranged
- GP & DN aware, special note with OOH
- Arrived home Thursday. Sudden event Saturday afternoon - Son called 999
- Paramedics arrived and attempted resuscitation
- Police arrived and took body to police mortuary from Sat-Mon

When do you need to make a decision about resuscitation ?

Is cardiac or respiratory arrest a clear possibility?

YES

Could CPR realistically be successful (sustainable life)

NO

Document DNAR if in hospital
Consider discussion if at home / care home

YES

Patient's decision (capacity) re benefit / burden balance

Feb 2008 – Revised DNAR policy

Clarification of common areas of misunderstanding;

- Patients with DNAR forms still need to be assessed and provided with appropriate treatment outwith arrest situation.

- ***Patient must be aware of DNAR form at home***

- Ambulance crews must not be given original form if it is not being left in the patients home

WIFE'S FURY AT DEATH ORDER

Family handed form telling doctors not to revive husband

ADRIAN MATHER

AN INVESTIGATION has been launched after doctors issued a "do not resuscitate" order on a terminally ill man without telling tell him or his wife.

Margaret Wilson, 72, said she was horrified to find the form telling medics treating her husband John, 79, to let him die in the event of his heart stopping. NHS Lothian chiefs have apologised to the Wilsons and have launched an inquiry.

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Fury over note telling medics not to resuscitate husband

Why was I not told of order to let John die?

ADRIAN MATHER

THE horrified wife of a terminally ill man has discovered ERI doctors issued him with a "do not resuscitate" note without telling them.

Retired builder John Wilson, 79, who is suffering from lung cancer and Parkinson's disease, was admitted to hospital on Saturday night after suffering a stomach haemorrhage.

He was discharged hours later after doctors told the couple there was nothing they could do for him.

But Mr Wilson's wife, Margaret, was shocked when he got home and she checked the paperwork he had been given.

She found herself reading a Do Not Attempt Resuscitation (DNAR) form, instructing anyone treating her husband to let him die in the event of his heart stopping.

NHS Lothian has apologised to the Wilsons and are investigating why they were not told.

Mrs Wilson, 72, a veteran campaigner who was awarded an MBE in 2003 for her community work in the Southside, said she was "disgusted" to find the form.

"It just isn't right for something like this to happen. We know that John is a very ill man but for the hospital to decide on this without discussing it with either him or his family first is appalling," she said.

"When I realised what the form was, I couldn't believe it. I just expected that we would be the first to be told if the doctors felt he shouldn't be resuscitated. I was shocked that they'd taken that decision without even having the courtesy to speak to us first.

"The form clearly shows that they didn't speak to him or us about it, and it doesn't even explain why they didn't. We know the nature of his illnesses are probably the reason, but you'd think they would have treated his case in a decent and dignified manner."

Mr Wilson, who has suffered from Parkinson's for the past five years and also has dementia and partial eyesight, was diagnosed with lung cancer last September.

He was admitted to hospital on Saturday night on the recommendation of a 24-hour GP who was called to his home on East Crosscauseway to treat his stomach bleed.

On his form, doctors detailed his conditions as the reason why CPR was unlikely to be successful, but did not explain why they had not discussed the subject with him or his family.

Mrs Wilson added: "We're not even sure what we have to do with this form now. Although he's back home now, he still has respite care so we don't know whether we need to give the form to the care home he goes to.

"We also don't know if the do not resuscitate recommendation is on his medical record now, either. If he gets ill again and has to go to hospital, do we need to show it to the doctors or ambulance crew that will treat him?"

British Medical Association guidelines state any DNAR decision should be made in consultation with the patient and their family.

Dr Charles Swainson, medical director, NHS Lothian, said: "I would like to apologise to the family for any distress this has caused them.

"NHS Lothian has very clear guidelines surrounding the need for Do Not Attempt Resuscitation decisions that relate to CPR and staff are aware of these protocols in dealing with what is a very sensitive issue. There is also a guidebook for staff about the need for clear and sensitive communication when deciding the patient's best interests as they near the end of their life.

"If these protocols have not been followed in this case, we will find out why and ensure they are adhered to in future.

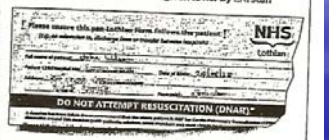
"We are currently investigating exactly what has been discussed with the family in this instance and will report our findings to them directly."

amather@allinkerprinter.com

Comment – Page 12

PATIENT: John Wilson

SHOCKED: Margaret Wilson found the order, below, in paperwork given to her by ERI staff



THE FACTS

The British Medical Association's Medical Ethics Today book – effectively a doctor's handbook of ethics and law – details when is it appropriate for medical staff to consider making a DNAR order.

