HSE National Consent Policy
Part 4: Do Not Attempt Resuscitation (DNAR)

Summary by the Hospice Friendly Hospitals Programme
The full policy is available at
http://www.hse.ie/eng/about/Who/qualityandpatientsafety/nau/National_Consent_Advisory_Group/
Common Myths

• It is the family’s responsibility to decide whether or not someone is for resuscitation
• Family must be consulted and give permission for CPR to be carried out
• ‘Sham resus’ and ‘slow walks’ are acceptable practices
• CPR is a very successful treatment
• DNAR status must be decided to gain entry to long-stay facility e.g. nursing home
• DNAR decision means no more care
Cardiopulmonary Resuscitation

• Intervention for treatment of cardiorespiratory arrest

• Survival rates:
  – In hospital: 13-20%
  – Out of hospital: lower again

• Includes:
  – Chest compressions
  – Defibrillation
  – Medication
  – Ventilation
HSE National Policy

• Provides a decision-making framework to facilitate advance discussion of personal preferences regarding CPR and DNAR orders

• Decisions are made consistently, transparently and in line with best practise

• Does not address technical and practical considerations
Terminology

- **DNAR**: Do Not Attempt Resuscitation
- **CPR**: Cardiopulmonary Resuscitation
- CPR, when appropriate, should be performed competently and weigh benefits vs burden of continuing
  - No ‘slow-coding’
  - No ‘sham resuscitations’
Scope

• Only applies to CPR

• Document decisions carefully and communicate effectively to all HC team members

• Individual assessment

• Applies to all who provide services on behalf of the HSE
General Principles

• Individual decision-making
• Involving individuals in discussions
• Involving family & friends in discussions
• Decision-making capacity
• Provision of information
• Decision-making regarding CPR & DNAR orders
Individual decision-making

• Individual assessment of each case
• Individual’s own views and values are central
• Balance benefits and risks involved in CPR and likelihood of success
  – Likely clinical outcome
  – Likelihood of successfully restarting heart and breathing for a sustained period
  – Level of recovery that can be reasonably expected
Involving the Individual

- Need to establish individual’s overall goals and preferences for treatment and care
- Context of success and potential risks
- Open, honest, sensitive discussions
- Ongoing communication with individual, those close to them and HC professionals
Involving Family or Friends

- Respect individual’s wishes to have them involved
- If individual has decision-making capacity:
  - Family/friends only involved with individual’s consent
- If individual does not have decision-making capacity, family/friends:
  - May have insight into individual’s preferred wishes
  - May have own views
  - The closer the relationship, the greater the weight attached to their views
  - DO NOT make the final decision & their permission is not needed not to perform CPR
Decision-making Capacity

- Judged in relation to the particular decision being made, at the time it is to be made
- Depends on the ability of the individual to comprehend, reason with and express a choice
- Where an individual lacks capacity, their previously expressed wishes should be considered
Decision-making CPR & DNAR Orders

• Accurate information about the benefits and risks of CPR
• Public and HC professionals tend to overestimate the survival rate and success of CPR
• Most senior healthcare professional-
  – Hospital: Consultant/ Registrar
  – Other healthcare settings: GP
  – Consult with other HC professionals
• If decision must be made quickly, decision-making responsibility can be delegated to less senior HC professionals
• Notify and discuss with senior colleague ASAP
When to consider CPR and DNAR decisions

- **Advance care planning**
  - Important part of good clinical care

- **Likelihood of cardiorespiratory arrest**
  - Unlikely
  - Inevitable, as a terminal event
  - Possible or likely
Cardiorespiratory Arrest is Unlikely

- Healthy individuals
- Cardiorespiratory arrest- unanticipated emergency situation
- Unlikely CPR and DNAR issues would have been discussed
- Advance Care Directive may apply if valid and applicable

General presumption in favour of CPR
Cardiorespiratory Arrest is Inevitable

- Death is imminent and unavoidable
- Cardiorespiratory arrest may be the terminal event in their lives
- CPR not clinically indicated

Sensitive but open discussion of EOLC

All care provided should follow palliative approach
Cardiorespiratory Arrest is Possible or Likely

- May be an identifiable risk of cardiorespiratory arrest
- Advance care planning should address
  - CPR/DNAR
  - Prognosis
  - Individual’s values
  - Concerns
  - Expectations
  - Goals of care
CPR Presumption

General rule:
– If no advance decision not to perform CPR
– Wishes of individual not known & cannot be ascertained

Presumption in favour of providing CPR

– Extent and/or duration of CPR based on:
  • Clinical circumstances
  • Progress of resuscitation attempt
  • Risks/benefits of continuing
CPR Considered Inappropriate

• No DNAR decision made but death is imminent and unavoidable

• CPR may be discontinued if additional information becomes available
  – Clinical information
  – Individual preferences

• Extent of CPR interventions at a facility should be discussed and alternative arrangements made if unsatisfactory
Balancing Benefits & Risks

• CPR should be based on:
  – Balance of risks and benefits to the person
  – Individual’s own preferences and values

• Healthcare professionals have an obligation to provide an opinion based on their expertise
Balancing Benefits & Risks

- **When the balance is uncertain**
  - Individual preferences and values are paramount
  - Acknowledge uncertainty
  - Assist individual in coming to a decision

- **When the risks outweigh the benefits**
  - Professional to explain the reasons
  - Seek views of the individual
Balancing Benefits & Risks

• **When there is disagreement about benefits/risks**
  – Continued discussion
  – Offer a second, independent opinion
  – Legal advice

• **Also use legal route if those close to individual who lacks capacity do not accept a DNAR decision**
Individual does not want to discuss it

- Reschedule conversation - this is a process
- Respect their wishes not to discuss CPR/DNAR
- Respect their wishes to speak with others
Readily Reversible Cardiorespiratory Arrest

• Unconnected to underlying illness
• Readily reversible cause: CPR is then considered appropriate

• May review DNAR order if to undergo medical or surgical procedure
  – Presumption in favour of CPR
  – May need to temporarily suspend DNAR order
  – Review procedure in light of increased risk if DNAR order to remain in situ
Documentation

• Clearly and accurately documented on HCR
  – How decision was made
  – Date of the decision
  – Rational for the decision
  – Who was involved in the discussion

• Develop specific mechanisms for documentation and dissemination of decisions relating to resuscitation
Review of DNAR Orders

• Review when
  – Individual’s clinical condition changes
  – Individual’s preferences regarding CPR change
  – Individuals who previously lacked decision-making capacity regains their capacity
  – Clinical responsibility for the individual changes
  – Document and communicate any changes appropriately