Main messages

All establishments that face decisions about attempting cardiopulmonary resuscitation (CPR), including hospitals, general practices, care homes, hospices and ambulance services, should have a policy about CPR decisions. These policies must be readily available and understood by all relevant staff and should also be available to the public.[2,3,4]

The main messages below are not designed to be read in isolation from the rest of the document. Given the very serious nature of the decisions being made, readers are urged to take the time to consider the whole document. These 'messages' are intended as an aide-mémoire to highlight some of the main points arising from the guidance.

1. Considering explicitly, and whenever possible making specific anticipatory decisions about, whether or not to attempt CPR is an important part of good-quality care for any person who is approaching the end of life and/or is at risk of cardiorespiratory arrest.

2. If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussion about CPR with patients.

3. For many people, anticipatory decisions about CPR are best made in the wider context of advance care planning, before a crisis necessitates a hurried decision in an emergency setting.

4. Every decision about CPR must be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

5. Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.

6. Triggers for review should include any request from the patient or those close to them, any substantial change in the patient's clinical condition or prognosis and transfer of the patient to a different location (including transfer within a healthcare establishment).

7. For a person in whom CPR may be successful, when a decision about future CPR is being considered there must be a presumption in favour of involvement of the person in the decision-making process. If she or he lacks capacity those close to them must be involved in discussions to explore the person's wishes, feelings, beliefs and values in order to reach a 'best-interests' decision. It is important to ensure that they understand that (in the absence of an applicable power of attorney or court-appointed deputy or guardian) they are not the final decision-makers, but they have an important role in helping the healthcare team to make a decision that is in the patient's best interests.

8. If a patient with capacity refuses CPR, or a patient lacking capacity has a valid and applicable advance decision to refuse treatment (ADRT), specifically refusing CPR, this must be respected.

9. If the healthcare team is as certain as it can be that a person is dying as an inevitable result of underlying disease or a catastrophic health event, and CPR would not re-start the heart and breathing for a sustained period, CPR should not be attempted.

10. Even when CPR has no realistic prospect of success, there must be a presumption in favour of explaining the need and basis for a DNACPR decision to a patient, or to those close to a patient who lacks capacity. It is not necessary to obtain the consent of a patient or of those close to a patient to a decision not to attempt CPR that has no realistic prospect of success. The patient and those close to the patient do not have a right to demand treatment that is clinically inappropriate and healthcare professionals have no obligation to offer or deliver such treatment.

11. Where there is a clear clinical need for a DNACPR decision in a dying patient for whom CPR offers no realistic prospect of success, that decision should be made and explained to the patient and those close to the patient at the earliest practicable and appropriate opportunity.

12. Where a patient or those close to a patient disagree with a DNACPR decision a second opinion should be offered. Endorsement of a DNACPR decision by all members of a multidisciplinary team may avoid the need to offer a further opinion.

13. Effective communication is essential to ensure that decisions about CPR are made well and understood clearly by all those involved. There should be clear, accurate, honest and timely communication with the patient and (unless the patient has requested confidentiality) those close to the patient, including provision of information and checking their understanding of what has been explained to them. Agreeing broader goals of care with patients and those close to patients is an essential prerequisite to enabling each of them to understand decisions about CPR in context.

14. Unnecessary delay in offering discussions, explanations and information about CPR decisions can lead to misunderstanding and dissatisfaction. Delivering these communications in an inappropriate or insensitive way can also lead to dissatisfaction. A decision to delay or avoid communication of a decision to a patient must be based on that communication being likely to cause the patient physical or psychological harm. A decision to delay communication of a decision to those close to a patient without capacity must be based on that communication being either not practicable or not appropriate in the circumstances.

15. Any decision about CPR should be communicated clearly to all those involved in the patient's care.

16. It is essential that healthcare professionals, patients and those close to patients understand that a decision not to attempt CPR applies only to CPR and not to any other element of care or treatment. A DNACPR decision must not be allowed to compromise high-quality delivery of any other aspect of care.

17. A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded. Examples of such reversible causes include but are not restricted to – choking, a displaced tracheal tube or a blocked tracheostomy tube.

18. Decisions about CPR must be free from any discrimination, for example in respect of a disability. A best-interests decision about CPR is unique to each person and is to be guided by the quality of future life that the person themselves would regard as acceptable or, in the case of children taken into account the views of the child and parents.

19. Clear and full documentation of decisions about CPR, the reasons for them, and the discussions that informed those decisions, is an essential part of high-quality care. This often requires documentation in the health record of detail beyond the content of a specific CPR decision form. Where such discussions are not practicable or not appropriate, the reasons for this must be documented fully.

20. A CPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time.

21. Use of a CPR decision form that is used, recognised and accepted across geographical and organisational boundaries is a basic recommendation and may be paper-based or electronic, subject to local agreement.

22. Recorded decisions about CPR should accompany a patient when they move from one setting to another.

23. Records of decisions about CPR must be accurate and up-to-date. Systems (whether paper-based or electronic) for recording these decisions must be reliable and responsive, in particular, to any change in the decision about CPR.

24. Where no explicit decision about CPR has been considered and recorded in advance there should be an initial presumption in favour of CPR. However, in some circumstances where there is no recorded explicit decision (for example for a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful) a carefully considered decision not to start inappropriate CPR should be supported.

25. Failure to make timely and appropriate decisions about CPR will leave people at risk of receiving inappropriate or unwanted attempts at CPR as they die. The resulting indignity, with no prospect of benefit, is unacceptable, especially when many would not have wanted CPR had their needs and wishes been explored.

Decision-making framework