It says that a DNAR order may be given when:

- A competent patient has refused CPR
- Medical staff are as certain as they can be that attempting CPR would not restart the patient's heart and breathing
- There is no benefit in restarting the patient's heart and breathing, for example if only a very brief extension of very poor quality life can be achieved and imminent death cannot be averted
- The benefits from the prolongation of life are outweighed by the burdens of the treatment to the patient.

The overall responsibility for decisions about CPR and DNAR orders rests with the consultant or GP in charge of the patient's care, but that person should always be willing to discuss the decision with other involved health professionals.

WIFE'S FURY AT ORDER TO ENSURE NATURAL, PEACEFUL AND DIGNIFIED DEATH AT HOME……

……doesn't have quite the same headline impact!!!

Patients with DNAR form being discharged home:

- Review if DNAR decision is still appropriate
- Clinical team should decide whether it is of benefit for patient to have DNAR form at home
  - likelihood of sudden death
  - importance of ensuring dignified, peaceful, natural death where possible
- If appropriate; sensitive discussion is needed to explain form's positive role to patient and family
- Inform OOH services

DNAR form – “crash helmet” for end of life journey

Ugly, obvious, uncomfortable, hate wearing it, ….protection against possible disaster

Patients with DNAR form being discharged home cont:

- Not always possible / appropriate / good timing to have that discussion
  - the GP should be informed - they may then choose to discuss the form at a more appropriate time

- No need to “reverse” the DNAR form prior to discharge - document why it wasn’t sent with the patient and either file original copy in notes or send to GP

NB. IF A DNAR PATIENT IS AT HOME WITHOUT THE FORM THERE IS ALWAYS A RISK OF INAPPROPRIATE PARAMEDIC AND POLICE INTERVENTION

Lothian Community Nursing End of Life Care Audit – March 2009

- Patients dying at home = 105
  - DNAR form in place = 73 (70%)
- Patients dying in care homes = 26
  - DNAR documentation in place = 15 (58%)

Feb 2008 – Revised DNAR policy

Responsibility for decision lies with Senior "Clinician" responsible for patient's care – Dr or nurse

(BMA/RC(UK)/RCN joint statement Oct 2007)

"Should nurses be given powers of life and death?"

The Telegraph Oct 2007

Gives nurses the power to ensure dying patients have a dignified and peaceful death

What does this have to do with nurses?

- Elderly in-patient with advanced prostate cancer and multiple bone mets
- Sudden deterioration overnight
- Nursing staff feel that likely he’s likely to die
- Clear that DNAR appropriate
- Nurses concerned about how on-call doctor would explain DNAR to patient and family

- Therefore doctor not called
- Patient's heart stops and 2222 call put out
- Resuscitation 'successful' and patient lives
- ***Semi-conscious with a flail chest from CPR***
- ***Dies 12 hours later***

Inappropriate resuss attempt audits

- 2006 – 18 consecutive CPR attempts and 7 (40%) were inappropriate (SJH only)
- 2009 – 28 consecutive CPR attempts and 2 (7%) were inappropriate (all 3 acute hospitals)

CPR/DNAR discussions

- *Core communication skill for all doctors and nurses caring for patients in any setting.*
- *Unique "breaking bad news" situation – forces patients to think of the possibility of sudden death*
- *Important part of end of life advance care planning for patients in hospital, hospice, care home or their own home*

When do I have to discuss DNAR?

1. Where death can be anticipated and CPR might realistically achieve sustainable life – benefit vs burden is patient's decision

2. Where you want to send a DNAR form home with the patient

We should all know how to do this…

….but that doesn't mean it's always easy!

With whom should we discuss DNAR?

- ***THE PATIENT*** …….unless
  - They request otherwise
  - They are not competent to understand the implications of such a discussion

**** Relatives should not be given the burden of making DNAR decisions ****
(unless legally appointed welfare guardian)

DNR discussions – How?

- **When you are certain CPR won't work**
  - Be honest and confident– avoid "slim chance", "very small percentage" etc.
  - Talk about death rather than cardiac arrest
  - Be willing to talk about consequences of CPR and paramedic / police intervention at home

- **Where CPR might achieve sustainable life**
  - Be realistic about chances of success and outcome of "successful CPR" ***for that patient*** ie. Admission to A&E/ITU, ventilation, death in unfamiliar unit, loss of capacity etc

DNAR DISCUSSIONS – HOW.... not to

"If your heart stops do you want us to try to get it going again with CPR?"

...or even worse...

"If your son's heart stops do you want us to try to get it going again with CPR?"

- makes no sense without full understanding of the context

Heart stops = cardiac arrest. *Will CPR work?*

(…… nothing to do with death).

***Patients/relatives* – yes definitely …with a cup of tea afterwards to help recover**

- ***(TV survival to hospital discharge = 63%)***

(NEJM (1996) Diem et al, 334(24);1578-1582)

- ***Doctors/Nurses* – probably yes….what if it's VT?**
  - ***(Drs overestimate prognosis by factor of 5)***

(BMJ (2000) Christakis & Lamont, 320;169-173)

- ***Reality* – probably not / definitely not**
  - ***(survival to hospital discharge 13-14%)***

(Resuscitation (2005) Cooper et al, 68; 231-237)

Do I need to discuss DNAR when CPR will not work?

"If CPR would not restart the heart and breathing it should not be attempted"

"In most cases the patient should be informed but for some patients, for example those who are approaching the end of their life, such information will be unnecessarily burdensome and of little or no value"

Decisions relating to CPR – a joint statement from the BMA, RC(UK) and the RCN Oct 2007

Continued reluctance for DNAR discussions

What if they get upset….?

When should I not discuss DNAR?

If death would be completely unexpected i.e. impossible to anticipate

Patient refuses discussion

If the benefit afforded by discussion would be outweighed by the burden it would impose

Conclusions

- *DNAR decision-making and discussion = core skill for all Drs and nurses involved in direct patient care*
- *Integrated policy gives new opportunity to avoid inappropriate resuscitation at home*
- *Set DNAR decision in context of end of life care goals and concerns to allow realistic informed choices*
- *Don't offer CPR as a choice when it won't work*

NHS Lothian integrated DNAR form

Revised Version 1207

Full name of patient: .....

Patient CHI: ..... Date of Birth: .....

Address: .....

..... Postcode: .....

GP name/address: .....

..... Postcode: .....

NHS Lothian

Please be aware the DNAR decision does not refer to any treatment other than CPR. Patients should be assessed and provided with whatever other treatments are appropriate for their health and comfort irrespective of their DNAR status.

DO NOT ATTEMPT RESUSCITATION (DNAR)*

A decision has been taken *(PLEASE INDICATE BELOW)* **that the above patient is NOT for attempted Cardio-Pulmonary Resuscitation (CPR). Any discussion around this decision (with patients, relatives, team members etc) must clearly be documented in patient's notes.**

Please tick one of the four boxes below.

○ CPR is unlikely to be successful due to:** .....

.....

(NB: In this situation only discussion with patient/relevant other is not compulsory ***unless the patient is at home or being discharged home with the form****).*

○ This **has** been discussed with patient/relevant other: (*name*.....)
(Tick whenever discussion has occurred and record details of discussion in patient's notes).

○ Successful CPR is likely to be followed by a length and quality of life which would not be of overall benefit to the patient. *(The patient's views and wishes in this situation are essential and must be respected).*

○ This has been decided with the patient/patient's legally appointed proxy (*name*.....)
(This must be discussed with the patient/patient's proxy. Please record details of discussion in patient's notes).

○ Patient is not competent to decide and no legal proxy has been identified. Decision made on basis of benefit to the patient in discussion with (*name(s)*.....)

☐ CPR is not in accord with the known or expressed sustained wishes of the patient who is mentally competent.

☐ CPR is not in accord with a valid applicable advance directive *(anticipatory refusal or living will)****

* See overleaf for full guidelines. ** Record underlying condition(s) e.g. poor LV function; end stage Obstructive Airway Disease; large intracerebral haemorrhage with coning; etc. *** See note 1d overleaf.

For hospitals inpatients Junior Doctors with *full GMC registration* can sign but the decision must be fully discussed and agreed with the Responsible Senior Clinician (see note 2 overleaf) who should then sign within 72 hours.

FOR HOSPITAL INPATIENTS		
Junior Doctor's Signature		Date:
Print full name		Time:
Responsible Senior Clinician's Signature (see note 2)		Date:
Print full name		Time:

This original pan-Lothian form may follow the patient (e.g. On admission to, discharge from or transfer between hospitals). Please note that if the DNAR form is to be at home with the patient this must be discussed with them and the relevant others to ensure they are aware of its role in ensuring the patient receives appropriate care at home.

DNAR status must be reviewed on a regular basis and on transfer of medical responsibility (e.g. hospital to community). It is essential that the OoH Service is informed for patients in the community (Fax: 0131 537 2705 or Tel: 0131 537 2713).

Review Date	Responsible Clinician's Signature	Outcome (circle review decision)		Review Date	Responsible Clinician's Signature	Outcome (circle review decision)	
		DNAR still applicable	DNAR reversed			DNAR still applicable	DNAR reversed
		DNAR still applicable	DNAR reversed			DNAR still applicable	DNAR reversed
		DNAR still applicable	DNAR reversed			DNAR still applicable	DNAR reversed

Reversal of a DNAR order should be recorded on the form, scored through with a permanent marker to indicate the order is now obsolete and then filed in the back of the medical notes.

