Decisions relating to cardiopulmonary resuscitation

Reviewer name	**Dr A D Dwarakanath FRCP Edin**				
Organisation	**Royal College of Physicians of Edinburgh**				
Title / Position	**Secretary**				
Email address	**l.lockhart@rcpe.ac.uk**				
Responding	(please select with X)	**as an individual**	**-**	**on behalf of organisation**	**X**

Document Please specify: **Section and page number**	**Type of comment** (please select with X)		**Comments** Please start a new row for each separate comment
	General	**Specific**	
Main messages p2	x		In general the document is well written and clearly laid out, but it would be helpful to have a section on what's new in the guidance. Although this revision is said not to include any "substantive changes", there are important new messages about the place of DNACPR decisions in end of life care plans, the recent controversy on whether to inform patients/relatives of DNACPR decisions on grounds of futility and, in later sections, extensive additional material on the use of DNACPR forms, electronic recording of decisions, and how to transfer information between care settings and professionals, including the ambulance service. The emphasis on recording reasons for decisions taken and communication made or not made is also new, and the emphasis on review of decisions is also important. There are new sections on switching off ICD's, the place of ICU treatments, the change in terminology for advance decisions in England, a section on patients with DNR tattoos, and an added section on confidentiality for children.
Introduction S1 p4	x	x	Little change in this section, and language appears a bit "softer", particularly in relation to the adverse effects of resuscitation eg "unavoidably physical and potentially traumatic" instead of "traumatic". The College agrees with this change, but it does add to the length, and similar changes elsewhere and the added sections (see later) means that, overall, the document is a long and sometimes tortuous read, with a degree of repetition. It may be impossible, but a shorter version would be easier to follow and more digestible for the busy clinician.
Advance care planning S2 p4-5	x		The emphasis on necessary training and experience is welcome, but frequently repeated through the document. Again, there are expanded paragraphs to try and cover all eventualities.
Presumption in favour of CPR S5 p5-6		x	This is one of the more concise and clear sections.

Protecting patients from futile interventions S6 p6		x	"The responsibility for making the decision rests with the most senior clinician currently responsible for the person's care, although they may delegate to another healthcare professional who is competent to carry this out". This pivotal section incorporates a number of assumptions and could lead to a very junior medical trainee being left with the responsibility. As the text says (elsewhere) many senior clinicians are unwilling/unable to make these and other end of life decisions themselves so may delegate. There is also an assumption that the 'most senior clinician' is in the position to assess another junior clinician's competence to carry out this decision making. In hospital practice the consultant responsible for the patient should be the person to make this decision in person. "Earlier discussions with people about their wishes…" - it should be emphasised that clinicians must sometimes make decisions on behalf of patients who will not survive CPR and that part of good practice is not to have a potentially upsetting, frightening discussion about a treatment which should never be initiated.
Organ support and CPR S6 p6		x	This also applies to patients receiving organ support in intensive care.
Clinical decisions not to attempt CPR S6 p6	x		The rewrite to exclude the Liverpool care pathway is understandable given recent events and media coverage and, in general, the advice in this section is very helpful.
Please continue comments on next page if required			

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Clinical decisions not to attempt CPR p6		x	Paragraph 2, 1st sentence "to be clinically successful" has been changed to "benefit the patient". This section is not about balancing benefits and harms, but about the situation when CPR will not work. The former language is preferable.
Communicating DNACPR decisions to patients(when it will not be successful) S 6.1 p7	x		This section is very important, and much of the added material is helpful. As noted above, this section should be highlighted to readers.

Sections 7-10 p8-14	x		The added material in these sections is helpful, and not too long!
Section 11 p15	x		The added paragraph on confidentiality is welcome.
Section 13 p15		x	Is largely repetitive of material elsewhere, but also was in 2007 guidance. Is it needed?
Section 14 Recording decisions p16-17	x		This section has been rewritten to reflect changes in practice. In Scotland a national DNACPR form has been in use since 2010. The problems of not copying forms, but the need to inform other agencies and make use of electronic technology are well rehearsed, but there is no easy solution. The suggested recording of information about the DNACPR decision (boxed text p17) is more comprehensive than current practice, and may be impracticable, in the level of detail suggested. In particular, the current form does not include a section for capacity assessment, space for details of discussion with relatives or patients, a section for reasons for not informing patient, or about patient information. Some of this information may be in the clinical record, but it is often difficult to find when reviewing DNACPR decisions, to clarify who was involved and why the decision was made. For the moment this may be seen as a gold standard to aspire to. It may be worth considering a separate document or training resource on "recording DNACPR Decisions" to improve clinical practice in this area.
Section 15 Communicating decisions to other providers.p18	x		This is largely new and incorporates text from the GMC guidance on communication and from the ambulance service. It is quite long, at the end of an already long document, and a short summary of the main points would be welcome. Also, DNAR should probably read DNACPR.
Section 16 Review p19	x		Again, this section is much enlarged and repeats themes (involvement of senior clinicians, individualised assessment, advance decisions, avoiding blanket policies, adequate staff training, and sensitive approach) which feature earlier in the document. Again, a shorter more focussed section would be more readable and therefore more memorable.
Decision tree		x	This is similar to 2007. The third step includes two parameters, lack of capacity, and advance directive. These should be separated out. In Scotland, the decision tree is based on the work of Regnard and Randall Clinical Medicine 2005, 5 354-60, and the flow of the diagram makes much more sense. The three questions posed are (1) Can a cardiac or respiratory arrest be anticipated? (similar to this tree). (2) Are you as certain as you can be that CPR would realistically have a successful outcome? If this question is answered 'yes' an advance decision is possible and the algorithm then considers the capacity of the patient (3) Are you as certain as you can be that CPR would not have a successful outcome? If 'yes', CPR is inappropriate. If 'no', seek advice. Full details can be found in the Scottish Policy.

Please list any other important statements / guidance from other bodies which you feel should be included in this joint statement	
Item (e.g. guidance, document, paper, etc.)	**Source of information** (e.g. website, journal, etc.)
RCPE commends the detailed comments from the DNACPR Leads group, many of whose members are our Fellows and Members	Response from the Scottish DNACPR Leads.

Thank you for your comments.