National Consent Policy
Part Four
Do Not Attempt Resuscitation (DNAR)
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1. Introduction

Cardiopulmonary resuscitation (CPR), including chest compressions, defibrillation (with electric shocks), the injection of drugs and ventilation of the lungs, is an important and potentially life-saving intervention for victims of cardiorespiratory arrest. Positive developments in recent years that have resulted in improved outcomes include CPR training for the public and the widespread availability of automated external defibrillators.

CPR, when instituted rapidly, is a valuable intervention for reducing the burden of sudden cardiac death. For this reason, when an individual’s expressed wishes regarding CPR are unknown and/or in an emergency situation there is a presumption in favour of providing CPR. The likelihood of success with CPR depends on factors such as the underlying health status of the individual, the cause of the cardiac arrest, and how quickly CPR is started. However, it is important for both service providers and the public to be aware that the overall survival rate after CPR is relatively low: following cardiorespiratory arrest in a hospital the chances of surviving to hospital discharge are about 13-20%; following out of hospital cardiorespiratory arrest, the survival rate is lower. The success rate is particularly poor in those with severe acute non-cardiac illness or those with multiple chronic illnesses. There is a risk that the individual may be left with long-term brain damage and disability, especially if there is delay between cardiorespiratory arrest and the initiation of the CPR. Finally, CPR can be a relatively traumatic procedure and in extreme cases adverse effects may include bone fractures and organ rupture.

These considerations have prompted extensive national and international debate regarding the appropriate use of this procedure. Existing local and regional guidelines in Ireland relating to CPR and do not attempt resuscitation (DNAR) orders show a lack of consistency in how resuscitation decisions are made and documented and a lack of clarity about the roles and responsibilities of different parties (i.e. the individual, those close to the individual if he/she is unable to participate and healthcare professionals) within the decision-making process. Hence, it is considered that there is a need for national guidelines in this area.

It is acknowledged that no single policy or guidelines can address all the complex individual clinical situations that will arise in healthcare. This policy document discusses issues pertaining to CPR and DNAR orders within the broader context of consent. It is not intended as guidance for technical and practical considerations relating to resuscitation procedures; therefore, such issues are not dealt with in this policy.
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The aim of the national policy is to provide a decision-making framework that will facilitate the advance discussion of personal preferences regarding CPR and DNAR orders and to ensure that decisions relating to CPR and DNAR orders are made consistently, transparently and in line with best practice. Where a decision is made to attempt CPR, it should be performed competently and any decision to restrict the extent and/or duration of the CPR attempt should be based on balancing the benefits and risks of continuing CPR. Unethical and inappropriate practices such as “slow-coding” and “sham resuscitations” where a full resuscitation is deliberately not attempted must not be performed.

This policy document should be read in conjunction with other relevant guidance, including the Medical Council’s, Guide to Professional Conduct and Ethics for Registered Medical Practitioners (2009) and An Bord Altranais, The Code of Professional Conduct for each Nurse and Midwife (2009).

2. Definition and scope of resuscitation decisions

2.1 Do not attempt resuscitation or do not resuscitate

Throughout this document the term “do not attempt resuscitation” (DNAR) orders will be used as opposed to “do not resuscitate” (DNR) orders. This change has been made in an effort to underscore the uncertainty surrounding the success of CPR: “do not resuscitate” may imply that resuscitation would likely be successful if it were undertaken, whereas “do not attempt resuscitation” emphasises that the success of any resuscitation intervention is less clear cut and situation dependent.

2.2 Scope of DNAR orders

A decision not to attempt CPR applies only to CPR. It does not apply to any other aspect of treatment and all other treatments and care that are appropriate for the individual should continue. If a decision is made to restrict the nature or extent of CPR, this should be carefully documented and communicated effectively to all members of the healthcare team caring for the individual.
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However, while a decision may be made to attempt CPR in the event of cardiorespiratory arrest it may not be clinically appropriate to provide certain other intensive treatments and procedures. For example, prolonged support for multi-organ failure (e.g. artificial ventilation and renal dialysis) in an intensive care unit (ICU) may be clinically inappropriate if the individual is unlikely to survive this, even though his/her heart has been re-started.

Decisions relating to CPR must be made separately for each individual based on an assessment of his/her case. An individual should not be obliged to put a DNAR order in place to gain admission to a long-stay care setting, such as a nursing home. Such an obligation could be seen as discriminatory and a breach of that individual’s autonomy.

This policy is applicable to all those who provide services on behalf of the HSE, which includes the ambulance service, acute and community hospitals, long-stay care settings as well as individuals being cared for in their own homes.

3. General principles

3.1 Need for individual decision making

Decisions about CPR must always be made on the basis of an individual assessment of each case and not, for example, on the basis of age, disability, the subjective views of healthcare professionals regarding the individual’s quality of life or whether he/she lives in the community or in long-term care. The individual’s own views and values are centrally important.

In particular, individuals are the best judges of their own quality of life; healthcare professionals and families may underestimate the quality of life of, for example, those with disabilities. However, quality of life is not the main criterion on which resuscitation decisions should be based and it is also necessary to consider the likelihood of CPR being successful as well as balancing the benefits and risks involved.
3.2 Involving the individual in discussions regarding CPR

Decisions pertaining to CPR and DNAR orders should be made in the context of the likelihood of success and the potential risks as well as the individual’s overall goals and preferences for his/her treatment and care. Determination of the former requires discussion with the individual him/herself.

Decisions relating to CPR and DNAR orders are complex and potentially emotive therefore, it is important for such issues to be dealt with in an open, honest and sensitive manner.

On-going communication between individuals, those close to them (where appropriate) and healthcare professionals is essential in achieving this goal (see also Section 6.5).

3.3 Involving family or friends in discussions regarding CPR

If the individual wishes to have the support or involvement of others, such as family or friends, in decision making, this should be respected. If a person has decision-making capacity then his/her family or friends should only be involved in discussions regarding his/her treatment and care with that individual’s consent. If the individual is unable to participate in discussions due to his/her physical or cognitive condition, those with a close, on-going, personal relationship with the individual may have insight into his/her previously expressed preferences, wishes and beliefs. They may also have their own views as to the appropriateness or otherwise of interventions, based on their knowledge of the individual’s circumstances. In general, the closer the relationship to the individual, the greater weight should attach to such views. However, the role of those close to the individual is not to make the final decision regarding CPR, but rather to help the senior healthcare professional to make the most appropriate decision. Where CPR is judged inappropriate, it is good practice to inform those close to the patient, but there is no need to seek their ‘permission’ not to perform CPR in these circumstance (see also Part One Section 5.6.1).
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3.4 Decision-making capacity

Best practice utilises a functional approach to defining decision-making capacity whereby capacity is judged in relation to the particular decision to be made, at the time it is to be made. Decision-making capacity also depends on the ability of an individual to comprehend, reason with and express a choice with regard to information about a specific treatment (e.g. the benefits and risks involved or the implications of not receiving the treatment).

However, where an individual lacks decision-making capacity, his/her previously expressed wishes should be considered when making a decision. Whether the benefits would outweigh the risks for the particular individual should be the subject of discussion between the senior healthcare professional and those close to the individual. Only relevant information should be shared with those close to an individual unless, when he/she previously had decision-making capacity he/she expressed a wish that information be withheld.

3.5 Provision of information

Good decision-making requires accurate information, tailored as much as possible to the individual, about the likely benefits and risks of CPR. There is evidence that members of the general public, and indeed a proportion of healthcare professionals, tend to overestimate the survival rate and overall success of CPR, and that the provision of accurate prognostic information influences decisions regarding the appropriateness of CPR.

3.6 Decision-making regarding CPR and DNAR orders

It is important that the healthcare professional involved in the decision-making process has the requisite experience, training, knowledge and communication skills to coordinate this process. In general, this duty rests with the most senior healthcare professional with responsibility for an individual’s treatment and care, which would be a consultant or registrar in the hospital setting or the individual’s GP in other healthcare settings. He/she should usually consult with other healthcare professionals who may have helpful insights into the individual’s condition.

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32 See Part One section 5.5. for further provisions on the assessment of capacity
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Situations may arise where a decision regarding CPR has to be made quickly and the most senior healthcare professional is unavailable. In such circumstances, decision-making responsibility can be delegated to other less senior healthcare professionals, who should notify and discuss with their senior colleague as soon as possible.

4. When should CPR and DNAR decisions be considered?

Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest and is preferable to making decisions only after a crisis has arisen. Hence, the likelihood of cardiorespiratory arrest occurring should be taken into account when determining how, when and if to consider the need for CPR/DNAR discussions or decisions for an individual. Three broad groups can be identified based on the likelihood of cardiorespiratory arrest within the foreseeable future:

- Cardiorespiratory arrest is considered unlikely
- Cardiorespiratory arrest, as a terminal event, is considered inevitable
- Cardiorespiratory arrest is considered possible or likely.

4.1 Cardiorespiratory arrest is considered unlikely

For most people, within the general population, the likelihood of cardiorespiratory arrest within a given period is very small. In general, these would be healthy individuals for whom cardiorespiratory arrest would represent an unanticipated emergency situation. Moreover, given the low likelihood of arrest, it is unlikely that the issues of CPR and DNAR orders would have been raised previously with such individuals since healthcare professionals are not required to discuss every possible eventuality with every individual. Instead, the general presumption in favour of CPR should operate in the unlikely event of an arrest. However, if an individual indicates that he/she wishes to discuss CPR, then this should be respected.
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However, a small cohort of individuals within the general population may have prepared an advance healthcare directive refusing CPR under specific circumstances. The wishes of such individuals should be respected if the directive is considered valid and applicable to the situation that has arisen.

4.2 Cardiorespiratory arrest, as a terminal event, is considered inevitable

Some individuals may be so unwell that death is considered to be imminent and unavoidable. For such individuals, cardiorespiratory arrest may represent the terminal event in their illness and the provision of CPR would not be clinically indicated (i.e. would not restart the heart and maintain breathing for a sustained period). Attempting CPR in such circumstances may cause harm to the individual, increase his/her suffering and/or result in a traumatic and undignified death. In many cases, a sensitive but open discussion of end-of-life care will be possible in which individuals should be helped to understand the severity of their condition. However, it should be emphasised that this does not necessarily require explicit discussion of CPR or an ‘offer’ of CPR. Implementing a DNAR order for those close to death does not equate to “doing nothing”; all care provided should follow a palliative approach and focus on easing that individual’s suffering and making him/her as comfortable as possible.

4.3 Cardiorespiratory arrest is considered possible or likely

For certain individuals there may be an identifiable risk of cardiorespiratory arrest occurring as a result of their clinical condition. These include individuals with acute severe illness and those with severe or multiple coexisting medical conditions or diseases.

Advance care planning, including consideration of issues such as CPR/DNAR is often appropriate for such individuals and should occur in the context of a general discussion about the individual’s prognosis and the likelihood that CPR would be successful, as well as his/her values, concerns, expectations and goals of care.

33 There is currently no specific legislation pertaining to advance healthcare directives in Ireland. However, the Irish courts have established that an individual with capacity has the right to refuse treatment to facilitate a natural death. The weight of legal opinion has been interpreted to mean that an advance healthcare directive made by an individual, when he/she had capacity, would be upheld. In addition, the Medical Council Guide to Professional Conduct and Ethics for Registered Practitioners (2009) also recognises advance healthcare directives
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Most CPR discussions and decisions will occur in this group. However, it must be emphasised that this is not a homogenous group, as the likelihood of success from CPR varies widely, and this necessarily influences how discussions are conducted.

