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HA Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)

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**Adopted from the Best Practice Guidelines on Advance Medical Directives, Hong Kong Academy of Medicine 2025.*

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Abbreviations

ACP	Advance Care Planning
AED	Automatic External Defibrillator
AMD	Advance Medical Directives
ANH	Artificial Nutrition and Hydration
BPG	Best Practice Guidelines
CMS	Clinical Management System
CPR	Cardiopulmonary Resuscitation
DNACPR	Do-Not-Attempt Cardiopulmonary Resuscitation
EOL	End-of-Life
eHRSS	Electronic Health Record Sharing System
HA	Hospital Authority
HKAM	Hong Kong Academy of Medicine
LST	Life-Sustaining Treatment
MCHK	Medical Council of Hong Kong
MHO	Mental Health Ordinance
Ordinance	Advance Decision on Life-Sustaining Treatment Ordinance
PVS	Persistent Vegetative State
RMP	Registered Medical Practitioner

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1. Introduction

- 1.1 Cardiopulmonary resuscitation (**CPR**) may represent the opportunity for life when cardiac arrest occurs. However, in a patient with an advanced irreversible illness, CPR may be futile or non-beneficial and against the patient's wish. Whether CPR should be withheld in such cases involves complex ethical considerations and these patients should have their decision of not having CPR made in advance when cardiac arrest is anticipated.
- 1.2 This set of guidelines identifies the key ethical and legal issues in Do-Not-Attempt Cardiopulmonary Resuscitation (**DNACPR**) decisions, taking reference from Section 34 on Care for the terminally ill in the Code of Professional Conduct of the Medical Council of Hong Kong (**MCHK**) [1].
- 1.3 The Advance Decision on Life-Sustaining Treatment Ordinance 《維持生命治療的預作決定條例》(hereafter referred to as **Ordinance**) was enacted by Legislative Council on 20 November 2024, which will come into effect after 18 months. The Ordinance makes provision for making, revocation and operation of DNACPR orders on a continuing basis and has provided statutory or prescribed DNACPR forms for mandatory use. The DNACPR orders with continuing effect include 2 categories, firstly, the AMD-based DNACPR order for a mentally capable adult who make an Advance Medical Directive (**AMD**) for refusal of CPR and secondly, the non-AMD-based DNACPR orders for mentally incapable adults and minors who are unable to make AMD. The Ordinance does not cover hospitalised DNACPR orders on an episodic basis.
- 1.4 For the purpose of co-signing the DNACPR order for mentally incapable adults and minors, the Ordinance has defined the terms “responsible persons” and “eligible persons” (refer to section 6.2 and 6.3). When the responsible persons are not available, an eligible person may serve the purpose. For adults, the responsible persons include the immediate family members, the cohabitants and the legal guardian; for the minors, the responsible persons include the parents and the legal guardian while the requirements for eligible persons are the same for adults and minors. When respecting the autonomy of the mentally capable adult patient, it is always a good practice to build up a consensus with the patient and the responsible or eligible persons for decisions concerning LST towards the end of life. In most situations, the immediate family members or the parents would be engaged as long as they are available.
- 1.5 The Hong Kong Academy of Medicine (**HKAM**) has released the Best Practice Guidelines (**BPG**) on Advance Medical Directives [2] in April 2025. Based on the BPG, the Hospital Authority (**HA**) has updated the last version of “HA Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)” to keep the staff abreast of the changes and implications on HA.

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2. **Objectives of the Guidelines**

- 2.1 To uphold the commitment of HA in providing quality patient care appropriate to treatment goals along the disease trajectory, and to safeguard the rights of patients in refusal of CPR in anticipation of end of life (**EOL**);
- 2.2 To provide the evidence base in the clinical assessment of the chances of success and overall benefits of CPR;
- 2.3 To provide the legal and ethical framework in making DNACPR orders; and to ensure that making, revocation and operation of DNACPR orders on a continuing basis are in accordance with the Ordinance;
- 2.4 To standardise the forms for hospitalised DNACPR order in HA, while replacing the DNACPR for non-hospitalised patients with the prescribed DNACPR order form with continuing effect as provided by the Ordinance;
- 2.5 To provide guidance to the consensus building approach in communication with the patient and his/her responsible or eligible persons during the decision-making process.

3. **Scope of the Guidelines**

- 3.1 The Guidelines cover the following DNACPR orders:
 - 3.1.1 For inpatient episode, which is meant to be invalidated upon discharge of the patient.
 - 3.1.2 DNACPR orders with continuing effect, which is regulated by the Ordinance.
- 3.2 Scope of patients for consideration of DNACPR
 - 3.2.1 The prescribed DNACPR form with continuing effect is used for patients with three specific preconditions including:
 - (a) Terminally ill: A person is terminally ill if he/she is suffering from
 - advanced, progressive, and irreversible disease; and
 - having a short life expectancy in terms of days, weeks or a few months; and
 - only with death postponed by applying LST, e.g. advanced cancer.
 - (b) Persistent vegetative state (**PVS**) or irreversible coma
 - A person is in PVS if he/she suffers from severe brain damage resulting in a persistent state of unawareness of self and his/her surroundings with the inability to give purposeful response to his/her surroundings (excluding reflexive behaviour*) and yet maintaining a state of wakefulness with sleep-wake cycles, provided that there is no hope of regaining awareness of self and surroundings.

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- A person is in irreversible coma if he/she suffers from severe brain damage resulting in a persistent state of unawareness of self and his/her surroundings with inability to give purposeful response to his/her surroundings (excluding reflexive behaviour*) provided that there is no wakefulness with sleep-wake cycles and there is no hope of regaining wakefulness and awareness of self and surroundings.
**Examples include spontaneous movement with no discernible reasons, reflexive movements such as brainstem reflexes, and generalised arousal response.*

(c) Other end-stage irreversible life limiting conditions

- This condition does not fall under (a) or (b) but is progressive and irreversible, has reached the end-stage of the condition and limits the survival of the patient.
- For example, patients with end-stage renal failure, motor neuron disease or chronic obstructive pulmonary disease who are not terminally ill (because the patient's survival may be prolonged by dialysis or assisted ventilation), irreversible loss of major cerebral function and extremely poor functional status but not falling into (b), e.g. severe stroke or advanced dementia.

3.2.2 However, consideration of DNACPR may not be limited to the above scope, but may also include patients with other clinical situations where cardiac arrest is anticipated [3]. e.g.

- Patients with multiple comorbidities and frailty who are expected to die within 12 months.
- Patients who are at risks of dying from sudden crisis or life-threatening acute conditions caused by sudden catastrophic events; whose death is imminent (expected within a few hours or days).
- Extremely premature neonates whose prospects for survival are known to be very poor, and to patients who are diagnosed as being in a Persistent Vegetative State (**PVS**), for whom a decision to withdraw treatment may lead to their death.

