NHS
Rotherham

Model

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

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Contents

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) POLICY

1. INTRODUCTION

There is much confusion and uncertainty about resuscitation and the process of making "do not attempt cardiopulmonary resuscitation" (DNACPR) decisions. This policy is based on the guidelines produced by the British Medical Association, Royal College of Nursing and Resuscitation Council (UK) and should be used in conjunction with the Yorkshire and Humber DNACPR form, decision making framework and patient information leaflet which can all be found appended to this policy. The purpose of the policy is to provide guidance and clarification for all staff working within NHS Rotherham commissioned services (all settings including Hospital, Hospice, Care Home and Home) regarding the process of making DNACPR decisions.

This policy, originally developed and ratified in 2007, has been reviewed and updated with the DNACPR form developed by the Strategic Health Authority Regional DNACPR group.

Cardio-pulmonary resuscitation (CPR) could be attempted on any individual in whom cardiac or respiratory function ceases. Such events are inevitable as part of dying and thus, theoretically CPR could be used on every individual prior to death. It is therefore essential to identify patients for whom cardio-pulmonary arrest represents the terminal event in their illness and for whom CPR is inappropriate. It is also essential to identify those patients who would not want CPR to be attempted in the event of an arrest and who competently refuse this treatment option. Some competent patients may wish to make an Advance Statement about treatment (such as CPR) that they would not wish to receive in some future circumstances (see Appendix 1). These statements must be respected as long as these decisions are informed, currently applicable and made without coercion from others.

Where patients are admitted to hospital acutely unwell or become medically unstable in their existing home or healthcare environment, their resuscitation status should be considered as soon as is reasonably possible. When no explicit decision has been made about resuscitation before a cardio-pulmonary arrest, and the express wishes of the patient are unknown, it should be presumed that staff would attempt to resuscitate the patient. Although this should be the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is in the terminal phase of an illness.

Throughout this document the term "relevant others" is used to describe patient's relatives, carers, representatives, advocates, welfare guardians and welfare powers of attorney. This policy addresses issues with regard to adult DNACPR decision-making. Such decision making for children and young people can be even more complex and guidance should be sought.

2. OBJECTIVES OF THE POLICY

- To avoid inappropriate resuscitation
- To ensure that decisions regarding CPR are made according to:
    - Whether CPR could succeed
    - The clinical needs of the patient
    - The patient's wishes and best interests
    - Current ethical principles
    - Legislation such as the Human Rights Act (1998) and the Mental Capacity Act (2005)
- To make DNACPR decision transparent and open to examination
- To clarify DNACPR decision making for clinical staff caring for people who have communication difficulties and other vulnerable groups.
- To ensure patients, relevant others and staff have information on making decisions about resuscitation and that they understand the process.
- To clarify that patients and relevant others will not be asked to decide about CPR when it would clearly fail and therefore is not a treatment option, or when the circumstances of a possible arrest cannot be anticipated and therefore informed discussion cannot take place.
- To encourage and facilitate open, appropriate and realistic discussion with patients and their relevant others about resuscitation issues.
- To ensure that a DNACPR decision is communicated to all relevant healthcare professions and services involved in the patient's care.

3. RESPONSIBILITIES

- The appropriate Director of a commissioned service will ensure that this policy is disseminated to appropriate staff groups and that identified training and development needs in relation to the implementation of the policy are addressed.
- **Clinical Team Leaders/Heads of Service** will ensure that the policy is implemented within their area and that any training as appropriate is provided. They should also monitor that staff adhere to the policy and monitor compliance.
- **All Staff** will ensure that they adhere to the policy and identify any training and development needs in relation to implementation of the policy to their line manager.

4. CARDIO-PULMONARY RESUSCITATION: WHAT IT IS AND WHAT IT IS NOT?

CPR measures include external chest compression, artificial respiration and defibrillation. These measures are normally instituted by local staff, and should precipitate an emergency call and other active resuscitation measures. CPR is instituted immediately and in full following an unexpected collapse if there is a realistic expectation of it being successful.

In situations where it is decided that CPR measures would not be successful it may still be appropriate to provide analgesia, antibiotics, and drugs for symptom control, feeding or hydration (by any route), investigation and treatment of a reversible condition, seizure control, suction, and treatment for choking. Comfort and treatment measures are instituted after assessment, consultation with patient and relevant others, and on the basis of clinical need.

5. THE PRINCIPLES UNDERLYING THIS POLICY

This policy is based on the following five principles:

5.1 Circumstances of cardio-pulmonary arrest

If the circumstances of a cardio-pulmonary arrest cannot be anticipated, it is not possible to make a DNACPR decision that can have any validity in guiding the clinical team. In order to make an informed decision about the likely outcome of CPR it is essential to be able to think through the likely circumstance(s) in which it might happen for the patient. It is an unnecessary and cruel burden to ask patients or relevant others about CPR when it seems unlikely that circumstances would occur where the patient would require CPR. This should never prevent discussions about resuscitation issues with the patient if they wish.

5.2 When CPR would fail

In the situation where death is expected as an inevitable result of an underlying disease and the clinical team is as certain as they can be that CPR would fail, resuscitation should not be attempted. It is an unnecessary and cruel burden to ask patients and relevant others to decide about CPR when it is not a treatment option. Although patients should not be offered CPR where it is clear that it will not work, discussion about resuscitation issues are important as part of helping the patient and their family understand the severity of the patient's condition, unless it is clear that such a discussion would be unwelcome or would cause harm.