5. Presumption in favour of providing CPR

As a general rule, if no advance decision not to perform CPR has been made, and the wishes of the individual are unknown and cannot be ascertained, there is a presumption in favour of providing CPR, and healthcare professionals should make all appropriate efforts to resuscitate him/her. In these circumstances, the extent and/or duration of the CPR attempt should be based on the clinical circumstances of the arrest, the progress of the resuscitation attempt and balancing the risks and benefits of continuing CPR.

In some instances where CPR has been started, additional information may subsequently become available which makes continued CPR inappropriate, for example clinical information which indicates that CPR is unlikely to be successful, or information regarding the individual’s preferences.

As was discussed in Section 4.2, there will be some individuals for whom no formal DNAR decision has been made, but where attempting CPR is clearly inappropriate because death is imminent and unavoidable, for example, in the final stages of a terminal illness. In these circumstances, it is reasonable for healthcare professionals not to commence CPR.

Some healthcare facilities may not provide all aspects of CPR such as defibrillation. In the event of a cardiorespiratory arrest occurring in such a facility, basic CPR and a call to the emergency services should occur in the absence of a prior decision not to perform CPR. The extent of the CPR interventions available in such facilities should be notified to prospective residents or users of the facility, and if there is dissatisfaction with how cardiorespiratory arrests will be responded to then an alternative arrangement should be made if possible.
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6. Balancing the benefits and risks of providing CPR

The decision to use any treatment, including CPR, should be based on the balance of risks and benefits to the person receiving the treatment and on that individual’s own preferences and values. When discussing CPR with individuals, it is important to ensure that they understand the relevant benefits and risks. While acknowledging the uncertainty inherent in many medical predictions, healthcare professionals still have an obligation to provide an opinion, based on their expertise.
Principles to be applied in reaching a decision about CPR\textsuperscript{34}

- Decisions about CPR must be made on the basis of an individual assessment of each person’s case.
- The likely clinical outcome of attempting CPR should be considered, including the likelihood of successfully re-starting the individual’s heart and breathing for a sustained period, and the level of recovery that can reasonably be expected after successful CPR.
- Advance care planning, including making decisions about CPR, is an important part of good clinical care for those at risk of cardiorespiratory arrest.
- Communication and the provision of information in a sensitive manner are central to discussions about CPR and should be undertaken by the most senior healthcare professional available.
- It is not necessary to initiate a discussion about CPR with an individual if there is no reason to believe that he/she is likely to suffer a cardiorespiratory arrest.
- Where no explicit decision has been made in advance there should be an initial presumption in favour of CPR.
- Where the expected benefit of attempted CPR may be outweighed by the risks, the individual’s informed views are of paramount importance. If the individual lacks decision-making capacity those close to him/her should be involved in discussions to explore his/her wishes, feelings, beliefs and values.
- If an individual with decision-making capacity refuses CPR, or an individual lacking decision-making capacity has a valid and applicable advance healthcare directive refusing CPR, this should be respected.
- DNAR decisions apply only to CPR and not to any other aspects of treatment and care.

\textsuperscript{34} This information has been modified from: Lannon R and O’Keeffe ST (2010). Cardiopulmonary resuscitation in older people – a review. Reviews in Clinical Gerontology 20: 20–29; British Medical Association, Resuscitation Council (UK) and Royal College of Nursing (2007). Decisions relating to cardiopulmonary resuscitation: A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. British Medical Association, London, 24p
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6.1 Respecting an individual’s refusal of CPR

If an individual with decision-making capacity refuses CPR, this should be respected, irrespective of whether the healthcare professional feels it is a wise decision or not. Similarly, if an individual lacking decision-making capacity has a valid and applicable advance healthcare directive refusing CPR this should also be respected (see also Section 4.1).

Ultimately, while such refusals of CPR should be respected, it does not follow that people (whether contemporaneously or in an advance healthcare directive) can demand whatever treatments they want, regardless of their effectiveness (see also Section 6.4). A healthcare professional is not obliged to provide a treatment that is not clinically indicated, which includes CPR.