3.3 The HA Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) should be read by all treatment providers in the HA setting (registered medical practitioners including doctors under limited or special registration, interns, registered dentists, registered nurses and enrolled nurses) and allied health.

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3.4 The guidelines should be read together with the other HA Guidelines on decision making for patients facing life limiting illness or EOL which have been revised simultaneously:

3.4.1 HA Guidelines on Advance Medical Directives for Refusal of Life-Sustaining Treatment 2025 [4];

3.4.2 HA Guidelines on Life-sustaining Treatment towards End of life 2025 for ethical considerations including assessment of patient's best interests [5];

3.4.3 HA Guidelines on Advance Care Planning 2025 [6] for the communication process with patients and their families before making AMD and DNACPR.

4. **About CPR**

4.1 **What is CPR?**

Cardiopulmonary resuscitation (**CPR**) is a relatively invasive medical therapy to support ventilation and circulation when cardiac arrest occurs. CPR buys time for the vital organs to be supported, and for the cardiac function to be restored if possible. At the most basic level, a bystander CPR refers to hands-only CPR with chest compression and may be use of Automatic External Defibrillator (**AED**) when available. In a more equipped setting, the following treatments may variably be included: attempted defibrillation with electric shocks, injection of drugs and artificial ventilation of the lungs [7].

4.2 **CPR outcome**

4.2.1 CPR may represent the opportunity for life when cardiac arrest occurs. CPR may restore life and health for some survivors but for most CPR recipients the chance for survival to discharge and for full functional recovery is small.

4.2.2 CPR outcome is usually expressed in terms of:

- (a) Immediate survival (referring to a successful CPR with post-CPR survival lasting for an hour or more);
- (b) Survival to hospital discharge; and
- (c) The degree of neurological impairment in long-term survivors.

4.2.3 Many factors would impact the CPR outcome (Table 1). Patients with older age, active malignancy, comorbidities, or frailty are reported to have poorer survival [8,9]. An initial shockable rhythm was associated with increased odds of survival [8]. Survival after out-of-hospital CPR is lower than that after in-patient CPR [10,11].

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Table 1: Outcome of CPR

	Immediate survival (%)	Survival to discharge (%)
In-hospital CPR	42.7-52.1%	13.7-22.3%
Out-of-hospital CPR	29.7%	8.8%
	CPR outcome: Odds of survival	
Active malignancy	0.57	
Congested heart failure	0.62	
Chronic kidney disease	0.56	
Chronic obstructive pulmonary disease	0.65	
Age > 70	0.42	
Initial shockable rhythm	5.28	
	CPR outcome: Odds of dying in-hospital	
Frailty	2.93	

4.3 Sequelae after having immediately survived CPR

4.3.1 Cardiopulmonary instability following CPR

The discrepancy between immediate survival and survival to discharge reflects the complexity of the medical condition. At post-CPR, many of these patients are in shock and respiratory insufficiency requiring prolonged cardiac support and mechanical ventilation, the outcome of which could still be fatal.

4.3.2 Post cardiac arrest brain injury [12,13]

Neurologic sequelae arising from cardiac arrest are also a key limiting factor in sustaining survival to discharge. Irreversible anoxic brain damage will ensue after a prolonged period of cerebral anoxia. Further brain injury can arise from unstable vascular tone, cerebral edema, calcium fluxes, etc. At post-CPR, serious neurologic damage can be manifested at the bedside by difficult-to-control convulsive activities and generalised myoclonus, and by the findings of persistent coma or brainstem dysfunction. Longer term neurologic impairment has been reported in CPR survivors in an overseas study in 6 months after discharge, including severe disability in 19% and unresponsive wakefulness state in 47% [14].

4.3.3 Other CPR-related bodily injuries [15]

In a systematic review on the prevalence of CPR-related bodily injuries, the pooled prevalence of rib fractures is 55.2%, and that of sternal fracture is 23.6%. Other reported injuries include pulmonary contusion in 20.2%, haemothorax in 10.1 %, cardiac contusion in 6.4%, pericardial/ epicardial injury in 5.7% and liver injury in 3.2%.

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4.4 Consideration of CPR

4.4.1 Emergency situation

As CPR is potentially life-saving, there is presumed consent for CPR in emergency situation.

4.4.2 In the presence of a valid and applicable AMD for refusal of CPR or a valid and applicable DNACPR order with continuing effect, the doctor should respect the DNACPR order. However, if there is doubt about the validity and applicability of the AMD / DNACPR, the doctor should proceed to perform CPR as indicated till there is proof. When time allows for further consideration, treatment decisions on CPR should be based on benefits-versus-burdens assessment, which is not solely a clinical decision. The following factors may be considered:

- The likely clinical outcome, including the likelihood of successfully re-starting the patient's heart and breathing for a sustained period, and the level of recovery that can realistically be expected after successful CPR;
- The patient's known or ascertainable wishes, including information about previously expressed views, beliefs and values;
- The patient's human rights, including the right to live and the right to be free from degrading treatment;
- The likelihood of the patient experiencing severe unmanageable pain or suffering. The level of awareness the patient has of his/her existence and surroundings.

4.4.3 When a patient is in the final stage of an incurable illness and death is expected within a few days, CPR is very unlikely to be clinically successful. Burden considerations may show that CPR may prolong or increase suffering and subject the patient to traumatic and undignified death. The patient and the responsible or eligible persons may hence choose natural death without CPR.

5. What is DNACPR?

5.1 DNACPR refers to withholding CPR in case when a person is in cardiac arrest. Whether other life-sustaining treatments (LSTs) are to be implemented should be individually considered, and may be specified [5].

5.2 In this set of Guidelines, the DNACPR orders consist of the following:

5.2.1 DNACPR order with continuing effect, consisting of:

- AMD-based DNACPR for a mentally capable adult with an AMD to refuse CPR.
- Non-AMD-based DNACPR order for mentally incapable adults and minors.

5.2.2 Inpatient or hospitalised DNACPR, to be invalidated upon discharge of the patient.

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6. Ethical and Legal considerations in Decision Making of DNACPR order with continuing effect

6.1 For all DNACPR decisions, good communication and consensus building is essential before decision making to minimise conflicts in the future. In all situations below, the prescribed DNACPR order forms provided by the Ordinance must be used for recognition by all parties, including the ambulance crew. All these DNACPR orders have to be signed by 2 RMPs, of whom one is a specialist. **For mentally capable adults**, we shall respect the **autonomy of the patient**. As CPR is a LST, a mentally capable adult has the right to refuse CPR in advance. A mentally capable adult may choose to sign an AMD for refusal of CPR under certain precondition after the Advance Care Planning (ACP), and the AMD is a legally binding document that no one can revoke except by the patient himself or herself when mentally capable. The RMP, if confirming that the patient has fulfilled the precondition, shall proceed to sign the prescribed AMD-based DNACPR for the patient with another RMP.

