

# 1. Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Decisions – Guideline

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## NB:

TPMH and the Orthopaedic Rehabilitation Unit (ORU) at Burwood Hospital use the form “Ref 2181, OPHS0203.” Refer to TPMH CPR status Decision in Volume K.

DNACPR for children use the form Child Health End of Life Care Plan.

## Purpose

### Part A

To provide clinical staff with a consistent approach to DNACPR orders and a guideline for withholding cardiopulmonary resuscitation (CPR).

### Part B

To ensure the appropriate action is taken for individual long term care (LTC) patients in the situation where a cardiac arrest occurs.

## Scope

All adult patients in CDHB Hospitals and Homes

## Risk Management

### Level of Risk

Moderate

### Treatment of Risk

Strict compliance with this policy will minimise the level of risk

### Risk Classification

Disease

## Associated Documents

- Code of Health and Disability Services Consumers Rights (“Code of Rights”)
- CDHB Manual Volume 11 – Clinical: Informed Consent Policy
- TPMH Policy and Procedure Volume K – CPR Manual
- Child Health End of Life Care Plan : Child Health e-Guidelines
- Rural Health Services Clinical Policy and Procedure Manual : Cardiac Arrest Action – Patient Medical Emergency
- Medical and Surgical Services Division Policy and Procedure Manual – Volume A: Cardiopulmonary Resuscitation
- Information for Doctors Regarding Resuscitation Decisions: available electronically via the Intranet websites for Palliative Care, Resuscitation Service and the RMO site.
- Information for Patients, Family/Whanau – Deciding about Resuscitation

Forms:

- QMR0217 - CDHB DNACPR Order
- QMR246 - CDHB Long Term Care Cardiopulmonary Resuscitation Status
- QMR246A - CDHB Long Term Care Cardiopulmonary Resuscitation Status Review

## Definitions

### **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)**

means that if a patient has a respiratory or cardiopulmonary arrest, neither basic nor advanced cardiopulmonary resuscitation will be carried out.

“**Advance Directive**” refers to the CDHB Informed Consent Policy.

## Exclusions

Variations to this approach may exist in certain specialised units. In all circumstances it is the joint responsibility of medical and nursing staff to know whether or not patients are for CPR and to be aware of the appropriate level of intervention.

## 1.1 Part A - Patient admitted into Acute Care

### 1.1.1 Special Points

A person who has a respiratory or cardiopulmonary arrest within a CDHB Facility will be deemed for cardiopulmonary resuscitation (CPR) unless:

- There is a clear entry in the patients clinical record to the contrary (on the Resuscitation Status Form QMR 0217 / QMR246)
- The patient is obviously dead e.g. rigor mortis

A “DNACPR” order is consistent with quality medical and nursing care in every other respect and should not reduce the care and attention owed to the patient/client and their family/whanau. If other specific interventions are to be discontinued and/or withheld, they should be specifically noted and an overall management plan devised and written in the patient’s clinical notes.

Decisions as to the appropriateness of CPR will be made by:

1. The Specialist/Consultant or
2. The Registrar with Specialist delegated authority or
3. The Medical Officer of the community hospitals looking after the patient.

The decision will be made taking into account the patient’s wishes, the medical condition and prognosis, and the probability of surviving a respiratory or cardiopulmonary arrest.

It is important to note that the form QMR0217 will be deactivated by:

1. Lapse of fortnightly review in the “Time Limited” option.
2. Double score through sheet and cancelled.

Review of this form is essential:

- 1: Fortnightly in the Time Limited option.
- 2: If there is a significant change in the patient’s condition.
- 3: Prior to anaesthesia or interventional procedure.
- 4: If a competent patient requests review or withdrawal of the order at any time. Document details in the clinical records.

### 1.1.2 Further Guidelines for Assessment and DNACPR Decisions

1. Cardiac arrest is an inevitable part of the process of death. CPR is an emergency technique to help prevent sudden death in the life-threatening situation of a cardiopulmonary arrest.
2. Refusal of medical care by a **competent and informed adult** must be respected, even if that refusal leads to serious harm to the individual. Refusal may be communicated verbally or in writing by the patient e.g. by way of an advance directive (living will). This should be documented in the patient notes.
3. All patients should receive CPR in the event of a respiratory or cardiopulmonary arrest unless there are special circumstances and there is a written order to the contrary. This puts an onus on

the Specialist, Registrar or Medical Officer Community Hospital to anticipate the possibility of cardiopulmonary arrest, and if CPR is not indicated, to consider and document a “DNACPR” order.

4. Only Specialists, Registrars, or Community Hospital Medical Officer may sign a “DNACPR” order. However, if Medical Officers or House Surgeons not directly responsible for a patient are involved in a cardiopulmonary resuscitation procedure, which is clearly failing, then, even in the absence of the relevant Specialist, there is no obligation for them to continue.
5. There are some patients who are either irreversibly close to death or for whom the probability of successful CPR approaches zero. In such cases CPR can rightly be said to be futile. It is not part of a doctor’s/nurse’s duty of care to administer such treatment and in these circumstances it is permitted to withhold CPR even in the absence of a completed “DNACPR” order.

**N.B.** Age, mental disease, intellectual disability and chronic disease are not grounds per se for withholding CPR.

6. A Specialist, Registrar or Community Hospital Medical Officer may believe that CPR would not be in the best interest of a **competent patient** on grounds other than a **futile** clinical condition. For example, a predicted poor quality of life or death in the near future. In such a case informed consent for a “DNACPR” order should be obtained wherever possible. For informed consent to be obtained, the patient must have:
  - i. a clear explanation and understanding of any underlying disease
  - ii. a basic understanding of CPR
  - iii. an appreciation of the probability of surviving a cardiopulmonary arrest

If consent is not obtained from the patient the reasons for this needs to be documented in the clinical notes. It is only appropriate to sign a “Time-Limited” DNACPR order in these circumstances.

7. If a **non competent patient** has previously expressed a preference, this should generally be honoured. However in doubtful cases it is best to discuss this with a Medical Advisor and if necessary seek legal opinion.
8. If no reliable indication of a **non competent patient’s** wishes exists, decisions about resuscitation should be based on clinical grounds acting in the patient’s best interests – Right 7(4) Code of Rights. Indications of a patient’s wishes may be available from relatives, nursing staff and other clinicians closely involved with the patient. If relatives insist on resuscitation of a non competent patient despite the existence of a futile clinical condition, the reasoning behind the decision not to resuscitate should be fully explained, although the decision stands. Likewise, if relatives insist on non resuscitation in the absence of a clinically futile condition, the Specialist should explain the

reasons for resuscitation but is under no obligation to accede to the request. Relatives / next of kin / Enduring Power of Attorney have no legal rights in determining the withdrawal of treatment of adults, but their input should be considered in determining what the patient's wishes may have been if the patient were competent.

9. There is the option for completion of an “Enduring DNACPR” order. This can be completed if it is stated within a valid Advance Directive OR if it is the informed and voluntary choice of a competent adult. The reasons for completion and the person(s) with whom this decision has been discussed MUST be recorded on the form. If this form is correctly completed, it can be brought forward for use in any subsequent admissions, without the need for holding further conversations. If there is any doubt as to the validity or applicability of this decision, it is best to confirm the order with patient and/or family.
10. **For children (under 16 years of age)** legal proxies, usually parents or those with legal parental authority, assume the rights of consent although this does not override a competent child's right to give or refuse consent. Parents are under a duty to consent to treatment only if it is in the best interests of their child.
11. The information for patients, family/whanau pamphlet “Deciding about Resuscitation” may be provided to assist understanding.
12. Information should be given in a simple language and manner which can be understood.

**NB:** For further information see the document “Information For Doctors Regarding Resuscitation Decisions.”

### 1.1.3 Documentation of DNACPR Orders and Patient Information

The decision for a “DNACPR” order should be documented within the patient's clinical record utilising the DNACPR form QMR0217 and be made known to everyone caring for the patient.

This order should also be documented within the patient's clinical notes stating “Not for Cardiopulmonary Resuscitation” or “DNACPR”.

When a patient who has a “DNACPR” order in one location moves to a different location (e.g. Operating Theatre, CCU, ICU) that order must be communicated and agreed on by the receiving team at the time of transfer.

The documentation on the form will include:

- The date of the decision being made.
- The DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION Order.
- The reason for the decision including medical facts and opinions underlying the order.

- A notation re: any discussion with patient/client, family/whanau, medical and other professional staff, OR if no discussion is held, the reasons for this.
- A fortnightly review if time limited.
- The name and signature of the authorising doctor.

It is important to note that the form QMR0217 will be deactivated by 1: lapse of fortnightly review for “Time-limited” only and 2: double score through the sheet and cancelled.

## **1.2 Part B – CDHB Long Term Care Facilities (either Rest Home or Hospital level)**

### **1.2.1 Special Points**

1. On admission of the patient (for long term care) the receiving hospital or rest home must establish if the patient is for resuscitation or not for resuscitation within 24 hours of the patient’s admission to the facility. Consideration must be given to Part A of this document prior to progressing implementation. If a QMR0217 has been completed in Acute Care indicating an “Enduring DNACPR” status, this form can continue to be used or the information transferred to the QMR246.  
For every patient transferred, the documentation (stated in 1.7.3) must be completed and clearly communicated to the receiving team.
2. The Medical Officer is the only person able to sign the “Cardiopulmonary Resuscitation Status” form QMR246 and QMR246A. If the QMR0217 is used this must be countersigned by the Medical officer and re-dated. The Medical Officer or Nurse Manager in charge must interview the patient and help them to make an informed decision about their DNACPR status. If the patient is no longer able to make decisions for themselves, then people involved in the patient’s life, including family members, can also contribute in terms of Right 7(4) Code of Rights. Nursing staff may document decisions in the clinical notes and advise the MO who must sign the order as soon as possible.
3. The decision must be reconsidered at the 3 monthly medical reviews or sooner if clinically indicated and documented on the QMR246A. Review should be based on the current condition of the patient and the competent patient’s wishes.
4. When a patient who has a “CardioPulmonary Resuscitation Status” or “DNACPR” order in one location moves to a different location (e.g. Operating Theatre, CCU, ICU) that order must be communicated and agreed on by the receiving team at the time of transfer.

## 1.2.2 Documentation

### Nursing/Medical Staff

The decision for a “DNACPR” order should be documented within the patient’s case notes utilising the QMR246 (or a re-validated QMR0217) and be made known to everyone caring for the patient. This also needs to be documented clearly in the patient’s clinical notes and care plan.

The documentation on the form QMR246 will include:

- The date of the decision being made.
- The DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION Order.
- The reason for the decision including medical facts and opinions underlying the order.
- A notation documenting any discussion with patient/client, family/whanau, medical and other professional staff.
- The name and signature of the authorising doctor.

The time limit of the order:

It is important to note that the order will be deactivated by either lapse of 3 monthly medical review or double score through the sheet and cancelled. If the order is to continue, the QMR246A must be dated, signed by a Medical Officer and any comments noted.

The patient information pamphlet “Deciding about Resuscitation” is available from the Supply Department for use when discussing this subject with patients or next of kin.