6.2 When the balance between risk and benefit is uncertain

In some cases, the healthcare professional may be uncertain whether the potential benefits of CPR outweigh the risks. In these situations, the preferences and values of the individual are of paramount importance, and the healthcare professional should acknowledge the uncertainty, outline the benefits and risks of each option and assist the individual in coming to a decision. In situations where attempting CPR is considered to have a reasonable chance of successfully restarting the heart and breathing and the individual has decided that the quality of life that can reasonably be expected would be acceptable then his/her wishes should usually be respected (see also Section 6.1).

6.3 When the risks outweigh the benefits

In other circumstances, the healthcare professional may judge that the risks associated with CPR outweigh the potential benefits and that a DNAR order should be put in place. However, there is often considerable variability in how strongly and the degree of certainty with which this judgement is held.

In these situations, it is appropriate for the healthcare professional to explain the reasons behind this judgement, including any uncertainty, to recommend that a DNAR order should be written, and to seek the views of the individual in this regard.
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6.4 When there is disagreement about the balance of benefits and risks of CPR

While in many cases, the individual and healthcare professional will agree that a DNAR order is appropriate or inappropriate; this may not always be the case.

Many disagreements result from miscommunication and misunderstandings, such as an unrealistic expectation by an individual of the likely success rate of CPR or an underestimation by the healthcare professional of the acceptability of the current or predicted future quality of life of the individual. In many such cases, continued discussion will lead to agreement, and an ultimate decision should be deferred pending further discussion. If disagreement persists, an offer of a second, independent opinion should be made. Where all previous efforts at resolution have proven unsuccessful it may be necessary for parties to consider obtaining legal advice. The same procedure should be carried out if those close to an individual who lacks decision-making capacity do not accept a DNAR decision.

6.5 Where an individual does not want to discuss CPR and DNAR orders

Situations may arise where an individual does not want to discuss CPR/DNAR orders. In some cases such refusals may be linked to the timing of the discussion and the individual should be given the opportunity to defer the discussion and revisit the issues of CPR and DNAR orders at a later time. However, if an individual refuses to participate in the discussion, his/her wishes should be respected. If the individual would prefer that the healthcare professional discuss the decision with somebody else such as a relative, partner or friend, this should be respected. However, it should be emphasised that the role of those close to the individual is not to make the final decision relating to CPR, but rather to help the senior healthcare professional to make the most appropriate decision.
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6.6 DNAR orders and readily reversible cardiorespiratory arrests

In certain situations, an individual with a DNAR order may suffer a cardiorespiratory arrest from a readily reversible cause unconnected to his/her underlying illness. In such cases CPR would be appropriate, while the reversible cause of arrest is treated. For example, choking restricts an individual’s intake of oxygen, which could potentially lead to a cardiorespiratory arrest if not treated promptly. The initial response should concentrate on removing the cause of the tracheal blockage, but in the event of a subsequent cardiorespiratory arrest, CPR should be provided.

Where an individual with a DNAR order in place is to undergo a medical or surgical procedure, it may be appropriate to review the DNAR order given the potential for cardiorespiratory arrest to occur under anaesthesia. In such situations, should a cardiorespiratory arrest occur, there should be a presumption in favour of providing CPR. Therefore, in advance of procedures involving anaesthesia it may be advisable to temporarily suspend an individual’s DNAR order. The process of reviewing the DNAR order should involve discussion with the individual as part of the consent process in advance of the procedure. If the DNAR order is to be suspended this decision should be clearly documented as well as the time at which the DNAR order is to be re-instated. If an individual wishes his/her DNAR order to remain valid during the procedure, despite the increased likelihood of cardiorespiratory arrest, this might significantly increase the overall level of risk associated with the procedure. This issue of elevated risk should be highlighted to the individual, by his/her healthcare team, as part of the overall discussion regarding the procedure. However, if the individual is willing to accept the additional risk then the healthcare professional should continue with the procedure.

