

<b>Adult Do Not Attempt CardioPulmonary Resuscitation Policy (DNACPR)</b>	<b>Type: Policy</b>  <b>Register No: 05102</b> <b>Status: Public</b>
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Contributes to CQC Core Regulation:	9, 10

Consulted With	Post/Committee/Group	Date
Clive Gibson,	Safeguarding	12.9.16
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## **1.0 Purpose**

- 1.1 The primary goal of healthcare is to benefit patients, by restoring or maintaining their health as far as possible, thereby maximising benefit and minimising harm. If treatment fails, or ceases to benefit the patient, or if an adult patient with capacity has refused treatment, that treatment is no longer justified.
- 1.2 Prolonging a patient's life usually provides a health benefit to that patient. Nevertheless, it is not appropriate to prolong life at all costs with no regard to its quality or to the potential burdens of treatment on the patient. The decision to use any treatment should be based on the balance of risk and benefit to the individual receiving the treatment, and that principle applies as much to cardiopulmonary resuscitation (CPR) as to any other treatment.
- 1.3 Health professionals are aware that decisions about attempting CPR raise very sensitive and potentially distressing issues for patients and those people emotionally close to them.
- 1.4 The guidelines that follow identify the key ethical and legal issues that should inform all these decisions. These basic principles are the same for all patients, in all settings, but differences in clinical and personal circumstances make it essential that all CPR decisions are made on an individual basis.
- 1.5 Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team. Each directorate should ensure that their clinical staff have the training and maintain knowledge and skills to undertake discussions about CPR when needed. Training on 'Do Not Attempt CardioPulmonary Resuscitation' (DNACPR) orders will be delivered in line with the Trust Training Needs Analysis.
- 1.6 This policy must be readily available and understood by all relevant staff and should also be available to the public.
- 1.7 This policy specifically excludes children and young people. Please refer to the Do not resuscitate: Children and Young People Policy.
- 1.8 Mid Essex is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

## **2.0 Responsibilities**

### **2.1 Chief Executive**

The Chief Executive has overall responsibility for ensuring that resources and systems are in place for the management of the risks associated with DNACPR orders.

### **2.2 Chief Medical Officer**

The Chief Medical Officer is responsible for ensuring that resources and mechanisms are in place for the implementation, monitoring and review of this policy.

### 2.3 **Medical Officers**

Individual DNACPR orders are the responsibility of the medical officer in charge of the patient's care, following discussion with the patient or carer and the multidisciplinary team.

### 2.4 **Deteriorating Patient Group (DPG)**

Responsibilities include;

- Ensuring adherence to various national guidelines and standards;
- Formulating and updating Resuscitation and 'DNACPR' policies;
- To review annual audit of DNACPR orders and develop and monitor action plans to address any identified deficiencies.

### 2.5 **Clinical Lead for Resuscitation**

- Will ensure that policy and practice match national standards;
- Will lead the DPG discussions relating to the audit of DNACPR decisions.

### 2.6 **Resuscitation Department**

- To act as advisors to the Trust on DNACPR orders related matters;
- To work with the Clinical Audit Department to carry out an annual audit of DNACPR reporting to the DPG;
- To participate in the National Cardiac Arrest Audit;
- To follow up cardiac arrest calls on a regular basis and identify areas of non compliance with this policy maintaining a log of all incidents and any actions taken.

### 2.7 **Clinical Staff**

- To ensure they comply with this policy;
- And to report any issues relating to this policy to their manager.

## 3.0 **Key Issues**

3.1 Cardiopulmonary resuscitation involves chest compressions, and may include the delivery of high-voltage electric shocks across the chest, attempts to ventilate the lungs and injection of drugs.

3.2 Cardiopulmonary resuscitation was introduced in the 1960's as a treatment that for some people may re-start their heart when they suffer a heart rhythm disturbance when they suffer a sudden cardiac arrest, most commonly a heart attack from which they would otherwise have been expected to make a good recovery

3.3 CPR has become more common in situations other than a sudden cardiac arrest due to a heart attack. This includes circumstances in which people were gravely ill with irreversible disease, and in which attempts to re-start their heart either would not work, subjecting them to violent physical treatment at the end of their life and depriving them of a dignified death, or might restore their heart function for a brief period and possibly subject them to a further period of suffering from their underlying terminal illness.

