RESUSCITATION DECISION AND CEILING OF TREATMENT

DO NOT ATTEMPT CPR
Now indicate ceiling of treatment

ICU / critical care
NIV/CPAP, all ward-based care
IV antibiotics / fluids
Oral antibiotics / SC fluids
Symptomatic care only
consider end of life care

Reason for decision:
Treatments above the indicated ceiling will not be successful:
OR
Treatments above the indicated ceiling are likely to result in a
poor quality of life:
Give further details:

Other instructions:

DISCUSSED WITH:
medical/nursing staff
patient
relatives
Summary of communication with patient and/or relatives/welfare attorney (continue on reverse):

If not discussed with the patient, document reason:
Patient lacks capacity (discuss with relatives if appropriate)
Other:

DOCTOR COMPLETING FORM (must be above F1/F2):
Signature: Name: Grade: Date:

ENDORSEMENT BY SENIOR HEALTHCARE PROFESSIONAL:
Signature: Name: Grade: Date:

REVIEWS DATE:
Signature: Name: Grade: Date:
Signature: Name: Grade: Date:

This form does not replace clinical judgement. Review decision if the clinical situation changes.
• This form incorporates CPR and ceiling of treatment decisions. No separate DNAR form is needed.

• If the patient is for full escalation, tick this box to document this decision. If the patient is not for attempted cardiopulmonary resuscitation, tick this box then proceed to ceiling of treatment decision.

• Indicate the ceiling of treatment by drawing a line across the form and crossing through treatments above this line – all treatments below this line will be undertaken if needed, all treatments above this line are deemed inappropriate and will not be offered. Document the reasons for the decision and add further details and other instructions if needed.

Example:

Example:

↑ Treatments above this line are inappropriate and will not be considered

↓ Treatments below this line will be instituted if clinically indicated

• Document a summary of communication with the patient and/or relatives or welfare attorney. If the decision was not discussed with the patient document why this was inappropriate. Use the space below for further documentation.

• The ceiling of treatment decision should be reviewed and endorsed by the most senior healthcare professional at the earliest opportunity.

• Review the ceiling of treatment decision if the clinical situation changes. If the ceiling of treatment remains at the same level, sign the review box. If the ceiling of treatment changes, cancel the form by crossing through and writing ‘cancelled’ with a signature and date. Then complete a new form.

• Specify a review date on the form if required.

• The form must be signed, dated, legible and filed at the front of the patient’s notes.

Further summary of discussion with patient and/or relatives/welfare attorney: