NO ACTIVE RESUSCITATION POLICY
HOSPITAL QUEEN ELIZABETH II
KOTA KINABALU, SABAH

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"No Active Resuscitation" POLICY

HOSPITAL QUEEN ELIZABETH II

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1.0 INTRODUCTION

The aim of this policy is to ensure that patients receive cardiopulmonary resuscitation (CPR) appropriately in the hospital setting. The clinical and spiritual needs of the dying should always be taken into consideration when formulating decisions on resuscitation. Thus, this policy is intended to help clinicians to make decisions on whom, why and when to attempt resuscitation. It is NOT concerned with how to perform CPR.

2.0 OBJECTIVES

2.1 This concise policy is intended to guide clinicians in making decisions on Do Not Resuscitate (DNR) in adult patients.

2.2 Most of the conditions where DNR orders are appropriate are likely to come from within the following main categories of disease, i.e. *terminal metastatic disease, severe cardiorespiratory failure and cerebrovascular disorders with poor prognosis*, among others.

2.3 However, CPR is still appropriate in ALL patients where there is no written instruction relating to DNR in the patient case records.

3.0 DEFINITIONS

3.1 CARDIAC ARREST: Sudden failure of the heart to maintain an adequate circulation. This may be due to asystole, ventricular fibrillation or pulseless electrical activity.

3.2 CPR (Cardio-pulmonary resuscitation): An emergency procedure in which the heart and lungs are made to work by performing chest compressions and artificial respiration, to restore blood circulation and prevent death or brain damage due to lack of oxygen.

3.3 DO-NOT-RESUSCITATE (DNR): This means that full CPR is not appropriate for that particular patient, so there is no need to commence CPR. If such a patient were to arrest, an immediate assessment has to be made as to the cause and appropriate simple measures initiated e.g. patient position, airway etc. No other attempts at basic or advanced life support should be commenced.

4.0 POLICY STATEMENT

4.1 Decisions not to resuscitate a patient must be made by the Specialist-in-charge or Consultant only, taking into account the diagnosis and prognosis of the patient. If the Specialist has any doubts about making a decision, he/she should always seek the advice of the Consultant.

In the event where there are no Specialists e.g. *District Hospital without Specialist,* the Medical Officer has to consult the On-call Specialist/Consultant at the nearest secondary/tertiary referral centre before a DNR order can be issued.

4.2 A "DNR" decision DOES NOT MEAN that all active treatment should cease. Supportive and therapeutic

care is an independent matter based on the clinical problems of the patient.

Investigations or treatment *e.g. IV fluids, drug therapy etc.* should not be stopped in the vast majority of cases.

4.3 Discussion with patients and relatives are of paramount importance. All discussions MUST BE fully documented in the patient's case records.

4.4 DNR orders for inpatients must be reviewed daily.

Entries in the case records must include date, time and the doctor's name and stamp.

Entry in the case records must be accompanied by the indication.

4.5 Patient confidentiality must be maintained at all times. When the patient is mentally competent, a discussion with the caregivers should only take place with the patient's permission. If the patient has an advanced directive, this should also be considered in the decision-making process.

If the patient is mentally incompetent, discussions with caregivers should take place subject to consideration of the patient's previous wishes.

4.6 Consent from patient or caregiver is not mandatory for the DNR decision but agreement should be sought. In the discussion, they should be informed of all the medical realities at hand, such as the patient's prognosis despite being on maximal treatment. In the event of disagreement between the Specialist and the patient or family, the assistance of an individual consultant and a patient representative is often helpful to reach resolution amongst all parties.

5.0 GUIDELINES FOR DISCUSSING DNR ORDERS WITH PATIENTS

Doctors often fear undertaking a discussion on DNR with their patients. Therefore, such discussions should rather improve and not detract from a healthy, trusting relationship.

Initiate the discussion with a general question as to whether the patient has any particular view or concerns about their diagnosis and its treatment. The doctor is urged to enquire as to whether the patient has completed an advance directive/ living will. The doctor should encourage the patient/caregiver to freely express his/her concerns.

5.1 When to discuss a DNR order:

- If the patient or caregiver/s wishes to discuss the decision on CPR.

- If CPR is thought to have some chance of success in a mentally competent patient who is perceived to have a poor quality of life.

- When the basis of a DNR decision is the absence of any likely medical benefit, discussion should aim at securing an understanding and acceptance of the clinical decision that has been reached. This would involve discussing issues such as palliative management and overall prognosis.

5.2 When not to discuss a DNR order:

- If the patient or caregiver/s indicates he/she does not want the discussion.

- If such a discussion is likely to harm the patient's wellbeing e.g. *if the patient has depression.*

6.0 APPENDIX 1.

SUGGESTIONS ON HOW TO DISCUSS DNR:

6.1 Setting – Make sure there is sufficient privacy with the patient and the caregivers.

6.2 Raising the topic – Be tactful and show empathy throughout your conversation. One example: *"Although it is unlikely to happen, we need to consider what we should do if your heart should stop."*

6.3 Timing – It is not encouraged to discuss DNR soon after the diagnosis is attained. Discussion should probably take place when the diagnosis and prognosis are clear and when patient has come to terms with their illness.

6.4 Seek – Try to establish the patient's understanding of their diagnosis and treatment. Patients and their caregivers often have unrealistic expectations of the value of resuscitation.

6.5 Information – Provide adequate information on CPR in lay terms and do check their understanding after the explanation.

6.6 Discussion – Decisions about CPR should be discussed in a positive context of supportive care. Most patients fear abandonment and pain more than death. It is essential to separate the DNR decision from decisions about other healthcare.

REFERENCES:

1. *NHS Wirral Provider Services 2010 British Medical Council*

2. *United Kingdom Ministry of Ethics & the Resuscitation Council (United Kingdom) 2010-2014*

3. *Goh LG, The Do-Not-Resuscitate Order, Singapore Med J 1995; Vol 36: 258-259*