Framework for Cardiopulmonary Resuscitation (CPR) Decisions

Can a cardiac or respiratory arrest be anticipated?
For example:
- Progressive cardiac or respiratory compromise.
- Previous life-threatening event or condition in which cardiac arrest is likely.
- Patient dying from irreversible condition e.g. advanced cancer.
- Patient whose death would not be unexpected.

Do not burden the patient or relevant others with a CPR decision
- Continue to communicate and assess any concerns of the patient and relevant others. This may involve discussion about CPR and its outcome.
- Review only when circumstances change.
- In the event of cardiopulmonary arrest, carry out CPR unless it would clearly be unsuccessful.
- For patients with strong views about CPR, advice may be given about creating an advance healthcare directive.

Are you as certain as you can be that CPR would realistically have a medically successful outcome?

YES

Advance Decision on CPR is possible
- Sensitive exploration of the patient’s wishes regarding resuscitation should be undertaken by the most experienced staff available.
- If the patient has capacity for this decision, discuss options of CPR and DNACPR with patient. Involve relevant others* if appropriate (with patient’s permission).
- If the patient does not have capacity to understand the implications of this decision, the medical team should make this decision based on available information regarding patient’s previous wishes (from relevant others*, advance healthcare directive, other healthcare professionals or members of the multidisciplinary team). Relevant others* should never be asked to make the decision unless they are the legally appointed welfare attorney/welfare guardian/person appointed under an intervention order. Healthcare staff must be aware of the principles of assessing capacity and the patient must be cared for in line with the terms of the Adults with Incapacity (Scotland) Act 2000 (see policy).
- Document the decision and any discussion around that process.
- Continue to communicate and assess concerns of the patient and relevant others*.
- Review at individualised clinically appropriate intervals to assess any change in circumstances.
- In the event of a cardiopulmonary arrest, act in accordance with the documented decision.

NO

CPR inappropriate
- As CPR would fail it cannot be offered as a treatment option. A DNACPR form should be completed and used to communicate this information to those involved in the patient’s care.
- Document the reasons for the decision and any discussion around that process.
- Do not burden the patient or relevant others* with a CPR decision.
- Continue to communicate and assess any concerns of the patient and relevant others (which may include discussion about why CPR is inappropriate).
- Patients at home or going home should be offered the DNACPR form if appropriate through sensitive discussion by experienced healthcare staff.
- Review when clinical responsibility for the patient changes.
- Review at individualised clinically appropriate intervals to assess any change in circumstances.
- Where the patient is clearly dying in days allow natural death with good palliative care and support for patient and relevant others.

Are you as certain as you can be that CPR would realistically NOT have a medically successful outcome?

NO

SEEK ADVICE

*Relevant others refers to the patient’s partner, relatives, carers, guardian etc

The following are summary notes only and should not be read in isolation from the NHSScotland DNACPR policy document. This policy is based on the good practice guidance that can be found in “Decisions relating to Cardiopulmonary Resuscitation: A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007” and “Treatment and care towards the end of life: good practice in decision-making” by the General Medical Council, May 2010.

Making a decision about resuscitation
A decision about the appropriateness of CPR can only be made if the situation(s) where CPR might be required can be anticipated for the particular patient (e.g. recent MI, pneumonia, advanced cancer etc). Where an arrest is not imminently anticipated it may still be possible to make an advance decision about CPR where the death of the patient would not be unexpected. If such a situation can’t be thought through then there is no medical decision to make and there is no need to burden patients with resuscitation decisions.

Advance directive – Patients who wish to refuse CPR in only certain future circumstances should be encouraged to make a formal Advance directive (see policy) as a DNACPR form would not be appropriate.

• The decision that CPR is not to be attempted should be recorded by the senior responsible clinician using the DNACPR form which should then be filed at the front of the healthcare notes that are in use during that care period and are most accessible in an emergency.