! For Ambulance Crew Transfer Instructions, please see reverse !

Ambulance Crew Instructions

In the event of a Cardio-Pulmonary Arrest, please do not attempt CPR or defibrillation for this patient. All other types of supportive care should be given as appropriate as with any other patient where there is a deterioration in clinical condition.

If whilst in transit the patient's condition suddenly deteriorates such that death occurs or is imminent, please

- **Contact (*name and tel no*) ..... and take the patient to .....**

Thank you for your cooperation in this matter.

Signed (*Nurse or Dr*): ..... Name: ..... Date: .....

For patients at home or being discharged home only

- The original form may go home with the patient on discharge if appropriate.
- The patient/patient's family **must be aware** of the DNAR form and understand its purpose and how it may be helpful in an emergency (**Essential if DNAR form is to be in the patient's home**)
- The appropriate GP/DN/OoH services must be made aware that a DNAR order is in place
- Where a DNAR form is not with a patient at home everyone should be aware that paramedics and police will provide a full emergency response if called to attend.

Have the GP/DN/OoH Services and the patient/patient's family been made aware that a DNAR order is in place?

Yes ☐ No ☐ Reason if No .....

NB. It is essential that the GP, DN and OoH services are aware of the DNAR form if it is to be with a patient at home.

Lothian Unscheduled Care Service (LUCS) Fax: 0131 537 2705 or Tel: 0131 537 2713

Decisions Relating to Cardio-Pulmonary Resuscitation

The following guidelines are based on "A Joint Statement from the British Medical Association and Resuscitation Council (UK) and the Royal College of Nursing", October 2007. Further guidance can be found in the DNAR policy section of the resuscitation guidelines document.

It will be appreciated that the decisions concerning whether or not a patient should be offered Cardio-Pulmonary Resuscitation are complex. Discussions with patients and relevant others must be conducted in an empathic and professional manner.

1. It is appropriate to consider a **Do Not Attempt Resuscitation (DNAR)** decision in the following circumstances:
   (a) where the patient's medical condition indicates that effective CPR is unlikely to be successful (discussion with terminally ill patients is not compulsory).
   (b) where successful CPR is likely to be followed by a length and quality of life which would not be of benefit to the patient to sustain. This decision must be made in discussion with the patient or patient's proxy.
   (c) where CPR is not in accord with the known or expressed sustained wishes of the patient who is mentally competent.
   (d) where CPR is not in accord with a valid, applicable, advance directive (anticipatory refusal or living will). A patient's informed and competently made refusal which relates to the circumstances which have arisen may be legally binding upon doctors.
2. The overall responsibility for making a decision not to resuscitate lies with the most senior clinician assuming medical responsibility for the patient during that care period (Consultant, GP, LUCS Doctor, Senior Nurse, Staff grade, Ass. Specialist etc).
3. Where CPR might be successful DNAR decisions should be made in conjunction with the patient's wishes, if known or ascertainable, other members of the clinical team and relevant others. Where the patient's wishes are not and cannot be ascertained and there are no relevant others to consult, great caution should be exercised in making a DNAR decision as this may involve some degree of subjective analysis of a patient's quality of life, which may be subject to subsequent challenge.
4. The decision not to resuscitate a patient should be recorded as "Not For Cardio-Pulmonary Resuscitation". This should be carried out by the responsible clinician using the approved "Do Not Attempt Resuscitation" form overleaf **and filed at the front of the medical or (community) nursing notes.** The senior nurse or key worker should record this decision in the nursing notes for hospital inpatients. A GP should record this decision in the GP notes. The OoH service should be informed for patients at home.
5. Decisions about resuscitation must be reviewed regularly and in the light of changes in the patient's condition and wishes. The frequency of review should be determined by the health professional in charge and will be influenced by the clinical circumstances of the patient. **Reversal of a DNAR order should be recorded on the form, scored through with a permanent marker to indicate the order is now obsolete, and then filed in the back of the medical notes. OoH services must be informed if the patient is at home or likely to be at home.**
6. If there is no record in the medical and nursing notes of a DNAR order then cardio-pulmonary resuscitation will be offered to every patient suffering a cardiac or respiratory arrest unless the patient is clearly irreversibly dying from a terminal illness.
7. The term "proxy" is used to describe the person the patient has nominated to make decisions about their care. The proxy may be the patient's relatives, carers, representatives, advocates, welfare guardians and welfare powers of attorney.

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