3.4 It is recognised that whilst there were some circumstances in which CPR could restore a person to a period of what the person considers a worthwhile life, there were other circumstances where attempting to prevent a natural and inevitable death could do harm.

- 3.5 Anticipatory decisions about CPR were recognised as the way to try to ensure that dying people were not subjected to the trauma and indignity of attempted CPR with no realistic prospect of benefit. Similarly the immediacy of response that is needed if CPR is appropriate and is to be successful is the driver for having a clear record made in advance.
- 3.6 It is essential to identify patients for whom cardiopulmonary arrest represents a terminal event in their illness and in whom attempted CPR is inappropriate because it will not be effective.
- 3.7 Decisions about cardiopulmonary resuscitation (CPR) must be made on the basis of an individual assessment of each case. These decisions should never be dictated by 'blanket policies'.
- 3.8 A Do not attempt cardiopulmonary resuscitation order (DNACPR) relates specifically to providing chest compressions, respiratory support, injection of drugs and/or defibrillation in a patient that has undergone a cardiac arrest (their heart is no longer beating) – it does not refer to any other form of medical treatment. A patient may have a DNACPR order but still be for active support up to this point.
- 3.9 CPR decisions should be based on the clinical and personal circumstances of individual patients. Decisions must not be made on the basis of assumptions based solely on factors such as patients' ages, disabilities, or on a professional's personal view of a patient's quality of life.

#### **4.0 Making Resuscitation (CPR) Decisions**

- 4.1 For many people receiving care, in hospital or in the community the likelihood of cardiorespiratory arrest is small and no clinical decision is made in advance of such an event.
- 4.2 If cardiorespiratory arrest is not predicted or reasonably foreseeable in the current circumstances or treatment episode, it is not necessary to initiate discussions about CPR with patients.
- 4.3 However even if the risk of cardiorespiratory arrest is low, clinicians should be prepared to discuss resuscitation (CPR) in an honest and transparent fashion if the patient requests it.
- 4.4 In other cases there is an identifiable high risk of cardiac or respiratory arrest, either because of an
  - a) Underlying incurable condition (such as cancer or advanced heart failure)
  - b) Because of the persons medical history (such as myocardial infarction or stroke)or
  - c) Current clinical condition (such as overwhelming sepsis)
- 4.5 If a high risk of cardiac arrest has been identified it is important to make decisions about CPR in advance of clinical deterioration such that medical and nursing staff can provide care appropriate to the patients needs in the event of clinical deterioration when the senior clinician who is responsible for the patient may not be present.

- 4.6 CPR decisions should only be made by a senior clinical doctor or suitably experienced and trained nurse who is responsible for the clinical care of the patient following a full clinical assessment.
- 4.7 The ultimate responsibility for the decision rests with the most senior clinician responsible for the persons care, however the views of members of the medical and nursing team involved in the patient's care, including those involved in a patient's primary and secondary care, are valuable in forming a decision about the likely clinical effectiveness of attempting CPR and about best interests where the patient lacks capacity to discuss this.
- 4.8 DNACPR decisions can be based solely on medical factors (i.e. CPR would not be successful), or on the balance of benefits and burdens, which involves a broader "best interests" judgement.
- 4.9 If a patient with capacity refuses CPR, or a patient lacking capacity has a valid advance decision refusing CPR, this should be respected.

## **5.0 Decisions not to attempt CPR because it will not be successful**

- 5.1 If the clinical team has good reason to believe that a person is dying as an inevitable result of advanced, irreversible disease or a catastrophic event and that CPR will not re-start the heart and breathing for a sustained period, if there is no realistic prospect of a successful outcome, CPR should not be offered or attempted.
- 5.2 The persons individual circumstances and the most up-to-date evidence and professional guidance must be considered carefully before any CPR decision is made.
- 5.3 The ultimate responsibility for the decision rest with the most senior clinician responsible for the patients care, but there should be:
- Discussion of the decision whenever possible with the other members of the healthcare team to ensure their agreement or consensus;
  - A presumption in favour of explaining the need for and reasons for the decision to the patient or to those representing a patient without capacity.
- 5.4 If cardiac or respiratory arrest is a clear possibility, and if there is a realistic chance that CPR could be successful in restoring the patient to full function, a DNACPR decision will only be appropriate if a patient specifically refuses CPR.
- 5.5 When a patient is in the final stages of an incurable illness and death is expected within a few hours or days, in almost all cases CPR will not be successful. Attempting CPR cannot reverse the patient's underlying condition and in some cases it may prolong or increase suffering.
- 5.6 For people who have a cardiovascular implanted electronic device (CIED), or in particular an implanted cardiac defibrillator (ICD), discussions about CPR towards the end of life should include discussion of deactivation of the shock function of their ICD. This is because as they approach the end of life, the benefit from the device attempting to prolong life may be outweighed by the burdens or repeated shocks from the device
- 5.7 Each decision about CPR should be subject to review based on the persons individual circumstances. In the setting on an acute illness, review should be

sufficiently frequent to allow a change of decision (in either direction) in response to the persons clinical progress or lack thereof. In the setting of end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision.

- 5.8 Decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person's condition or in their expressed wishes. This applies to a decision that CPR is appropriate as well as to a DNACPR decision.
- 5.9 The frequency of review should be determined by the healthcare professional responsible for their care and will be influenced by the clinical circumstances of the patient.
- 5.10 The required frequency of review of CPR decisions may differ greatly between different types of care setting. It may also differ greatly between individual patients within any one-care setting, so the frequency must be based on the needs of the individual patient and not on any blanket policy.
- 5.11 In acutely ill people, review and, when appropriate, revision of decisions about CPR should be as responsive to changes in a patients clinical condition and physiological observations as review and revision of any other aspect of their treatment.
- 5.12 Transfer of the patient to a different location (including transfer within a healthcare establishment) should also trigger a review of the DNAR CPR decision.
- 5.13 Once a DNACPR order has been made, this decision must be communicated effectively to the relevant health professionals.
- 5.14 There may be exceptional cases where a patient has a DNACPR decision in place but cardiac or respiratory arrest occurs in circumstances that do not match those envisaged, and the cause of the arrest is easily reversible, such as choking, anaphylaxis or a blocked tracheostomy. In this situation a DNACPR decision does not override clinical judgement and active management of this acutely reversible problem should occur.

## **6.0 Decisions about CPR that are based on a balance of benefits and burdens**

- 6.1 If CPR may be successful in re-starting the patient's heart and maintaining breathing for a sustained period, the potential benefits of prolonging life must be weighed against the potential harms and burdens of CPR.
- 6.2 This is not solely a clinical decision and for a patient with capacity there should be open dialogue and shared decision-making between the patient and professionals, unless the patient declines any such discussion.
- 6.3 People should be informed sensitively about what CPR involves and its possible risks and adverse effects, as well as its likely chance of success in their specific circumstance, to try to help them to make informed decisions about whether or not they would want it.