Medical decisions about DNACPR
• The role of the clinical team is to decide if CPR is realistically likely to have a medially successful outcome (sustainable breathing and circulation). Such decisions do not involve quality of life judgements.
• It may help in making a medical decision to decide whether the patient would be appropriate for Intensive Care (likely outcome of a “successful” prolonged resuscitation).
• The overall responsibility for making an advance decision about CPR lies with the most senior clinician assuming clinical responsibility for the patient during that care period (GP, Consultant, Out of Hours clinician, Senior Nurse, Staff Grade doctor, Associate Specialist etc) but it is wise to reach consensus with the patient, staff and relevant others.
• It is not necessary to burden the patient with resuscitation decisions if the clinical team is as certain as it can be that CPR realistically will fail and the clinician is not obliged to offer CPR in this situation. This must never prevent continuing communication with the patient and relevant others about their illness, including information about CPR, if they wish this.
• The exception to this is where a patient is at home or being discharged home and it is clear medically that CPR will fail. If the form is to serve any helpful purpose in the patient’s home the patient and relevant others should be aware of it. The timing and nature of this discussion is a matter of sensitive judgement by experienced members of the clinical team about the overall benefit to the patient of having that conversation.

Patient decisions about resuscitation issues
• Where CPR is likely to be medically successful but is judged to have doubtful overall benefit for the patient, the patient's wishes must be given priority.
• Doctors or nurses cannot make a DNACPR decision for a patient who has capacity based on judgement of overall benefit for that patient unless the patient specifically requests that they do this.

The Patient who lacks capacity to make a decision about resuscitation
• Where CPR is realistically likely to be successful, if a legally appointed welfare attorney/welfare guardian/person appointed under an intervention order has been previously established for the patient this person should be approached and supported to be involved in the decision-making process.
• If no legally appointed welfare attorney/welfare guardian/person appointed under an intervention order has been previously established the clinical team should make a decision based on a judgment of overall benefit for the patient made with as much information as possible from relevant others about the patient’s previously expressed wishes. A valid applicable advance directive should be respected in this regard.

The role of the relatives/relevant others
• Where a patient has capacity their permission must be sought before any discussion takes place with the relevant others.
• Relatives should never be given the impression that their wishes override those of the patient. They can give information about the patient’s wishes but should not be burdened with the decision unless their status as welfare attorney/welfare guardian/person appointed under an intervention order for the patient has been legally established.

Patient with a DNACPR order at home or being discharged home
• It is the medical and nursing team’s responsibility to ensure that the patient and/or family are aware of the DNACPR form and its positive role and that the family know what to do in the event of the patient’s death.
• The OoH service and all other relevant services must be made aware of the existence of the DNACPR order. Every effort must be made to ensure the emergency services are not called unnecessarily where a patient’s death is expected.
• If it is not felt appropriate or possible to have the DNACPR form at home with the patient everyone should be aware that paramedics and police may provide a full emergency response if called to attend.

Patient with a DNACPR order being transported by ambulance
• The ambulance section of the DNACPR form must be completed for any such patient being transported in Scotland by the Scottish Ambulance Service.
• Ambulance control must be informed of the existence of the DNACPR order at the time of booking the ambulance.
• If the patient is being transported home the crew must be informed that the patient and family are aware of the DNACPR form. If this is not the case the crew will not leave the form in the patient’s home and so should not be given the original form for the journey but they must be shown the original form prior to the journey to ensure they have the information they require for the patient’s journey.

Where no DNACPR decision has been made and a patient arrests
• The presumption is that staff would attempt to resuscitate a patient in the event of a cardiopulmonary arrest. However, there will be some patients for whom attempting CPR is clearly inappropriate, for example a patient in the final stages of a terminal illness where death is imminent and unavoidable and CPR would clearly fail. Where CPR will clearly fail it should not be attempted and experienced healthcare workers who make this considered decision should be supported by their colleagues.

The presence or absence of a DNACPR form should not override clinical judgement about what will be of benefit to the patient in an emergency (e.g. choking, anaphylaxis etc).