A Review of Documentation of Do Not Attempt Resuscitation Orders in a Specialist Palliative Care Inpatient Unit
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Background
Decision-making for do not attempt resuscitation (DNAR) orders is an important element of advance care planning for patients admitted to a specialist palliative care unit. Accurate documentation is necessary to communicate and deliver appropriate individualised care. Sensitive discussion is encouraged to ascertain patient’s preferences to aid decision making. Where the patient is unable to communicate and CPR is deemed inappropriate, it is good practice to inform those close to the patient of medical decisions. The absence of completed documentation or readily available information in emergency situations may necessitate “on the spot” decision by clinicians who are unfamiliar with patient details, with potential to lead to distress and inappropriate cardiopulmonary resuscitation.

Aims and Objectives of the Study
To assess completion of DNAR orders of the “Treatment Options Decision Documentation” proforma document by admitting doctors in the hospice setting.

Methods
Medical records for 56 patients were reviewed. Data was collected over 4 consecutive Fridays. Friday was the selected day as it was deemed that accurate documentation is crucial for on call staff covering the weekend period. Information was recorded using a formulated extraction tool.

Results
56 patients were included. 96% (n=54) had a documented decision for DNAR with 4% (n=2) without documented evidence. In 46% (n=26), documentation recording level of discussion of the medical DNAR decision with patients or families was absent. The document was not validated with signature of the doctor in 75% (n=42) and medical council registration number was absent in 86% (n=48). The treatment options decision sheet was revised to a double sided page to include reasons why medical decisions were not discussed with patients. A template to prompt signature and medical council registration number was included. Figures 1 and 2

Conclusion
Although completion of DNAR order with decision about CPR was 96%, in majority of cases the DNAR documentation did not meet required standard of recording doctors signature and MCRN and details of discussion with patients and/or their families was being routinely documented in the proforma. This information was used to revise our documentation in order to improve practice. The revised document is currently in use in our unit and a repeat review is underway to assess the effect of the implemented change.

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