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)

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YES

NO

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

Document DNAR if in hospital

Consider discussion if at home / care home
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 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
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)

- **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*