Do Not Attempt Cardiopulmonary Resuscitation Forms - Who'd have one?

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Wednesday 5 November 2025

Cardiopulmonary resuscitation (CPR) was first described in 1960, when Kouwenhoven and colleagues described a novel technique of 'closed chest cardiac massage'. CPR is an emergency medical intervention undertaken in an attempt to restore breathing and circulation following a respiratory or cardio-respiratory arrest. The intervention includes the administration of external chest compressions, artificial ventilation, and consecutive electric shocks applied to the bare chest (known as defibrillation), as well as rapid administration of medicines intravenously or intra-osseously (into the bone). But there are clear differences in who will and will not respond to these ferocious interventions in cardiac arrest situations. Recognising situations when future attempts at cardiopulmonary resuscitation (CPR) will or will not be successful, is an important role for healthcare professionals.

But patients should also be given an opportunity to have a say about future treatments, and hear from their clinicians when certain future interventions may be unsuccessful. The added complexity with CPR, is that prior discussion, sometimes even years before such an event may be required, is preferential, because it is not possible to ask a patient to consent or refuse when this emergency procedure is about to start - every second counts. Patients deserve the opportunity to have an open discussion about what matters most to them when nearing the end of life.

Clinicians have a duty to consult with their patients, if and when they feel future CPR will not be successful and a written decision needs to be documented. Exceptions to this can be if they feel such a conversation may lead to harm.[1] Triggers for Do Not

Attempt Cardiopulmonary Resuscitation (DNACPR) conversations and forms are when a clinician or clinical team feel that a naturally anticipated and accepted death is likely to occur in the next 6-12 months.[2]

There has been much disinformation about DNACPR forms, including in the popular press. Patients or their families, for instance, do not sign their own forms, this is done by a clinician. Disinformation spread during the pandemic led to fear about “DNR” forms, but misuse of forms by clinicians was also a problem: some did not consult with patient or their families when a form was filled in and added to a person’s notes.[3]

But when patients hear about the realities and low success-rates of CPR for people with significant progressive and severe health conditions, they often view it differently, as an isolated procedure; opting out of future CPR needn’t preclude them from other health interventions. In a large meta-analysis, only 1.8% of patients with metastatic cancer survived to discharge after receiving CPR.[4] CPR is not indicated in ordinary dying, where the body slows down over several hours or even days, and an agonal rhythm or asystole is not amenable to electric shocks. Futility of CPR has been extensively looked at and guidelines are in place,[5] but clinicians, sometimes fearful of litigation, have administered CPR. Complications such as rib fractures, internal bleeding and hypoxic brain damage, can be factors why patients, loved-ones and clinicians feel that this is one potential intervention too many. Frank yet sensitive conversations are important to involve patients in any decision making around future CPR. When CPR is deemed inappropriate, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form should be completed to document this decision and to communicate it to others. Patients have a right to be consulted and informed of this decision, and this is sometimes referred to as the duty to consult. [6] Instances when a DNACPR decision is not explicitly discussed require even more careful communication, including when a patient has specifically asked for this challenging topic not to be brought up, or when clinicians and significant others feel that a discussion would lead to harm.

In the United Kingdom, a DNACPR form is a document issued and signed by doctors, nurses, or allied healthcare practitioners, and counter-signed by a senior responsible clinician. The form communicates to healthcare providers which decisions and discussions have been held, and with whom, with regard to not attempting cardiopulmonary resuscitation (CPR) in future. The form is designed to be easily recognisable, allowing anyone who is new to the care setting and the patient, to quickly get relevant information and shift their focus to other important care measures, including ensuring pain is controlled, comfort measures are in place and dignity is maintained. This is particularly important if the patient is in the last stages of life, when CPR is not going to be successful: a newly arriving out of hours practitioner may not be aware of how advanced the person's illness is. In these situations, forms such as Advance Decisions to Refuse Treatment (ADRT), or DNACPR decisions are an important part of documentation and communication between healthcare providers, patients and their significant others. They can protect patients and those close to them from having to undergo forceful manual chest compressions, electric shocks to the bare chest, insertion of tubes into airways and other interventions.

Once a DNACPR decision is made, all professionals involved in the person's care should be informed, to avoid inappropriate CPR. Where patients have expressed that they do not wish to further discuss this topic, a repetition of this potentially emotionally challenging conversation should be avoided, and widely available forms should help with this. In 2015, the All Wales DNACPR policy was introduced to ensure a consistent approach to the initiation, discussion, documentation and communication of decisions for patients across Wales. The policy also set out standards to ensure that the forms are completed fully and correctly, and this should be assessed regularly in the form of local audits every 2 years. Health Inspectorate Wales ensures that these audits are carried out. Other forms, some of which can be filled out by patient's who want to make their wishes clear in advance, can also incorporate CPR decisions, such as the All Wales Advance Decision to Refuse Treatment (ADRT) form and guidance notes. These forms can be found here www.wales.nhs.uk/afcp

Whilst DNACPR forms are guidance-only, an ADRT form, by contrast, is legally binding. Information resources such as the NHS Wales www.talkCPR.com videos [7] to explain what CPR and DNACPR mean, and why these topics are important, have helped many patients, families, as well as health and social care professionals understand what is at stake: better conversations about how we envisage the end of our lives, can help inform this challenging area. In the Welsh Future Care Planning approach [8] [9], the goal is for any DNACPR conversations to take place in a much wider context, with better information and a policy that is openly accessible to everyone.

So who'd have a DNACPR form? Many people hold such forms, including those who are receiving treatments such as immunotherapy or other medical interventions. But they are clear that should they suddenly collapse and die, or have a slow deterioration towards natural dying, they would forgo having CPR attempts on their body to try against all odds to bring them back into life.

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