Sometimes, the decision to refuse CPR may seem unwise, but if the patient has understanding of the nature and implication of the DNACPR refusal and sign an AMD, it has to be respected.

6.2 **For mentally incapable adults**, the doctor has to assess whether CPR is in **patient's best interests**. There is no universal definition of the patient's best interest. If no prior wish is known, the RMP should determine the best interests of the patient, based on what he/she considers the patient would reasonably wish to the best knowledge of the RMP and having taken into account of all the relevant factors. It involves an evaluation of a basket of factors relevant to the patient including [2]:

- 6.2.1 clinical needs, which include the balance of risks and benefits of various treatment options and prognosis;
- 6.2.2 social and functional needs;
- 6.2.3 cultural and religious belief, wishes, life values and perceived quality of life;
- 6.2.4 previous preferences for medical treatment; and
- 6.2.5 any other factors the patient would consider if he/she were able to do so as the above list is not exhaustive.

The source of information may include past medical records, including the ACP form, the immediate family members, or other responsible and eligible persons. Upon reaching consensus, the RMP shall sign the prescribed non-AMD-based DNACPR for mentally incapable adults if the patient meets the precondition of the prescribed form, and with the responsible or eligible person as cosigner, indicating his/her agreement with the doctor's assessment. For mentally incapable adult patients, the responsible person may be one of the following:

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- (a) An immediate family member of the patient, including:
 - spouse;
 - parent (whether natural parent, adoptive parent or step-parent);
 - grandparent (whether natural, adoptive or step-grandparent);
 - sibling (whether sibling of full or half blood, by virtue of adoption or step-sibling);
 - child (whether natural child, adoptive child or step-child); or
 - grandchild (whether natural, adoptive or step-grandchild).
- (b) A cohabitee.
- (c) A guardian of the patient within the meaning of Part IIIA or Part IVB of the Mental Health Ordinance (Cap. 136) (**MHO**); but does not include the Director of Social Welfare or any Assistant Director of Social Welfare.

If no responsible person can be secured to act, the doctor may consider an eligible person as reasonably determined by the RMP as being in a good position to form a view as to whether performing CPR on the patient during cardiac arrest would be in his/her best interests. The factors to be considered by the RMP include the relationship between the person and the patient, their frequency of contact, the level of perceived closeness between them, the degree of perceived importance of the person to the patient, and his/her willingness to sign.

There may be situations where locating/ securing a responsible or eligible person to co-sign the non-AMD-based DNACPR order is impracticable or not successful despite reasonable efforts. In that case, the 2 RMPs, one of whom must be a specialist, may still sign the non-AMD-based DNACPR order in the absence of such co-signer. This option is not available if the patient is a minor. Reasonable efforts to locate a responsible or eligible person may include the following: checking the guardianship status with the Guardianship Board, reviewing past medical records and verifying contact with the medical social worker system.

- 6.3 **For minors**, the doctor also has to assess whether CPR is in patient's best interests, and to discuss with the responsible person as defined below or an eligible person as described above. The responsible persons of a minor may be one of the following:

- 6.3.1 A parent (whether natural parent, adoptive parent or step-parent); or
- 6.3.2 A guardian of the patient under the Guardianship of Minors Ordinance (Cap. 13); but does not include the Director of Social Welfare or any Assistant Director of Social Welfare.

A minor may be involved in ACP and DNACPR discussion if the minor is of enough maturity. The mentally maturity refers to the emotional and cognitive maturity of the minor in managing his/her own emotions, in making decisions logically instead of impulsively and in taking responsibility of own words and actions. If there is consensus

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that CPR is not in the minor's best interests, the RMP shall sign the prescribed non-AMD-based DNACPR order for minors if the patient meets the precondition of the prescribed form, and with the responsible or eligible person as cosigner, indicating his/her agreement with the doctor's assessment.

Parents cannot require doctors to provide treatment contrary to their professional judgment, but doctors should try to accommodate parents' wishes where there is genuine uncertainty about the minor's best interests. The local hospital/cluster clinical ethics committee may be consulted if necessary.

- 6.4 **A doctor is not obliged to provide futile or non-beneficial treatment, including CPR. A treatment is being considered futile or non-beneficial when (a) the treatment is of no benefit (b) it cannot achieve its purpose or (c) not in patient's best interest [16].**

Table 2: DNACPR order with continuing effect: Ethical and legal considerations

	AMD-based DNACPR	Non-AMD-based DNACPR	
Patient	Mentally capable adult	Mentally incapable adult	Minor
Mandatory form	Prescribed AMD-based DNACPR order to be signed by 2 RMPs, one must be specialist No need for patient's signature or cosigner	Prescribed non-AMD-based DNACPR order for mentally incapable adult to be signed by 2 RMPs, one must be specialist Needs a responsible or eligible person as cosigner When a responsible or eligible person cannot be secured to act despite reasonable efforts, 2 RMPs, one must be specialist can sign the form (refer to section 6.2)	Prescribed non-AMD-based DNACPR order for minor to be signed by 2 RMPs, one must be specialist Needs a responsible or eligible person as cosigner (refer to Section 6.3) The option of signing the DNACPR by 2 RMPs only is not available for minors.
Legal status	Only paper copy recognised, no electronic storage Valid on continuing basis, has to be reviewed in <12months For minors, only valid till age 18		
Ethical principle for decision making	Respect patient's autonomy to refuse CPR, even when DNACPR may not be in patient's best interests	RMP considers that CPR is not in patient's best interests (refers to Section 6.2)	
Communication before making DNACPR order	ACP with patient and to involve family members or significant others for - consensus building and - supporting patient's decision	ACP with responsible or eligible person, with/without mature minor for - consensus building - agreement with the RMP's assessment - cosigning the non-AMD-based DNACPR order	

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7. **The DNACPR order forms with continuing effect: revision and transition of HA forms**

7.1 **The prescribed DNACPR order forms with continuing effect** covers the same three categories of specific preconditions as in the model AMD forms. They are:

7.1.1 Terminally ill

7.1.2 Persistent vegetative state (**PVS**) or irreversible coma

7.1.3 Other end-stage irreversible life limiting conditions (refer to Section 3.2.1 for definitions)

7.2 **The Revision of existing HA DNACPR forms (Table 3)**

The HA DNACPR for non-hospitalised patients (HA9614/MR) will be replaced by the forms in a format as prescribed by the Ordinance. The prescribed DNACPR order forms for 3 categories of preconditions including:

7.2.1 AMD-based DNACPR form for adult patients with an AMD for refusal of CPR;

7.2.2 Non-AMD-based DNACPR form for mentally incapable adult patients;

7.2.3 Non-AMD-based DNACPR form for minors;

7.2.4 DNACPR continuation form for further extension of 7.2.1 or 7.2.2 and 7.2.3 respectively.

Table 3: Revision of existing HA AMD and DNACPR forms

The prescribed DNACPR order with continuing effect for mentally capable adults, mentally incapable adults and minors are separated and not in a combined form as in HA9614/MR. The concept of AMD-based and non-AMD-based DNACPR is introduced to differentiate DNACPR as a free choice of mentally capable adult (AMD-based) and the DNACPR made based on patient's best interests for mentally incapable adults and for minors (non-AMD-based).

Forms	Existing HA forms	New revised forms according to the Ordinance
AMD	HA short AD form (HA9612/MR) for refusal of CPR in terminal illness	HA short AMD form (HA9632/MR) for refusal of CPR in 3 preconditions
	HA AD long form (HA 9610/MR) for refusal of LST in 3 preconditions	HA full AMD form (HA9630/MR) for 3 preconditions with the following instructions: (a) Refusal of CPR only (b) Refusal of LST (specify) (c) Refusal of all LST except Artificial Nutrition and Hydration (ANH) (d) Refusal of all LSTs
DNACPR	HA DNACPR for non-hospitalised patients (HA9614/MR) (with mentally capable adult, mentally incapable adult and minor in the same form)	Separate prescribed DNACPR orders with continuing effect for 3 preconditions: (a) AMD-based DNACPR (b) Non-AMD-based DNACPR for mentally incapable (c) Non-AMD-based DNACPR for minors (d) Continuation form for extension of any of the above

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7.3 Transition of the HA AMD and DNACPR forms to revised forms (Table 4)

- 7.3.1 There is an interval of 18 months before the Ordinance comes into effect. Transition of forms should take place within this preparatory period.
- 7.3.2 For new patients put on DNACPR order with continuing effect, the prescribed DNACPR forms should be used, but they would only be recognised by the ambulance crew after the Ordinance is in effect. This is to allow a progressive transition for vast majority of patients.
- 7.3.3 For patients who are still holding the non-hospitalised DNACPR (HR9614/MR) forms when the Ordinance becomes effective, the doctor has to change to the prescribed HA DNACPR form to ensure for continuity of effect.

Table 4: Transition of HA AMD and DNACPR forms

Forms	18 months of working window	When the ADLST Ordinance comes into effect
Existing HA AD	Remain valid, no need to change unless making new AMD	
New revised HA AMD	Start to use for patients making new AMDs	
Existing HA non-hospitalised DNACPR	• Can continue to use, fading out as patients pass away. • Not recognised by FSD but recognised by HA • Early arrangement for changing to new DNACPR is recommended	• Already converted to new DNACPR forms for patients who are still alive. • Recognised by FSD and all treatment providers
New prescribed DNACPR order with continuing effect	• Start to use it for new patients. • Not recognised by FSD but recognised by HA.	• Mandatory use for all patients. • Recognised by FSD and all treatment providers.

7.4 Updating of HA CMS and eHRSS

- 7.4.1 The HA Clinical Management System (CMS) is also updated to provide the following options for flagging by the RMP:
- Short AMD for refusal of CPR;
 - Full AMD for refusal of CPR and other LST;
 - Full AMD for refusal of other LST;
 - DNACPR order with continuing effect.
- 7.4.2 Corresponding alert for AMD is also synchronised in the Electronic Health Record Sharing System (eHRSS).
- 7.4.3 **There is no electronic storage or making for DNACPR orders with continuing effect.**

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8. **Communication on DNACPR Order with continuing effect**

8.1 Advance Care Planning and consensus building

Advance care planning (ACP) is an overarching process of communication among healthcare workers, patients and their responsible or eligible persons in deciding on the type of personal and medical care at the EOL care when patient is no longer mentally capable. For mentally incapable adults and minors, the Ordinance has defined the responsible or eligible persons to be the cosigner of the non-AMD-based DNACPR order.

For discussion of DNACPR, in most situations, it should be a consensus building process with the patient/responsible/ eligible person.

8.2 **Communication Tips**

8.2.1 Realise that communication of CPR for EOL care could be distressing for all parties.

8.2.2 Adopt an open sincere and empathetic attitude.

8.2.3 For mentally capable adult patients, presence of a supporting person is helpful. For mentally incapable adult patients or minors, responsible or eligible persons should be involved when contemplating DNACPR decisions. Any first step to establish rapport with the patient and/or responsible or eligible persons ahead of a DNACPR discussion would highly facilitate mutual understanding and consensus building during the subsequent DNACPR discussions.

8.2.4 In most situations, discussion of DNACPR should be a consensus building process with the patient/responsible or eligible person.

8.2.5 Be sensitive to emotions experienced by the participants of the DNACPR discussion.

8.2.6 Elicit with sensitivity and listen with empathy to patient's values, religious and cultural belief, preferred goal of treatment, and preferred limits on medical treatment. Should the responsible or eligible persons express difference in opinion, be ready to handle the conflicts and highlighting the importance of respecting patient's autonomy.

8.2.7 In providing information for decision making including risks and benefits of CPR, chance of success, diagnosis, extent of disease and prognosis. Use easy-to-understand terms during communication, realizing that there is often a significant knowledge and expectation gap between the healthcare team's understanding of the likelihood of success and the burdens of CPR and the expectation of the patient and/or the responsible or eligible persons.

8.2.8 The discussion may take several sessions. Allowance should be given if the patient or family members show reluctance to continue or request more time for consideration. While a DNACPR decision can be perceived by the patient and/or responsible or eligible person as a "life-versus-death" decision, the healthcare team

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should firmly clarify the concept of a DNACPR decision as a decision to allow natural death to occur without subjecting the patient to the burdens of CPR.

8.2.9 Reassurance should be given that there is no abandonment of patient and each medical treatment would be given individual consideration. Patient should not be deprived of other treatment based on the refusal of CPR.

8.2.10 DNACPR discussions should preferably be led or supervised, whenever practicable, by the clinician supervising the healthcare team to enable a most effective, knowledge-based decision-making process. It is appropriate and wise to invite other members of the healthcare team, often the nurse, to be present during the discussion, who can serve as a witness of the process, facilitate the communication and provide emotional support.

8.2.11 Any significant discussion should be documented in the medical record, recording the salient points of the discussion that has taken place with the patient or the responsible/ eligible person(s) and the relationship to the patient.

8.2.12 Normally, before consensus is reached with a mentally capable adult or with the responsible or eligible persons of a mentally incapable adult or a minor, a DNACPR order should not be made in advance (Refer to Q&A Q3).

8.3 **Active clarification of myths and misunderstandings including:**

8.3.1 The confusion of active treatment with CPR;

8.3.2 The worry about abandonment in case of DNACPR;

8.3.3 Information about the nature of possible CPR interventions, the length of survival and level of recovery that one might unrealistically expect if the patient were successfully resuscitated;

8.3.4 The responsible or eligible person has mixed up his/her own wishes or views with that of the patient's;

8.3.5 The burden of decision making should not be put solely on the responsible or eligible person.

8.4 **When a mentally competent adult patient does not want discussion**

8.4.1 If a competent adult patient is not prepared to discuss about future care, or find the prospect of doing so too distressing, the healthcare team should respect the patient's wish and defer the discussion. The doctor should also make it clear that the patient can change his/her mind and seek further information at any time.

8.4.2 The healthcare team may consider measures to support the patient, such as inviting the patient's preferred family members or other close persons to participate in the discussion as well as involving other professionals for psychological support.

8.4.3 The doctor should record that the patient has declined relevant information.

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8.4.4 Normally, a DNACPR decision should not be made until after discussion with a mentally competent adult patient. When a mentally competent adult patient does not want discussion, the view of the healthcare team and the responsible or eligible persons on whether CPR is appropriate or not can be solicited and be documented in the medical record, but normally, a DNACPR decision has to be left to the time when the patient becomes incompetent (refer to Q&A Q3).

8.5 **When others want information to be withheld from the mentally capable adult patient**

8.5.1 Unless the patient refuses information, the healthcare team should not withhold from the patient information necessary for making decisions even if asked by the responsible or eligible persons of the patient to do so.

8.5.2 If there is worry that giving the information would cause serious psychological harm to the patient, the doctor should consider measures to support the patient, and disclose the information sensitively and step-by-step, taking into account how much the patient wishes to know.

8.5.3 **It is helpful to advise the responsible or eligible persons that doctors would not withhold or provide incorrect information deliberately if the patient actively asks for specific information. It is also likely that patient may gather information or hints along the disease journey and may feel perplexed if not being told directly.**

9. **Roles of doctors in making DNACPR order with continuing effect for mentally capable adults with AMD (AMD-based DNACPR)**

(adopted from Section G, BPG on AMD, HKAM 2025)

9.1 The prescribed AMD-based DNACPR order form must be used for timely and easy recognition by the ambulance crew. The prescribed AMD-based DNACPR order form covers the same 3 categories of specific preconditions as in the model AMD forms.

9.2 The AMD-based DNACPR order must be signed by 2 RMPs, one of whom must be a specialist. By signing, both RMPs confirm that:

9.2.1 there is an underlying instruction in the patient's AMD to refuse CPR when he/she becomes mentally incapable AND the patient has now met the specified precondition; both RMPs are not interested persons; and

9.2.2 both RMPs agree on the effective period of the order, which should not exceed 1 year.

The entry of specified precondition on the AMD-based DNACPR order should match with that in the AMD to avoid confusion. The patient's signature is not required.

9.3 The signing of the AMD-based DNACPR order which confirms that the patient has met the specified precondition, will allow treatment providers to act without undue delay. Without the AMD-based DNACPR order, the ambulance crew would not be able to immediately withhold CPR as wished by the patient, and the treatment providers would have to assess whether the

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AMD is valid and applicable before complying with the DNACPR instruction in the AMD.

- 9.4 The AMD-based DNACPR order should be reviewed and signed by one RMP who is not an interested person (can be specialist or non-specialist) before the effective period expires. Extension of the DNACPR order, which also must not exceed 1 year, requires re-signing by one RMP (who does not have to be the RMP signing the initial order) after review. If needed, continuation sheets for DNACPR orders should be used for further extension after the last expiry date and attached to the parent DNACPR order. If not reviewed and re-signed, the DNACPR order becomes invalid after the effective period has passed.
- 9.5 There will be circumstances where the RMPs are unable to sign the AMD-based DNACPR order at the time of making the AMD because the specified precondition has not been met. For example:
 - 9.5.1 The potentially incurable disease is still at an earlier stage e.g. cancer or organ failure;
 - 9.5.2 The patient has not reached the stage of severe dementia which is stated as the specified precondition when signing the AMD;
 - 9.5.3 The patient specified PVS or irreversible coma as a precondition which has not yet occurred. In such circumstances, the RMPs shall only complete the AMD-based DNACPR order at a later time and decisions should be documented in the patient's records to facilitate subsequent review. If the patient sustains a cardiac arrest before an AMD-based-DNACPR order is made, the attending doctor has to rely on the per se AMD for action after being satisfied that the AMD is valid and applicable.
- 9.6 After making the AMD-based DNACPR, the RMP should make the alert in the CMS. There is no electronic storage of the DNACPR and the paper copy remains the proof.

10. Roles of doctors in making DNACPR order with continuing effect for mentally incapable adults and minors (non-AMD-based DNACPR)

(adopted from Section I, BPG on AMD, HKAM 2025)

- 10.1 The prescribed non-AMD-based DNACPR order forms for mentally incapable adults and minors must be used respectively (the Ordinance Schedule 2).
- 10.2 The non-AMD-based DNACPR order must be signed by 2 RMPs, one of whom must be a specialist. By signing, both RMPs confirm that:
 - 10.2.1 the patient is (i) terminally ill, in a PVS or state of irreversible coma, and/or in any other end-stage, irreversible, life-limiting condition (within the meaning of the Ordinance), and (ii) mentally incapable;
 - 10.2.2 they are not aware that the adult patient has an AMD containing an instruction to refuse CPR;
 - 10.2.3 CPR is not in the patient's best interests in case of cardiac arrest;

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- 10.2.4 at least one of the two signing RMPs has explained to the responsible or eligible person (as the case may be) that performing CPR on the patient when he/she is in cardiac arrest would not be in his/her best interests;
- 10.2.5 both RMPs are not interested persons; and
- 10.2.6 both RMPs agree on the effective period of the order, which should not exceed 1 year.
- Unlike the AMD-based DNACPR order, the non-AMD-based DNACPR order requires the additional signature of a responsible person who may be an immediate family member/cohabitee/ guardian, or if no such responsible person can be found, any other eligible person determined by one of the two signing RMPs to be in a good position to form a view as to whether performing CPR on the patient would be in his/her best interests.
- 10.3 The DNACPR order decision should be based on the patient's best interests. It is the role of the RMP to make medical decisions based on his/her assessment of the patient's best interests (please refer to Section 6.2 & 6.3 for what is patient's best interests).
- 10.4 The RMPs should reach a consensus with the patient's family members before completing and signing a DNACPR order. For minors, although they cannot make an AMD, some of them may be mentally mature enough to understand and participate in the discussion and their views should be taken into consideration by the RMP.
- 10.5 Role of responsible person or eligible person
- 10.5.1 A responsible person may be an immediate family member, a cohabitant or the legal guardian of the patient. An eligible person is one whom the RMP considers close enough to consider the best interests of the patient (please refer to Section 6.2 & 6.3 for details).
- 10.5.2 A responsible or eligible person should not be given the burden to assess what is in the patient's best interests, but they can provide valuable information on the patient's prior wish on medical treatment, patient's preferences on treatment limits, and patient's values.
- 10.5.3 The responsible or eligible person should be reminded that they should refer to the patient's preferences and values and not their own.
- 10.5.4 The signature of the responsible or eligible person confirms that he/she has been advised by the RMP that performing CPR on the patient is not in the patient's best interests, and that he/she agrees with the assessment.
- 10.5.5 The responsible or eligible persons are responsible for custody of the validating copy (original or certified true copy) of the DNACPR order and for presenting to rescuers and treatment providers as proof. When the responsible or eligible person has doubts about the DNACPR order decision in future, he/she should contact an RMP for discussion and reassessment of patient's best interests.
- 10.6 A non-AMD-based DNACPR order should be reviewed in the same manner as stipulated in Section 9.4. The last expiry date of a non-AMD-based DNACPR order for minors should

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not fall beyond their 18th birthday, as DNACPR orders for minors are automatically revoked upon the minor attaining majority. Transition to adult care should be anticipated and prepared in advance to ensure continuity of the DNACPR order.

- 10.7 Doctors should not complete a non-AMD-based DNACPR order before having attempted to resolve any conflicts between the family members. Doctors should also note that the guardian of a mentally incapable adult or minor patient may not necessarily be the family member of the patient and in some cases, there may be difference in views. However, family members or guardians should be clearly informed that a doctor is not obliged to provide treatment that is not in the patient's best interests.
- 10.8 For mentally incapable adult patients, there may be situations where finding a responsible or eligible person to co-sign the non-AMD-based DNACPR order is impracticable or not successful despite reasonable efforts. In that case, the 2 RMPs, one of whom must be a specialist, may still sign the non-AMD-based DNACPR order in the absence of such co-signer. This option is not available if the patient is a minor. Reasonable efforts may include the following: checking the guardianship status with the Guardianship Board, reviewing past medical records and verifying contact with the medical social worker system.

11. Custody of DNACPR order forms with continuing effect and making certified copies

- 11.1 It is the primary responsibility of the patient or his/her responsible persons to keep custody of the paper DNACPR order forms, with/without AMD form.
- 11.2 HA has provided a standardised pouch (refer to Appendix II) for storage of AMD, DNACPR and ACP forms. Patients or family members should be advised to put the bag in a safe yet reachable place.
- 11.3 Apart from the original paper copy of the DNACPR forms, the patient and the responsible or eligible person may choose to have copies of DNACPR certified by an RMP or solicitor of the Legal Practitioners Ordinance (Cap. 159) holding a current practicing certificate in Hong Kong. Both the original copy and the certified copies are considered as validating copies. For HA patients, please instruct the patient or his/her responsible/eligible persons to approach the Medical Record Office for processing of certified true copies.
- 11.4 There is no electronic storage or making will be implemented for DNACPR order forms with continuing effect. The flagging alert in CMS only alerts the healthcare providers that the DNACPR order form with continuing effect has been signed. The ambulance crew will only recognise the validating copies of DNACPR order with continuing effect made in the prescribed forms. Although a treatment provider or rescuer has no obligation to search for the DNACPR order form, the authorization statement on the HA pouch allows them to look into the designated bag for the forms.
- 11.5 There is no limit on the number of certified copies made. However, patient and their families should be educated about the potential risk for having excessive number of certified copies. If the DNACPR order has been renewed by signing and appending continuation sheets to

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the parent DNACPR order, the previous certified copies of the parent DNACPR order are no longer valid and new certification of the renewed DNACPR order (i.e. comprising both the parent order and the continuation sheet as a whole) is required.

12. **Who can revoke DNACPR order with continuing effect?**

(adopted from Section K, BPG on AMD, HKAM 2025)

12.1 For both AMD-based and non-AMD-based DNACPR orders:

2 RMPs may revoke a DNACPR order if they consider that the patient no longer meets the specified preconditions e.g. improvement in clinical condition. 2 RMPs, one of which one must be a specialist, have to cross out the content of each page of the order and to sign on each page of the order with date of revocation inserted.

12.2 For AMD-based DNACPR orders, the AMD maker may revoke his/her AMD-based DNACPR order by doing any one of the following:

12.2.1 Write a statement of revocation (either in paper or electronic form);

12.2.2 Burn, destroy or tear the order or by another adult in his/her presence and by his/her direction;

12.2.3 Cross out the content of and sign on each page of the order or by another adult in his/her presence and by his/her direction;

12.2.4 Express the intention to revoke verbally in the presence of one or more adult witnesses who are present physically or by audio-visual link in real time;

12.2.5 Express the intention to revoke by any means other than in writing or verbally in the presence of one or more adult witnesses who are present physically or by audio-visual link in real time;

12.2.6 Revoke the underlying AMD of the AMD-based DNACPR order.

12.3 For non-AMD-based DNACPR orders:

12.3.1 A non-AMD-based DNACPR order can be revoked by 2 RMPs as mentioned in Section 12.1.

12.3.2 A non-AMD-based DNACPR order cannot be revoked by a responsible person on behalf of the patient. Queries from the responsible person should trigger further discussions or reassessment of the patient's best interests by the RMP.

12.3.3 A non-AMD-based DNACPR order made for a minor patient is automatically revoked upon his/her 18th birthday. The patient may choose to make an AMD for refusal of CPR and/or other LST, or alternatively, a non-AMD-based DNACPR order may be signed by 2 RMPs for mentally incapable adult patients with the additional signature by a responsible person / eligible person (if any). To avoid undue delay or time gaps, planning in advance of the anticipatable event is required.

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12.3.4 A non-AMD-based DNACPR order made for a mentally incapable adult patient is automatically revoked when the adult ceases to be so mentally incapable.

12.4 The RMP's should communicate with both the patient and his/her responsible person (if any) for the revocation. The revocation should be documented clearly in the patient's records for effective communication with other healthcare providers.

Table 5: Revocation of DNACPR orders: What? How? By whom?

What?	How?	By whom?
AMD-based DNACPR (only one copy) and its certified true copies (can be multiple copies)	Cross out the content of each page of the order and sign on each page of the order with date of revocation inserted.	By 2 RMPs, one of which one is a specialist*
	a) Write a statement of revocation (either in paper or electronic form) or b) Burn, destroy or tear the AMD-based DNACPR order; or c) Cross out the content of and signs on each page of the AMD-based DNACPR order; or d) In the presence of one or more adult witnesses (may be physical presence or by audio-visual link in real time) i. Express the intention to revoke verbally ii. Express the intention to revoke by any means other than in writing or verbally e) Revoke the underlying AMD of the AMD-based DNACPR order	By the patient (a, e) By the patient or by an adult in the patient's presence and as instructed by the patient (b, c) By the patient and in the presence of one or more adult witnesses (d)
*Only DNACPR orders can be revoked by 2 RMPs. The underlying AMD remains valid if the patient has not changed his/her mind. However, if the patient has revoked an AMD for refusal of CPR, the AMD-based DNACPR order will also be automatically revoked. In such cases, the patient should be advised to simultaneously remove and destroy all existing validating copies of the AMD-based DNACPR order and notify the treatment provider as soon as possible.		
Non-AMD-based DNACPR order for a mentally incapable adult patient (only one copy) and its certified true copies (can be multiple copies)	Cross out the content of each page of the order and to sign on each page of the order with date of revocation inserted.	By 2 RMPs, one of which must be a specialist
	Revoked when the adult ceases to be so mentally incapable.	Automatic expiry
Non-AMD-based DNACPR order for a minor patient (only one copy) and its certified true copies (can be multiple copies)	Cross out the content of each page of the order and to sign on each page of the order with date of revocation inserted.	By 2 RMPs, one of which must be a specialist
	Revoked on the 18 th birthday of the patient	Automatic expiry

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13. Notice of DNACPR order with continuing effect by treatment providers in HA

- 13.1 Notice of DNACPR order with continuing effect by the treatment providers refers to seeing the presented validating copies. The validating paper copy has to be checked for its validity and applicability.
- 13.2 No digital copy of DNACPR orders will be stored in CMS. The CMS shall only show an alert that DNACPR order with continuing effect has been made.
- 13.3 Patients and their responsible or eligible persons should be educated to bring along their validating copy of DNACPR order with continuing effect when attending the Accident and Emergency Department, admitting to a hospital or attending a RMP for review or extension of DNACPR order, or as advised by relevant specialty clinics e.g. palliative care, oncology and geriatrics.
- 13.4 In circumstances where DNACPR orders with continuing effect are not presented or made known to the treatment providers e.g. no flagging in the CMS, no one to present the DNACPR order, a search for the validating copies in the patient's belongings by the treatment provider is not required. However, if the designated HA pouch is brought to the attention of the treatment providers, the bag should be searched.
- 13.5 For admissions to HA hospitals:
 - 13.5.1 A local system or workflow should be in place to ensure the validating copy of DNACPR order with continuing effect presented is made known and accessible to other treatment providers during the same episode of care.
 - 13.5.2 The receiving healthcare team attending the patient should ascertain that the DNACPR order form with continuing effect is valid (refer to Section 14.2) and applicable (refer to Section 14.3).

14. Operation of DNACPR order with continuing effect

(adopted from Section N, BPG on AMD, HKAM 2025)

- 14.1 A DNACPR order will come into effect when:
 - 14.1.1 The patient is mentally incapable and in cardiac arrest; and
 - 14.1.2 The DNACPR order is valid and applicable.
- 14.2 The DNACPR order is valid if:
 - 14.2.1 The DNACPR order is brought to the notice of the treatment providers;
 - 14.2.2 The DNACPR order is clearly completed and properly signed for an AMD-based DNACPR order and a non-AMD-based DNACPR order;
 - 14.2.3 The DNACPR order has not expired;
 - 14.2.4 There is no suspicion of foul play e.g. falsified DNACPR order

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14.2.5 For an AMD-based DNACPR order:

- (a) The underlying AMD for refusal of CPR has not been revoked.
- (b) Where an AMD has not been revoked, the patient has not done anything clearly inconsistent with the AMD and indicated that he/she no longer wants the AMD to be followed.

14.3 A DNACPR order is applicable unless the following circumstances exist:

14.3.1 There are reasonable grounds for the attending RMP to believe that the current circumstances are not anticipated by the signing RMPs who signed or extended the effective period of the DNACPR order, and if the signing RMPs had so anticipated, he/she would not have signed and extended it.

14.3.2 The attending RMP has made a diagnosis or prognosis that is different from that made by the signing RMPs, and reasonably believes that the signing RMPs would not have signed the DNACPR order or extended it (as the case may be) had they made the same diagnosis and prognosis.

14.3.3 For an AMD-based DNACPR order, the attending RMP reasonably believes that, the patient did not anticipate the circumstance to arise at the time of making the underlying AMD, and had the patient so anticipated, it is likely that he/she would not have signed the AMD or made the underlying instruction.

14.3.4 For a non-AMD-based DNACPR order, the attending RMP reasonably considers that there is any exceptional circumstance which warrants disregarding the DNACPR order, which is in the patient's best interests. As this is an exceptional situation, the attending RMP must exercise caution and clearly document the rationale and reasons behind his/her decision.

14.4 If the patient sustains a cardiac arrest before an AMD-based-DNACPR order is made, the attending doctor has to rely on the per se AMD for action after being satisfied that the AMD is valid and applicable (refer to Section 9.5).

15. **Dealing with doubts and conflicts**

15.1 Doubts and conflicts are often related to the validity and applicability of the DNACPR order with continuing effect with/without the AMD. In most cases, doubts regarding the DNACPR making process arise from the responsible or eligible persons. The responsible or eligible persons may request CPR even though patient has a prior wish to refuse CPR or CPR is considered not in patient's best interests by the doctors. In less common situations, the attending doctors have doubts about the validity of a DNACPR e.g. being falsified or concealed.

15.2 Potential conflicts at the time when the patient becomes mentally incapable could be minimised by engaging patient early when he/she is still mentally capable, a well facilitated ACP process with active clarification of myths and misunderstandings and

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consensus building (refer to Section 8.3). The DNACPR orders with continuing effect should only be signed after conflict resolution. For a patient with AMD made for refusal of CPR when mentally competent, it should be respected. A valid and applicable AMD for refusal of CPR cannot be overruled by others. The doctor has to explain that the AMD is legally binding, and its making follows the requirement of the Ordinance.

- 15.3 For mentally incapable adult patients and minors, the DNACPR order with continuing effect is made by 2 RMPs based on patient's best interests. If the responsible or eligible persons have changed their views after the ACP, they should discuss with the doctors as only doctors may revoke such DNACPR order with continuing effect.
- 15.4 Sometimes the dying scene could be emotionally charging even with prior preparation. The emotions expressed do not necessarily imply disagreement with DNACPR. Grief reactions and emotions should be handled with empathy and understanding and refer for professional support as appropriate.
- 15.5 If conflicts remain unresolved after repeated communication, the doctor may consider holding a conference with the responsible or eligible persons, seeking advice or opinion from another doctor who is more experienced, the hospital management, or from the local and cluster clinical ethics committee, or from the legal advisor.
- 15.6 The patients and the responsible or eligible persons cannot insist on medical treatment that the doctor considered inappropriate. A doctor is not obliged to perform futile or non-beneficial CPR (refer to Q&A Q3).
- 15.7 In rare circumstances, the attending RMP reasonably considers that there is any exceptional circumstance which warrants disregarding the DNACPR order for a mentally incapable adult patient or minor, which is in the patient's best interests. The responsible or eligible person may disagree or feeling confused. As this is an exceptional situation, the attending RMP must exercise caution, clearly document the rationale and reasons behind his/her decision, and communicate with the responsible or eligible persons.
- 15.8 The treatment providers may also apply to the Court of First Instance to declare whether the AMD for refusal of CPR is valid or applicable. While determination by the Court is pending and the patient is in an urgent critical state, treatment providers are advised to provide the LST based on the best interests of the patient.
- 15.9 Any significant discussion should be documented in the medical record, recording the salient points of the discussion that has taken place with the patient or the patient's family, their names, and the relationship to the patient. The presence of a witness during the discussion is strongly recommended and the identity of the witness should be documented in the medical record.

