PATIENT SAFETY TOOL BOX TALKS ©

EFFECTIVE CARE & SUPPORT

END OF LIFE CARE
CPR AND DNAR DECISIONS

v1.0

Key Messages

WHO IS RESPONSIBLE FOR DNAR DECISION?

This duty rests with the most Senior healthcare professional: a consultant/registrar In the hospital or the individual's GP in the home/nursing home. He/she should consult with other healthcare professionals who'll have insights into the individual's condition.

If a patient, lacking decision making capacity, who has a valid an applicable healthcare directive refusing CPR, then this should be respected

The survival rate after CPR is only about 13-20% in hospital and even lower if the arrest happened out of hospital.

When a patient is in the final stages of an incurable illness and death is expected within a few days, the success rate of CPR is very low (various studies have suggested it is less than 5%).

A decision not to attempt CPR (DNAR) does not apply to any other treatment and care e.g. IV antibiotics, oxygen therapy, dialysis. There should always be a **Care Plan** in place which has been developed and reviewed **in discussion with the patient**.

A person is not obliged to put a DNAR order in place to gain admission to a long-term care setting e.g. nursing home

CPR decisions must always be made on the basis of an **individual assessment**

When making a decision regarding DNAR, clinicians need to consider:

1. the likelihood of CPR being successful
2. the balance of benefits and risks
3. the individual's goals and preferences

CPR decisions must always be made in the context of advanced care planning. Advanced care discussions could include:

- the patient's concerns
- their values and expectations of care
- their understanding of their illness and prognosis
- their preferences for the future including wishes regarding treatments and place of care

There will be some individuals for whom no formal DNAR decision has been made but where attempting CPR is clearly inappropriate, for example in the final stages of a terminal illness. In these circumstances it is reasonable for healthcare professionals not to commence CPR.

Unethical and inappropriate practices such as "slow coding" and "sham resuscitations" where a full resuscitation is deliberately not attempted must not be performed.

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 the patient's suffering & making him/her as comfortable as possible.

Talking to patients and families about resuscitation

WHAT IS CPR?

CARDIOPULMONARY RESUSCITATION (CPR) including chest compressions, defibrillation (with electric shocks), the injection of drugs, ventilation of the lungs, is an important and potential life saving intervention for victims of cardio-respiratory arrest.

REFER TO OTHER HANDOUTS RELATING TO END OF LIFE CARE:

"AM I DYING— DEALING WITH DIFFICULT QUESTIONS" AND "ADVANCE CARE DISCUSSIONS"

The following outlines some recommendations for clinicians to consider:

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 cardio-respiratory arrest.

If a patient has capacity and wishes to participate in decision-making about CPR and DNAR decisions, their input is important.

A patient who has capacity has the right to refuse medical treatment.

When the wishes of a patient who lacks capacity are not known, decisions about CPR must be based on judgment about its benefits and risks for this patient in this particular condition.

For patients who lack capacity, the nature, benefits and risks of CPR as they apply to the patient's situation should be explained to the family and the CPR decision should be conveyed to them. **There is no need to seek permission from the family not to perform CPR however, it is good practice to inform those close to the patient.**

When a patient is in the final stages of an incurable illness and death is expected within a few days, the success rate of CPR is very low (various studies have suggested it is less than 5%).

Any decision that CPR will not be attempted should be documented on the patient's record and details given of the factors that led to that decision. It may also be necessary to consider if/when this decision should be reviewed.

Patients and families should be reassured that a DNAR order does not result in the denial or withdrawal of other treatments that might be thought helpful (for example, radiotherapy or antibiotics). There should always be a care plan in place which has been developed and reviewed in discussion with the patient. Families can also be involved as long as the patient has given consent.

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