7. DNAR decisions and children

In any matter relating to children, the child’s best interests are of paramount importance. This policy advocates for a child-centred approach to be taken in relation to any decision in the area of health and social care services as they relate to children.

35 For a more detailed discussion regarding the issue of who can give consent on behalf of a child, see Part Two of this policy
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It is important that respect for the child’s autonomy is integrated into all decision-making in the same way as for adults.

This does not mean that the interests and views of parent(s)/legal guardian(s) will be displaced, as in most instances the child’s interests will be best represented by its parent(s)/legal guardian(s), although their interests are not the same. However, respect for the autonomy of the child entails the facilitation, wherever possible, of the child’s right to make his/her own decisions.

As discussed in Part Two of this policy, involving children in decision-making may be different from obtaining consent in the adult context due to the age or capacity of the child to understand and participate in the decision and the role of the parents/legal guardians in decision-making. However, even where children are unable to give a valid consent for themselves, they should nonetheless be as involved as possible in decision-making as even young children may have opinions about their healthcare and have the right to have their views taken into consideration by giving their assent to the proposed treatment or service. This principle is in keeping with legal and international human rights standards and ethical guidance which provide that the child’s wishes should be taken into account and, as the child grows towards maturity, given more weight accordingly.

Acting in children’s best interests generally involves sustaining their lives and restoring their health to an acceptable standard, which may include attempting CPR.

In general, if a child suffers a cardiorespiratory arrest before a definite decision about resuscitation has been made there should be an initial presumption in favour of attempting CPR. However, situations may arise where attempting CPR is unlikely to be successful or the risks associated with CPR would significantly outweigh the benefits of providing it. In such circumstances attempting CPR may no longer be in the child’s best interests and a DNAR order should be put in place.

Given the additional complexity and the emotionally-demanding nature of decisions relating to CPR for children this process should be underpinned by a number of fundamental guiding principles:

- Parent(s)/legal guardian(s) and the healthcare team should work in partnership when deciding about CPR, with decisions being made on the basis of consensus
- Where appropriate, given the child’s level of knowledge, understanding and experience, he/she should also be involved and participate in the decision-making partnership
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- Therefore, children should be informed and listened to and their ascertainable views and preferences should be taken into consideration.
- The final decision reached should be in the best interests of the child.

In some instances, consensus may be reached on a child’s proposed treatment and care plan following a detailed discussion about his/her condition and prognosis, the likelihood of CPR being successful as well as the benefits and risks associated with CPR. However, disagreements with parent(s)/legal guardian(s) may be more likely to arise where a healthcare professional considers that the provision of CPR would be clinically inappropriate. In such cases continued communication and obtaining a second opinion from an independent senior healthcare professional may help to resolve the disagreement. Nonetheless, if the disagreement persists, healthcare professionals should seek ethical and legal advice and court involvement may ultimately be required to reach a solution.

8. Documenting and communicating CPR/DNAR decisions

A decision whether or not to attempt CPR should be clearly and accurately documented in the individual’s healthcare record, along with how the decision was made, the date of the decision, the rationale for it, and who was involved in discussing the decision.

It is recommended that service providers should develop specific mechanisms for the documentation and dissemination of decisions relating to resuscitation\(^\text{36}\).

\(^{36}\) For example, the development of a standardised and colour-coded DNAR card, to be included in an individual’s records, to help highlight his/her DNAR status.
9. Reviewing DNAR orders

The need to review a DNAR order will depend on the rationale for the decision and should be considered within the context of an individual’s condition and overall care. Therefore, it may be appropriate to review decisions relating to CPR when:

- the individual’s clinical condition changes
- the individual’s preferences regarding CPR change
- an individual who previously lacked decision-making capacity regains his/her capacity
- clinical responsibility for the individual changes (e.g. where he/she is being transferred or discharged).

Any review and any subsequent decision made should be documented accordingly.