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16. **Protection for treatment providers**

(adopted from Section Q, BPG on AMD, HKAM 2025)

- 16.1 The protection for liability extends to both public officers and those working in private practice and includes civil liability, criminal liability and liability for professional misconduct.
- 16.2 With consequential amendment of the MHO come into operation, there will be explicit legislation provision that an AMD made by an adult patient for refusal of CPR (when he/she is still mentally capable of deciding on LST) shall prevail over any subsequent judgment of doctors or dentists in providing LST in urgent or non-urgent situations based on the patient's best interests.
- 16.3 A doctor is not liable for not performing CPR in a person-in-arrest if the doctor:
 - 16.3.1 **Has notice of a DNACPR order;**
 - 16.3.2 Honestly and reasonably believes that the DNACPR order is valid and applicable; and
 - 16.3.3 Has no suspicion that the cardiac arrest arises from an unnatural cause or inflicted injury.
- 16.4 A doctor is not liable for performing CPR on a person-in-arrest if the doctor:
 - 16.4.1 Has no notice or knowledge of a DNACPR order;
 - 16.4.2 Is not satisfied that there is a valid and applicable DNACPR order (refer to Section 14); or
 - 16.4.3 has suspicion that the cardiac arrest arises from an unnatural cause or inflicted injury.
- 16.5 For a patient with AMD refusing CPR, but with no DNACPR available, a doctor who withholds or withdraws the specified CPR is not liable if he/she:
 - 16.5.1 Has notice of the AMD; and
 - 16.5.2 Honestly and reasonably believes that the AMD is valid and applicable.
- 16.6 On the contrary, if a doctor, while knowing the presence of a valid and applicable DNACPR, continues to perform CPR, he/she can be liable for assault and battery.
- 16.7 In an emergency or critical situation, and there is reasonable doubt about the existence, validity or applicability of the DNACPR or AMD for refusal of CPR, CPR should be initiated according to clinical indications as a safeguard to preserve life. If a valid and applicable proof is later made available, discontinuation of CPR should be considered.
- 16.8 The above protection does not extend to other liabilities, such as any negligence committed during the course of CPR.
- 16.9 The doctor should clearly document the process and the rationale behind his/her decision-making.

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17. DNACPR order for inpatient episode only (Hospitalised DNACPR)

- 17.1 The adoption of the standardised hospitalised DNACPR forms for HA inpatient (Appendix II) is mandatory to avoid confusion and ambiguity and to facilitate communication and audit.
- 17.2 The hospitalised DNACPR form is episode based and will be automatically invalidated when the patient is discharged from the hospital. The hospitalised DNACPR order will be temporarily suspended during home leave or during transportation from one hospital to another.
- 17.3 When a patient admitted to the hospital already has a valid and applicable DNACPR order form with continuing effect, the hospitalised DNACPR form can be made by one non-specialist doctor. Please refer to Section 14.2 and 14.3 for assessment of the validity and applicability of the DNACPR order with continuing effect.
- 17.4 When a patient admitted to the hospital without a valid and applicable DNACPR order form with continuing effect and a DNACPR decision has not been made in advance, and the patient has not expressed a refusal of CPR, CPR should be attempted, unless CPR is clearly futile or non-beneficial.
- 17.5 The management of seriously ill patients involves many decision-making processes, in both diagnosis and treatment; a DNACPR decision is therefore not made in isolation, but an integral part of the whole management process. In HA, a team approach is usually adopted in managing hospitalised patients and junior doctors are supervised by senior doctors or specialists. The hospitalised DNACPR form should be made or endorsed by a doctor of specialist grade.
- 17.6 If the patient is mentally incapable and has no responsible or eligible persons, the direct involvement of 2 RMPs, one of whole being a specialist, is mandatory in the decision making.
- 17.7 For patients transferred from one hospital to another with a hospitalised DNACPR order, the hospitalised DNACPR order must be reviewed by the receiving team in order to reinstate it. If the DNACPR order is considered appropriate, the receiving doctor should sign a new hospitalised DNACPR form. It may not be necessary to go through the whole process of discussion with the patient and the responsible or eligible persons like a new case and the decision may be made by one non-specialist doctor in the receiving hospital. In an emergency situation when a specialist is not on site and cardiac arrest is likely to occur within a short period in a patient without a valid DNACPR order form with continuing effect, an on-site higher specialist trainee approved by the Chief of Service (COS) may make a DNACPR decision if:
 - 17.7.1 the patient is terminally ill as defined in Section 3.2.1, and the terminal condition is previously known to HA; or

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17.7.2 the patient has other end-stage illness and patient has expressed his/her wish not to have CPR (if mentally capable) or there is documented preference of patient's prior wish of refusing CPR, and the family concurs with patient's wish to refuse CPR in respect of the same end-stage illness. Examples of documented preference against CPR include DNACPR orders in previous admissions, a valid AMD refusing CPR, and a medical note or ACP form documenting preference against CPR in an ACP process.

In both situations, there should be clear consensus with the patient (if mentally capable) and the family on the DNACPR decision.

- 17.8 The COS is ultimately accountable for the clinical governance of his/her department. When there is operational need, the COS may delegate the authority of making hospitalised DNACPR for a patient in the stipulated group of patients under the stipulated conditions based on assessment of their knowledge and skills.
- 17.9 The healthcare team should review the hospitalised DNACPR decision at regular intervals appropriate to the care. It should also be reviewed in response to changes in clinical condition or circumstances, such as a need to undergo anaesthesia, transfer from one department to another, etc. A DNACPR decision made by the on call doctors at night should be reviewed by a specialist of the attending team the following day. When the DNACPR decision is reversed, the form should be crossed out clearly, and the decision should be clearly documented and communicated to avoid inadvertent omission of CPR.

18. Education, training, evaluation and audits

- 18.1 The hospital should have an education system in place, for their staff to understand the principles of decision-making regarding DNACPR, and to acquire the appropriate communication skills and attitudes.
- 18.2 The hospital should have a system in place for review of the death cases and the DNACPR documentation e.g. mortality and morbidity meeting, audits.

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Member List of HA Clinical Ethics Committee (HACEC)

(October 2023)

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Member List of Sub-Working Group for review of DNACPR guidelines

(January 2025)

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