RUH

Royal United Hospital Bath NHS
NHS Trust

RESUSCITATION DECISION AND CEILING OF TREATMENT

FULL ESCALATION, INCLUDING CPR ☐

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

Does the patient have capacity? YES / NO

If no, is there an advanced decision? YES / NO

Is there a welfare attorney? YES / NO

Name:

Hospital No:

Date of Birth:

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:

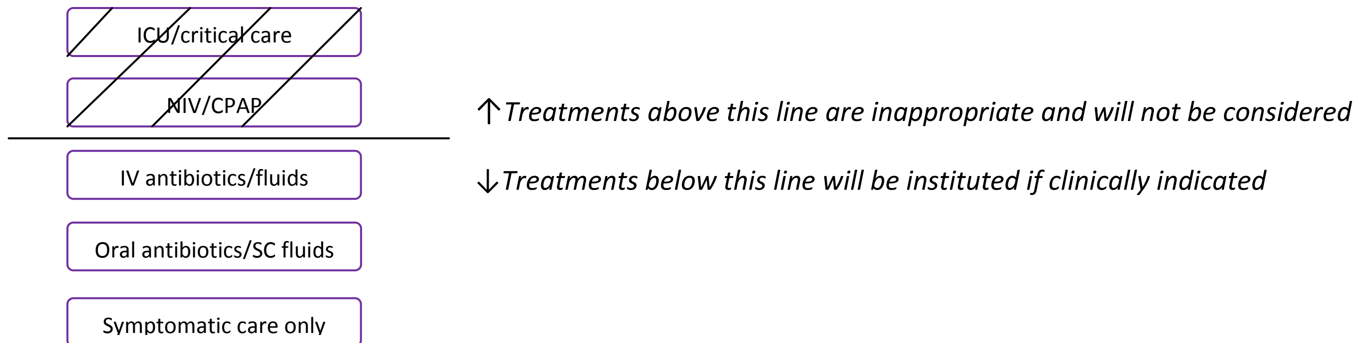
ENDORSEMENT BY SENIOR HEALTHCARE PROFESSIONAL:
Signature: Name: Grade: Date:

REVIEW 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:



- 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:

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CEILING OF TREATMENT

Name:

Hospital No:

Date of Birth:

Does the patient have capacity? YES / NO

If no, is there an advanced decision? YES / NO

Is there a welfare attorney? YES / NO

IF CEILING OF TREATMENT **EXCLUDES** CPR/DEFIBRILLATION COMPLETE **DNAR** FORM

Please circle or indicate ceiling of treatment below.

Comments

CPR

Defibrillation

ICU
For monitoring/vasopressors/renal replacement therapy/intubation

NIV/CPAP
Consider CCU/respiratory high care

IV antibiotics

IV fluids

Oral antibiotics

SC fluids

Comfort care

Care of the dying pathway

Reasons for decision:

Discussed with: medical/nursing staff patient relatives

MUST BE SIGNED BY REGISTRAR OR CONSULTANT

Signature: Name: Grade: Date: Time: