Top Tips for Clinicians

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Subject	**Resuscitation and DNAR**
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Disclaimer	These are intended only as good practice prompts. Use your clinical judgement.
Top Tip 1	**Having an appropriately documented and communicated DNACPR decision helps to:** • avoid unwanted or futile CPR where there is no prospect of success • reduce unnecessary burden/distress to family & maintain the person's dignity around the time of death
Top Tip 2	**Do I always need to inform a patient or their family if I decide that CPR is not appropriate / futile?** People should be given as much information as they want about their situation, including resuscitation decisions. • Ask the person if they would like to discuss 'what if' circumstances or whether they would prefer you to discuss it with someone close to them • People should not be excluded from the opportunity to discuss CPR merely because it may cause them distress or because CPR attempts may be futile It may be defensible not to involve the patient in DNACPR decisions if the clinician considers that the discussion would cause the patient physical or psychological harm, but ideally the family should be informed
Top Tip 3	**What If the patient wants CPR and medical opinion is that it is futile?** Patients or relevant others have no absolute right to insist on treatments that are clinically inappropriate, including CPR where there is no realistic prospect of success. You must consider their wishes and a discussion to understand why they are insistent on CPR is required (e.g. unrealistic expectations, cultural issues, concerns about withdrawal of care). • Give information about likely outcomes, risks and stats (see COVID framing conversations guide) • Point out that DNACPR does not mean withdrawing other care or treatment • It is good practice to offer a second opinion where disagreements are not resolved
Top Tip 4	**Do staff have to resuscitate if there is no DNACPR in place?** There is a strong presumption that CPR will be attempted for any individual in whom cardiac or respiratory function ceases, unless there is a direct order not to attempt CPR. • Without a DNACPR form, staff may be nervous about using their clinical judgement not to begin resuscitation, even where it would be futile or that death has already occurred • Staff may be instructed to begin CPR by YAS where a DNACPR is not in place
Top Tip 5	**All decisions and consultations must be carefully documented in the patient's record** If a DNACPR decision is made, clinicians must: • Complete the standard DNACPR form and inform relevant members of the care team • Record the detail and rationale for any DNACPR decision in the patient record, including details of any consultation with the patient and others and when / if the decision will need to be reviewed
Top Tip 6	**Acting in best interests is not the same as making a best interest decision under the Mental Capacity Act** We are always required to act in the best interests of patients, which can include not offering potentially harmful treatment which might be futile. 'Best interest decisions' under the MCA (2005) must follow the MCA code of practice, e.g. • Assessment to confirm the persons' lack of capacity to make the DNACPR decision • Taking all practicable steps to support the person to make their own decision • Consultation with all relevant persons to inform your best interest decision **When consulting, do not imply that the burden of decision is with the relatives**
Information	Additional guidance is available for 16-17-year-olds with life limiting conditions (Sec 11 Joint DNACPR policy)
My CPD/QI	*Document the key points simply, reflect on what it means for me, so what? Take action*