Open and honest communication is essential in this situation. Where a medical DNACPR decision has been made because CPR will not work for the patient, it is the responsibility of the medical and nursing team to ensure that the patient and family have the opportunity to discuss this.

5.3 Communication

Throughout their care, the patient should be given as much information as they wish about their situation including information about resuscitation. Relevant others can be given such information **if the patient agrees**. There should be a presumption in favour of the patient and relevant others wanting to be involved in discussions about DNACPR. It is not the professional's responsibility to decide how much information the patient should receive, their task is to find out how much the patient wishes to know or can understand. If a patient is not competent for this decision then the clinical team must decide the best option – taking into account the knowledge of relevant others about the patient's previous wishes. **Relatives should never be placed in a position such that they feel they are making a DNACPR decision** unless they are the legally appointed proxy for the patient. Their role is to provide information about the patient's previously expressed wishes or what they believe the patient would wish in this situation. The responsibility for making a DNACPR decision lies with the most senior clinician who has medical responsibility for that patient. Discussions about resuscitation are sensitive and complex and should be undertaken by experienced medical or nursing staff. It is recommended that staff have formal communication skills training in preparation for this clinical responsibility.

5.4 Quality of Life

This policy adopts the view that medical decisions should be based on immediate health needs as well as a professional's opinion on quality of life. This is primarily because opinions on quality of life made by health professionals are subjective and sometimes at variance with the views of the patient and relevant others. Where CPR may be medically successful but result in a poor quality or length of life, the patient's wishes about wanting or not wanting resuscitation to be attempted, are of paramount importance.

5.5 Presumption to Resuscitate

When no explicit decision has been made about resuscitation before cardio-pulmonary arrest, and the express wishes of the patient are unknown, it should be presumed that staff would attempt to resuscitate the patient. Although this should be the general assumption, it is unlikely to be considered reasonable to attempt to resuscitate a patient who is clearly in the terminal phase of an illness. Experienced nursing staff are therefore not obliged to initiate resuscitation measures for a patient where the death is clearly expected and due to an irreversible illness such that CPR would be unsuccessful and unquestionably inappropriate.

6. THE PROCESS OF MAKING A DNACPR ORDER (SEE FRAMEWORK – APPENDIX 3)

If it is not possible to anticipate circumstances where cardio-pulmonary arrest might happen, there is no clinical DNACPR decision to make.

- Do not initiate discussion about CPR with the patient or relevant others.
- The patient and relevant others should be informed that they can have a discussion, or receive information, about any aspect of their treatment. If the patient wishes, this may include information about CPR and its likely success in different circumstances.
- Continue to communicate progress to the patient and relevant others if the patient agrees.
- Review only when circumstances change.
- In the event of an unexpected cardio-pulmonary arrest there should be a presumption that CPR would be carried out.
- No DNACPR form should be completed.
- If the patient wishes to make an advance decision that he/she would not wish to have CPR in the event of an unanticipated arrest this should be explored in a sensitive and realistic manner by an experienced member of the clinical team.

If it is possible to anticipate circumstances where cardio-pulmonary arrest seems likely for a particular patient then it is possible to make a decision in advance which would help a clinical team decide whether to attempt CPR in that event (see A and B below).

A. If the patient is dying as a result of an irreversible condition, CPR is unlikely to be successful. If the medical team is as certain as it can be that CPR would not realistically have a medically successful outcome, it is inappropriate to offer it as a treatment option.

- Allow a natural death.
- Good palliative care should be in place to ensure a comfortable and peaceful time for the patient, with support for the relevant others.
- Do not burden the patient or relevant others with having to decide about CPR when it is not a treatment option.
- Ensure that patient has and understands as much information about their condition as they want and need (the reasons why CPR will not work should be considered part of this information).
- Document the fact that CPR will not benefit the patient.
- Complete DNACPR form.
- The absence of a DNACPR form should not alter the appropriate management of an arrest.
- Review if medical circumstances change in a way the means CPR could result in a successful outcome.
- Review if medical responsibility for the patient changes (e.g. patient discharged home from hospital)
- All reviews that take place should be documented and signed (see section 2 of the DNACPR form) and within the patient record.

B. If the patient is thought not to be dying and the team is as certain as it can be that CPR would realistically have a possibility of a medically successful outcome, the next decision is whether the patient is competent to take part in this discussion and fully comprehend the implications of the decision.

- Competent patients are able to understand their situation and the consequences of their decisions. Adults should be presumed to be competent unless there is evidence to the contrary. Evidence that a patient is suffering from depression or is under the influence of others would warrant a formal assessment of competence. An assessment of competence should relate to the specific decision the patient is being asked to make and their ability to fully comprehend their situation and the implications of their decision. Patients who are judged to be incompetent to make decision about their care should be managed according to the principles of the Mental Capacity Act (2005).

- If the patient is competent for this decision:

  - Discuss the options with the patient unless they make it clear they do not wish to have this discussion.
  - Continue to communicate progress to the patient and relevant others if the patient agrees.

- If the patient is not competent for this decision:

  - Enquire about previous wishes from the relevant others to help the clinical team make the most appropriate decision. Continue to communicate progress to them
  - Patients should be managed according to the principles of the Mental Capacity Act (2005).
  - Continue to communicate progress to the relevant others.

- Document this discussion in the medical and nursing records detailing the circumstances that any decision relates to and who was involved in the decision making process.
- Complete DNACPR form if appropriate.
- Review regularly and if circumstances change.
- In the event of a cardio-pulmonary arrest, act according to the patient's previous wishes (or if the patient was not competent, follow the decision made by the clinical team).

7. THE DNACPR FORM

- Whilst in hospital, the DNACPR form will be used as usual in accordance with that hospital's DNACPR procedures. Whilst in Rotherham Foundation Trust the DNACPR form will be used in accordance with this policy.
- In the community setting the DNACPR form will be used in accordance with this policy.
- For any patient being transported within Rotherham by Yorkshire Ambulance Service, the DNACPR form in this policy is to be used. Ensure that ambulance control is aware of the existence of the DNACPR form at the time of booking the ambulance.
- The DNACPR form should follow the patient from setting to setting.
- On transfer of medical responsibility of the patient from the care of one senior healthcare professional to another the DNACPR status should be reviewed by the senior healthcare professional who is assuming medical responsibility for the patient. For patients being discharged to the community this will usually be the GP. It is the responsibility of the supervising healthcare professional to inform the receiving healthcare professional of the presence of a DNACPR form.
- Where a patient with a DNACPR form is being discharged home or is dying at home it is the medical and nursing team's responsibility to ensure that the family are aware of its existence and know what to do in the event of an arrest. Where it is considered potentially harmful for the DNACPR form to be in the patient's house it should be sent immediately to the GP.
- Ensure that out of hours services are informed (where appropriate) whenever a DNACPR order is reversed.
- When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form; writing **CANCELLED** in large capital letters and adding your signature and date. It should then be recorded and filed in the patient's records.
- There is agreement across the Yorkshire and Humber region, that black and white forms will be acceptable as well as the red bordered ones. However, the form that follows the patient should be original.

8. THE DIFFICULTIES OF MAKING A DNACPR DECISION

Patients and relevant others can surprise us with their decisions:

- Some patients will wish to receive resuscitation despite marked illness with an advanced and irreversible condition. Where CPR might be successful, offering resuscitation to these patients is our acknowledgement of their desire to continue treatment and makes the bereavement of relevant others less complicated since all possible treatments were carried out.
- Some patients will wish to refuse resuscitation despite an apparent good or reasonable quality of life. These are people who would not want to prolong their lives regardless of the cost. Withholding resuscitation from these patients is our acknowledgement of their wish not to suffer unnecessarily and makes the bereavement of relevant others less complicated since they feel the patient had their wishes respected.

9. THE ROLE OF THE FAMILY/RELEVANT OTHERS

- If a patient is competent (i.e. capable of understanding their situation and the implications of what is being discussed), his or her agreement must be sought before discussing resuscitation issues with the relevant others. Where a competent patient refuses to allow such information to be disclosed to relevant others this refusal must be respected.
- Family often see themselves as natural decision-makers in this situation and may be surprised and/or distressed if they are not allowed to "protect" the patient from such sensitive discussions. Sensitive exploration of these issues should be undertaken by experienced medical and/or nursing staff.
- It is generally good practice to involve those closest to the patient in discussions about resuscitation decisions and patients should be encouraged to let staff know who they would like to be involved. Patients should also be asked who they would like to be involved in such discussions if and when they are no longer competent to do so themselves. A formal legally appointed proxy (Attorney) would be able to make a decision if the patient was deemed to be incapable of making the decision themselves and it was specified in the Lasting Powers of Attorney.
- Relevant others should never be burdened with feeling they are making a decision about resuscitation. Where resuscitation might realistically be successful, the role of the relevant others is to assist the patient in decision-making or to state what they understand the patient's wishes to be.

10. MEDICAL PREDICTION OF THE OUTCOME OF RESUSCITATION

- Unfortunately, many patients have unrealistic expectations of the success of CPR and its consequences. Explanations of the probability of survival to discharge can significantly influence the resuscitation choices of patients.
- Large studies have shown that for in-hospital arrests the success rates as defined by discharge from hospital are in the order of 15% (38% immediate survival and 25% at 24 hours). Features associated with almost no chance of success are pneumonia, poor mobility, advanced cancer, renal failure and hypotension. The most successful resuscitation attempts are those which involve acute respiratory failure or the prompt treatment of ventricular arrhythmias although this has not been shown to alter the overall survival to discharge from hospital.
- Medical prediction of the outcome of resuscitation should be as realistic as possible and take into account the clinical condition of the patient, the likely cause of the anticipated arrest and also the environment within which the patient is being cared.

- It is recommended that medical predictions be made on the likely outcome of a prolonged resuscitation unless the patient is in a Coronary Care or Intensive Care setting.

11. WHEN CONSENSUS IS DIFFICULT TO ACHIEVE

- The senior doctor responsible for the patient's care has the authority to make the final decision, but it is important to reach a consensus with the patient, relevant others and staff.
- On occasions a clear decision is difficult. When one or two members of the team hold a minority view, the rest of the team should respect their view and be prepared to review the situation after a time agreed by the whole team.
- Staff or relevant others with continuing concerns should approach the senior clinician for a discussion.
- Staff who continue to have concerns should approach their line manager.
- Staff and relevant others who still feel dissatisfied should contact their Head of Service or General Manager. All relevant organisations have Clinical Governance Leads and can offer advice on further action as necessary.
- The courts may have to be approached for the final say. This is usually a last resort, although courts can be helpful in deciding complex cases.

12. KEY POINTS

12.1 Making a decision about resuscitation

A decision about the appropriateness of CPR can only be made if the situation where cardio-pulmonary arrest might occur can be anticipated for the particular patient (e.g. recent MI, pneumonia, advanced cancer etc). If such a situation can't be thought through then there is **no medical decision to make** and there is no need to burden patients with resuscitation decisions.

12.2 **Advance decisions –** the exception to this would be where a patient wants the opportunity to make it known that they would not wish resuscitation in the event of any future unexpected cardio-respiratory arrest from any cause. Staff must clarify that the patient fully understands the implications of such a request and the discussion must be fully documented in the medical notes. Patients who wish to refuse CPR should be encouraged to make a formal Advance Decision to Refuse Treatment (ADRT) as a DNACPR form would not be legally binding.

12.3 The legal status of a DNACPR decision

- If a DNACPR decision has been made because it is thought that CPR would not be successful then this is classed as 'clinical advice' and the DNACPR form is appropriate for communicating this.

- If a DNACPR decision has been made by a patient who is competent to make that decision despite the fact that CPR could represent a realistic treatment option then they must be encouraged to make an Advance Decision to Refuse Treatment (ADRT). This must be signed by the patient and witnessed. ADRTs are legally binding and must be followed. A DNACPR form can be used to highlight the fact that a decision has been made by the patient but in itself it is not legally binding (See Appendix 1).

- If a DNACPR decision has been made by a medical team acting in the best interests of a patient who is not competent to make such a decision, it is classed as 'clinical advice' and the DNACPR form is appropriate for communicating this.

12.4 Medical decisions about DNACPR

- The role of the medical team is to decide if CPR is **realistically** likely to have a medically successful outcome. Such decisions should not be solely based on quality of life judgements.
- It may help in making a medical decision to decide whether the patient would be appropriate for Intensive Care (likely outcome of a "successful" prolonged resuscitation).
- It is not necessary to ask the patient to decide about resuscitation if the clinical team is as certain as it can be that CPR realistically will not have a medically successful outcome and the clinician is not obliged to offer CPR in this situation. This must never prevent continuing communication with the patient and relevant others about their illness, including information about CPR, unless it is clear this discussion is unwelcome or would cause harm.

12.5 Nurse decisions about DNACPR

- In October 2007 the British Medical Association (BMA) the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance re nurses and DNACPR orders. The guidance makes it clear that the responsibility for decision making and CPR must always rest with the most senior clinician in charge of a patients/client care. In the majority of cases this will be a registered medical practitioner but is some cases a senior nurse with appropriate training may fulfil this role, subject to local discussion and agreement. (Resuscitation Council 2007)
- Following discussion and agreement by the Clinical Commissioning Group, it has been decided that suitably experienced senior nursing staff (for example specialist nurses, nurse practitioners and nurse consultants) have a role to play in making DNACPR decisions and should be allowed to sign DNACPR forms. It is for individual commissioned services to decide which nursing staff should be given authority to sign DNACPR forms and to ensure that they are adequately trained. Where possible, all senior healthcare professionals involved in a patients care should be aware of and in agreement with a DNACPR decision but, it is accepted that it may be necessary for a senior member of the healthcare team to make a timely decision (particularly during the out of hours period or at weekends) to ensure the best treatment for the patient.

12.6 Patient Decisions about resuscitation issues

- Where CPR is likely to have a medically successful outcome, consideration of a DNACPR decision for quality of life reasons **must be** discussed with the patient and their wishes must be given priority in this situation.
- **Doctors cannot make a DNACPR decision for a competent patient based on a quality of life judgement unless the patient specifically requests that they do this.**

12.7 **The Patient who is not competent to make a decision about resuscitation**

- Enquire about previous wishes from the relevant others to help the clinical team make the most appropriate decision. Continue to communicate progress to them.
- Patients should be managed according to the principles of the Mental Capacity Act (2005).
- Continue to communicate progress to the relevant others.

12.8 **The role of the relatives/relevant others**

- It is the medical and nursing team's responsibility to ensure that the family is aware of the existence of the DNACPR form and know what to do in the event of the patient's death.
- The Out Of Hours service must be made aware of the existence of the DNACPR order. Every effort must be made to ensure the emergency services are not called inappropriately where a patient's death is expected.

12.9 **Patient with a DNACPR order being transported by ambulance**

- Ambulance control must be informed of the existence of the DNACPR order at the time of booking the ambulance.

12.9 **Where no DNACPR decision has been made and a patient arrests**

- The presumption is that staff would attempt to resuscitate a patient in the event of a cardio-pulmonary arrest. However, it is unlikely to be considered reasonable for medical staff or experienced nursing staff to attempt to resuscitate a patient who is in the terminal phase of an illness.

NB: The presence or absence of a DNACPR form should not override clinical judgement about what is in the patient's best interests in an emergency (e.g. choking, anaphylaxis etc)

13. ACKNOWLEDGEMENTS

Juliet Spiller and Colleagues, NHS Lothian

With permission, this policy has been based on the NHS Lothian DNAR policy and the work of Juliet Spiller and colleagues. We would like to acknowledge the work that NHS Lothian has produced and the advice offered to NHS Rotherham in the development of the policy.

14. REFERENCES

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APPENDIX 1

Advance Statements and ADRTs

Advance Statement

This is a statement of a patient's views and wishes, indicating preferences and what forms of medical treatment a patient would or would not want to receive should they be unable to communicate their wishes at a later date. It does not need to be a written statement but if a patient has strong views about what treatment they would or would not want in certain future circumstances, they should be encouraged to discuss this with medical or nursing staff so that it can be documented for future reference. An advance statement can also be used to indicate an individual that the patient would like to be consulted regarding their wishes if the patient becomes unable to take part in decision-making. Patients should be made aware that appointing a legal proxy (lasting powers of Attorney) is preferable as they would have the legal power to make decisions for the patient under the Mental Capacity Act.

Where an advance statement relates to the patient's wish to not have cardio-pulmonary resuscitation in the event of a future unexpected cardiac and/or respiratory arrest, a DNACPR form may not be appropriate and a patient should be encouraged to formulate a more formal advance decision to refuse treatment (ADRT). In the event of an unexpected arrest, a clinical judgement will need to be made regarding whether the circumstances of the arrest are covered by the advance statement.

Advanced Decision to Refuse Treatment (ADRT)

These are a type of advance statement in the form of a more formal written document detailing the patient's wishes regarding future treatment for a situation where they had become unable to express their wishes. More information about ADRTs can be found on the NHS end of life care website which gives details of how to draw up an ADRT and offers templates etc.

An advance statement of any kind may not be used by a patient to do the following:

1. request anything that is illegal such as euthanasia or for help to commit suicide
2. demand any treatment that is contrary to the clinical judgment of the healthcare team
3. refuse the offer of food and drink by mouth
4. refuse the use of measures designed solely to maintain a patient's comfort such as appropriate pain relief

Where there is doubt or disagreement regarding the patient's competence, prognosis or best interests with regard to withholding or administering treatment according to an advance decision, legal advice should be sought.

Appendix 2

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over (v13)

In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.

NHS No	Hospital No	Next of Kin / Emergency Contact
Name		
Address		Relationship
Postcode	Date of Birth	Tel Number

Section 1 Reason for DNACPR decision: Select as appropriate from A - D

Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.

(Guidance overleaf)

A. ☐ **CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.**

(Guidance overleaf)

B. ☐ **CPR is against the wishes of the patient as recorded in a valid advance decision**
The right to refuse CPR in an Advance Decision only applies from the age of 18.

(Guidance overleaf)

C. ☐ **The outcome of CPR would *not* be of *overall benefit* to the patient and:**

i) They lack the capacity to make the decision ☐ **or**

ii) They have declined to discuss the decision ☐

This represents a best interests decision and must be discussed with relevant others

This **has** been discussed with ……(name) on…… (date/time) Relationship to patient:……

(Guidance overleaf)

D. ☐ **CPR would be of *no clinical benefit* because of the following medical conditions:**

……

In these situations when CPR is not expected to be successful, it is good practice to explain to the patient and/or relevant others why CPR will not be attempted.

This **has** been discussed with the patient ☐ Date:……/……/…… Time: ……

This **has not** been discussed with the patient ☐ *Specify Reason:* ……

This **has** been discussed with ……*(name)* on ……(date/time) Relationship to patient:……

Section 2 Review of DNACPR decision: Select as appropriate from i OR ii

i) DNACPR decision is to be reviewed by: …… *(specify date)*

Review Date	Full Name and Designation	Signature	DNACPR still applies	Next Review Date
			☐ *(tick)*	
			☐ *(tick)*	
			☐ *(tick)*	

ii) DNACPR decision is to remain valid until end of life ☐ *(tick)*

Section 3 Healthcare professionals completing DNACPR form *(Guidance overleaf)*

Date: …… Time: ……

Signature: ……

Print name:……

Designation & Organisation ……

GMC / NMC No:……

(Countersignature if required)

Date: …… Time: ……

Signature: ……

Print name:……

Designation & Organisation ……

GMC / NMC No: ……

These guidelines are based on an agreement within the Yorkshire and Humber region.
This form can be red or black-bordered.
For more details refer to your local policy relating to DNACPR.
This is not a legally binding document; the decision may change according to clinical circumstances

Section 1 Guidance (*Please write legibly and with black ink)*

Option A

Record details in the patient's notes, including the assessment of the patient's mental capacity to make this decision.

Option B

The Mental Capacity Act (2005) confirms that an advance decision refusing CPR will be valid and therefore legally binding on the healthcare team, if:

1. The decision is in writing, signed, witnessed and the patient is aged 18 or over;
2. It includes a statement that the advance decision is to apply even if the patient's life is at risk;
3. The advance decision has not been withdrawn;
4. The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf;
5. The patient has not done anything clearly inconsistent with its terms; and
6. The circumstances that have arisen match those envisaged in the advance decision.

16 and 17-year-olds: *Whilst 16 and 17-year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility*

Option C

1. The term "*overall benefit*" is used in the context defined by GMC Guidance 2010 (Treatment & Care towards the End of Life; pg. 40-46; paragraphs 6, 13) and takes into account "*best interests*" as defined by the Mental Capacity Act, 2005.
2. Whenever possible, this situation **must** be discussed with relevant others before completing the form. Record details of your discussion in the patient's notes.
3. The term "*relevant others*" is used to describe a patient's relatives, carers, representatives, people with lasting power of attorney, independent mental capacity advocates (IMCAs), advocates, and court appointed deputies (refer to Mental Capacity Act) http://www.dh.gov.uk

Option D

Record underlying condition/s (e.g. poor Left Ventricular Function, End stage obstructive airway disease, disseminated malignancy) and complete necessary discussions with patient and/or relevant others as soon as possible

Section 2 Review – In accordance with your Local Policy

It is considered good practice to review DNACPR status in the following circumstances:

- At the consultant ward round, MDT or Gold Standards Framework meeting;
- On transfer of medical responsibility (e.g. hospital to community or vice versa); or
- Whenever there are significant changes in a patient's condition.

Cancellation of DNACPR: When the form is no longer valid, either because the patient is for CPR or because a new form has been completed, it must be marked as cancelled by making two thick, dark, diagonal lines across the form, writing **CANCELLED** in large capitals and adding your signature and date. It should then be filed in the patient's notes.

Section 3 Authorisation

Responsibility for making the DNACPR decision lies with a senior doctor (e.g. Consultant, GP) who has responsibility for the patient. In some localities, other healthcare professionals who have undertaken the necessary training may make the DNACPR decision.

Countersignature: If junior medical staff or other authorised professionals have been instructed to sign the form by a senior clinician, the form should be countersigned by the senior doctor, as soon as possible or as per local policy.

Any supplementary information (e.g. family informed by nursing staff at later stage) should be signed and dated by the entry.

COMMUNICATING DNACPR DECISIONS

It is the responsibility of the healthcare team completing the form to ensure that the DNACPR status is communicated to all who need to know.

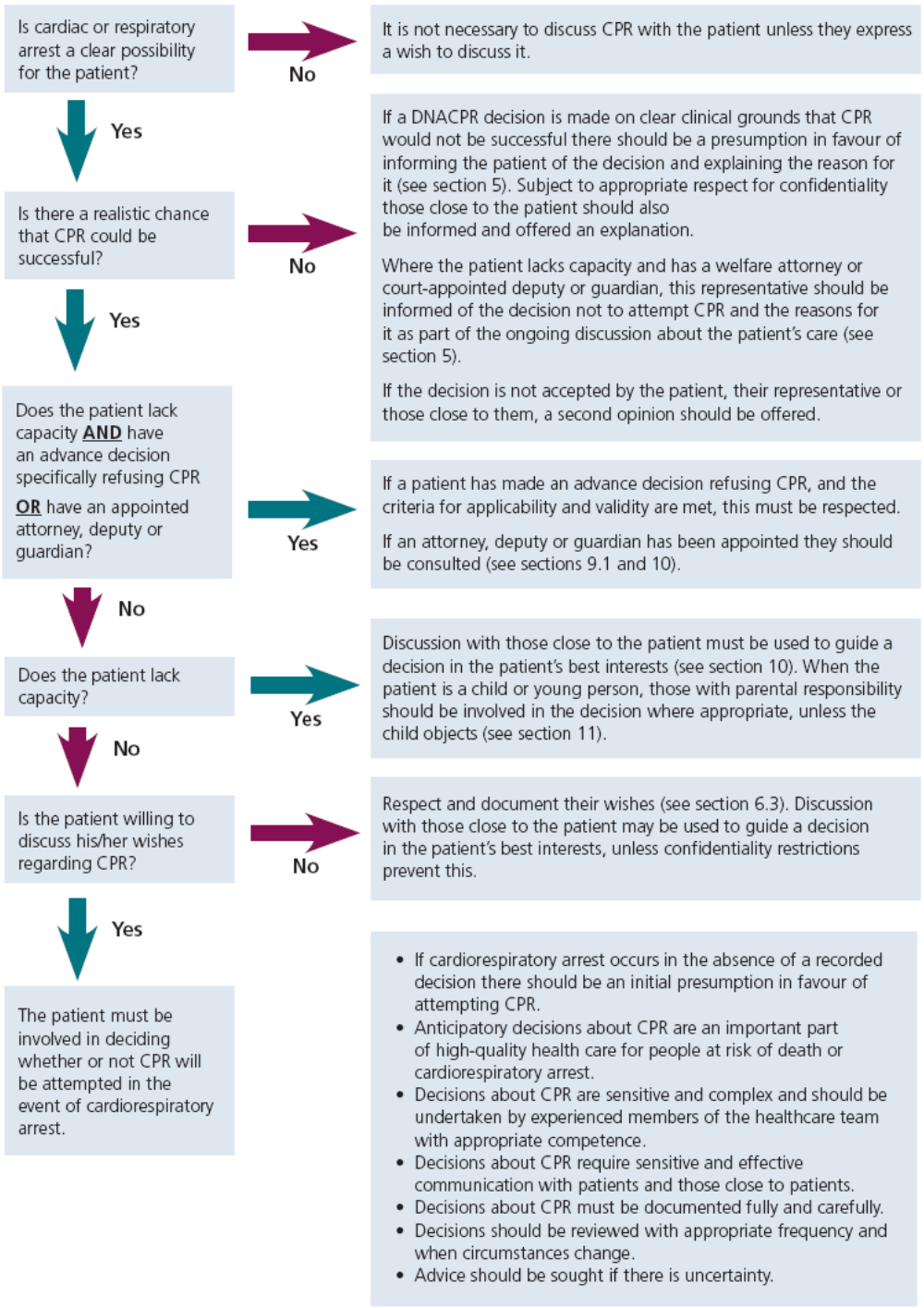
For patients being transferred between different care settings, it is essential that:

1. Where patients are being transferred to community (e.g. home or care home): the DNACPR status and an explanation of the role of the form in an emergency should be communicated to patient (if appropriate) and '*relevant others*'.
2. Send the **original form** with the patient. A photocopy or carbon copy version should be retained in the patient's notes for audit, marked with the words '**COPY**' in large capitals, signed and dated.
3. For discharges to community settings: communicate to the GP, Out of Hours service and any other relevant services as appropriate.

v13 January 2014
Regional Review Date: January 2017
Regional Lead Contact: Palliative Medicine Consultant
Calderdale & Huddersfield NHS Foundation Trust, West Yorkshire

Appendix 3

Decision-making framework



Appendix 4

Ethics Department

Decisions about cardiopulmonary resuscitation

Model patient information leaflet

April 2008

Royal College of Nursing

Resuscitation Council (UK)

BMA

This leaflet explains:

- what cardiopulmonary resuscitation (CPR) is;
- how you will know whether it is relevant to you; and
- how decisions about it are made.

It is a general leaflet for all patients but it may also be useful to your relatives, friends and carers. This leaflet may not answer all your questions about CPR, but it should help you to think about the issue. If you have any other questions, please talk to one of the health professionals (doctors, nurses and others) caring for you.

What is CPR?

Cardiorespiratory arrest means that a person's heart and breathing stop. When this happens, it is sometimes possible to try to restart their heart and breathing with emergency treatment called CPR. CPR might include:

- repeatedly pushing down very firmly on the chest;
- using electric shocks to try to correct the rhythm of the heart; and
- inflating the lungs with a mask or tube inserted into the windpipe.

Is CPR tried on everybody whose heart and breathing stop?

Yes, in an emergency if there is a chance that it will work and the person has not refused CPR. When the heart and breathing stop without warning, for example if a person has a serious injury or heart attack, the healthcare team will try to revive the patient. Some members of the public are also trained to do CPR. The priority is to try to save the person's life.

A person's heart and breathing also stop working as part of the natural and expected process of dying. If people are already very seriously ill and near the end of their life, there may be no benefit in trying to revive them each time their heart and breathing stop. This is particularly true when patients have other things wrong with them that mean they don't have much longer to live. In these cases, re-starting their heart and breathing may do more harm than good by prolonging the pain or suffering of a terminal illness.

Do people get back to normal after CPR?

Each person is different. A few patients make a full recovery, some recover but have health problems and, unfortunately, many attempts at CPR do not restart their heart and breathing despite the best efforts of everyone concerned. It depends on why their heart and breathing stopped working and the patient's general health. It also depends on how quickly their heart and breathing can be restarted.

Patients who are revived are often still very unwell and need more treatment, usually in a coronary care or intensive care unit. Some patients never get back the level of physical or mental health that they enjoyed before the cardiorespiratory arrest. Some have brain damage or go into a coma. Patients with many medical problems are less likely to make a full recovery. The techniques used to try to restart the heart and breathing sometimes cause side effects, for example, bruising, fractured ribs and punctured lungs.

Am I likely to have a cardiorespiratory arrest?

Only your healthcare team can advise you on the likelihood of you having a cardiorespiratory arrest. Even when they have the same symptoms, people respond differently to illness, and planning what will happen if they have a cardiorespiratory arrest is a normal part of providing good care for many patients. Somebody from the healthcare team caring for you, probably the healthcare professional in charge, will talk to you about:

- your illness;
- what you can expect to happen; and
- what can be done to help you.

What is the chance of CPR reviving me if I have a cardiorespiratory arrest?

The chance of CPR reviving you will depend on:

- why your heart and breathing have stopped;
- any illnesses or medical problems you have (or have had in the past); and
- the overall condition of your health.

Attempted CPR in hospital is successful in restarting the heart and breathing, so that about 2 out of 10 patients survive long enough to leave hospital. The figures are much lower for patients with serious underlying conditions. It is important to remember that these only give a general picture and not a definite picture of what you personally can expect. Everybody is different and the healthcare team will explain what CPR could do for you.

Does it matter how old I am or that I have a disability?

No. What is important is:

- your state of health;
- your wishes; and
- the likelihood of the healthcare team being able to achieve what you want.

Your age alone does not affect the decision, nor does the fact that you have a disability.

Will I be asked whether I want CPR?

You and the healthcare professional in charge of your care will decide whether CPR should be attempted if you have a cardiorespiratory arrest. The healthcare team looking after you will look at all the medical issues, including whether CPR is likely to be able to restart your heart and breathing if they stop, and for how long. It is beneficial to attempt resuscitation if it might prolong your life in a way that you can enjoy. Sometimes, however, restarting people's heart and breathing leaves them with a severe disability or prolongs suffering. Prolonging life in these circumstances is not always beneficial. Your wishes are very important in deciding whether resuscitation may benefit you, and the healthcare team will want to know what you think. If you want, your close friends and family can be involved in these discussions.

What if I don't want to decide?

You don't have to talk about CPR if you don't want to, or you can put discussion off if you feel you are being asked to decide too much too quickly. Your family, close friends and carers might be able to help you make a decision you are comfortable with. Otherwise, the healthcare professional in charge of your care will decide, taking account of your wishes.

If you are under 18 (16 in Scotland), your parents can decide for you.

What if I am unable to decide for myself?

England and Wales

Adults can choose somebody to make decisions for them (a 'proxy') if later they cannot make decisions for themselves. If you have not formally chosen a proxy the healthcare professional in charge of your care will make a decision about what is best for you. Your family and friends are not allowed to decide for you but it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be asked about your care, you should let the healthcare team know.

Northern Ireland

The healthcare professional in charge of your care will make a decision about what is best for you. Your family and friends are not allowed to decide for you. But it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be asked about your care, you should let the healthcare team know.

Scotland

Adults can choose somebody to make decisions for them (a 'proxy') by contacting a solicitor if they cannot make decisions for themselves. If you have not formally chosen a proxy the healthcare professional in charge of your care will make a decision about what is best for you. Your family and friends are not allowed to decide for you. But it can be helpful for the healthcare team to talk to them about your wishes. If there are people you do (or do not) want to be asked about your care, you should let the healthcare team know.

I know that I don't want anyone to try to resuscitate me. How can I make sure they don't?

If you don't want CPR, you can refuse it and the healthcare team must follow your wishes. You can make a living will (also called an 'advance decision') to put your wishes in writing. If you have a living will, you must make sure that the healthcare team knows about it and puts a copy of it in your records. You should also let people close to you know so they can tell the healthcare team what you want if they are asked.

If it is decided that CPR won't be attempted, what then?

The healthcare team will continue to give you the best possible care. The healthcare professional in charge of your care will make sure that you, the healthcare team, and the friends and family that you want involved in the decision know and understand the decision. There will be a note in your health records that you are 'not for cardiopulmonary resuscitation'. This is called a 'do-not-attempt-resuscitation' decision, or DNAR decision.

What about other treatment?

A DNAR decision is about CPR **only** and you will receive all the other treatment that you need.

What if I want CPR to be attempted, but the healthcare professional in charge of my care says it won't work?

Although nobody can insist on having treatment that will not work, no healthcare professional would refuse your wish for CPR if there was any real possibility of it working successfully and helping to bring you back to good health. If there is doubt whether CPR might work for you, the healthcare team will arrange a second medical opinion if you would like one. If CPR might restart your heart and breathing, but is likely to leave you severely ill or disabled, your opinion about whether these chances are worth taking is very important. The healthcare team must listen to your opinions and to the people close to you if you want them involved in the discussion. In most cases, healthcare professionals and their patients agree about treatment where there has been good communication.

What if my situation changes?

The healthcare team will review decisions about CPR regularly and especially if your wishes or condition change.

What if I change my mind?

You can change your mind at any time, and talk to any of the healthcare team caring for you.

Can I see what's written about me?

Yes, you can see what's written about you. You can ask the healthcare team to show you your records and, if there is anything in them that you do not understand, they will explain it to you. You also have a legal right to see and have copies of your records.

Who else can I talk to about this?

[Contact information to be added locally. Wherever possible, direct contacts to be given so that the healthcare team is not the "gatekeeper" to further support.

- *Counsellors*
- *Spiritual carers (such as a chaplain)*
- *Independent advocacy services*
- *Patient support groups]*

If you feel that you have not had the chance to have a proper discussion with the healthcare team, or you are not happy with the discussions you have had, please contact … who can help you or the people close to you and deal with your suggestions, worries or complaints.

For further information about this leaflet

BMA members may contact:

***ask*BMA** on 0870 60 60 828 **or**

British Medical Association
Department of Medical Ethics, BMA House
Tavistock Square, London WC1H 9JP
Tel: 020 7383 6286
Fax: 020 7383 6233
Email: ethics@bma.org.uk

Non-members may contact:

British Medical Association
Public Affairs Department, BMA House
Tavistock Square, London WC1H 9JP
Tel: 020 7387 4499
Fax: 020 7383 6400
Email: info.public@bma.org.uk

Royal College of Nursing
20 Cavendish Square
London W1G 0RN
Tel: 020 7409 3333

Resuscitation Council (UK)
5th Floor, Tavistock House North
Tavistock Square, London, WC1H 9HR
Tel: 020 7388 4678
Fax: 020 7383 0773
Email: enquiries@resus.org.uk

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Clarity approved by Plain English Campaign