- 6.4 Careful explanation will be needed to help them to understand that:
- Cardiopulmonary arrest is part of the final stage of dying
  - CPR is unlikely to be successful when someone is dying from an advanced and irreversible or incurable illness
  - Healthcare professionals may start CPR inappropriately when someone dies unless a DNACPR decision has been made and recorded
- 6.5 Prolonging life is not always beneficial. The courts have confirmed that it is lawful to refrain from an attempt at CPR on the basis that it would not be in a persons best interests.
- 6.6 Some patients may, however, have specific reasons for wanting to try to delay death, even if this is only for a very short period of time. If such a wish is expressed, accurate information must be provided about the likelihood and length of survival that might realistically be expected, and about the potential risks and effects of attempted CPR.
- 6.7 In assessing the potential benefits of attempting to prolong life, it is important to consider whether cardiopulmonary arrest is likely to recur and whether the patient is likely to experience unmanageable or long-term pain or other distressing adverse effects.
- 6.8 If such a wish is expressed, accurate information must be provided about the realistic likelihood, length and quality of survival that might be expected, and about the potential harms and burdens of attempted CPR. The patient should be invited to discuss the risks and benefits of CPR in order to reach an agreed decision on whether or not it should be attempted.
- 6.9 Some patients ask for CPR to be attempted even though the clinical evidence suggests that the harms and burdens are likely to outweigh the possible benefit. Although the healthcare team may doubt whether the risks associated with CPR are justified by a very small chance of success, the individual whose life is at stake may be willing to accept that chance.
- 6.10 Following a realistic and sensitive discussion, if a patient requests that no DNACPR decision be made, this should usually be respected. If they subsequently suffer cardiac or respiratory arrest, further clinical decisions must be made in accordance with the advice in this guidance, taking account of both the clinical situation at the time and the patients wishes.
- 6.11 A clinician cannot be forced to perform any intervention that she or he considers to be harmful or against a person's interest. However clinicians should be willing to consider and discuss people's wishes to receive treatment, even if it offers only a very small chance of success or benefit.
- 6.12 Where attempted CPR has a reasonable chance of successfully re-starting the heart and breathing for a sustained period, and a person has decided that the quality of life that can reasonably be expected is acceptable to them, their wish for CPR should be respected. In the unusual circumstance in which the doctor responsible for a patients care feels unable to agree to their expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, a second opinion should be sought.

- 6.13 Transfer of the patient's care to another doctor or team can be considered if there is still a lack of agreement and it is feasible.
- 6.14 A decision that CPR will not be attempted because the risks outweigh the benefits should be made only after careful consideration of all factors relevant to the patient's current situation, and after discussion with the patient (unless they refuse such discussion) or with those close to patients who lack capacity. These factors include:
- The likelihood of restarting the person's heart and/or breathing for a sustained period.
  - The level of recovery that can be expected realistically after successful CPR
  - The person's known or ascertainable wishes, including information about previously expressed views, feelings, beliefs and values of patients who lack capacity;
  - The patient's human rights, including the right to life and the right to be free from degrading treatment (which may include the right to a dignified death) and the right to respect for a private and family life
  - The likelihood of the person experiencing continuing pain or suffering that they would find intolerable or unacceptable.
  - The level of awareness the person has of their existence and surroundings.
- 6.15 Balancing benefits against harms and burdens in these cases also involves balancing rights under the Human Rights Act 1998. The Act guarantees protection for life (article 2), but also declares that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment" (article 3).
- 6.16 Some people do not wish to be kept alive in a state of total dependency or permanent lack of awareness, or to have an undignified death. If people express such views, healthcare professionals should take these into account when decisions about CPR are being considered.
- 6.17 Clinicians should not attempt to prolong life if it is clear that the person would not want this or would consider the likely outcome unacceptable.
- 6.18 The duty to protect life must be balanced with the obligation not to subject the person to treatment that they would regard as inhuman or degrading.
- 6.19 The fact that a decision has been made to attempt CPR in the event of cardiorespiratory arrest does not mean that all other intensive treatments and procedures will also be appropriate. For example prolonged support for multi-organ failure in an ICU may be clinically inappropriate if the patient is unlikely to survive these other treatments, even though the heart has been re-started.
- 6.20 Some people may have DNACPR order in place but it will be appropriate to admit to a critical care unit for organ support of a reversible condition.
- 6.21 Ineligibility for multi-organ ICU support is not in itself a justification for an automatic DNACPR decision.
- 6.22 Each decision about CPR should be subject to review based on the persons individual circumstances. In the setting on an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the persons clinical progress or lack thereof. In the setting of end-of-life care for a

progressive, irreversible condition there may be little or no need for review of the decision.

- 6.23 Decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person's condition or in their expressed wishes. This applies to a decision that CPR is appropriate as well as to a DNACPR decision.
- 6.24 The frequency of review should be determined by the healthcare professional responsible for their care and will be influenced by the clinical circumstances of the patient.
- 6.25 The required frequency of review of CPR decisions may differ greatly between different types of care setting. It may also differ greatly between individual patients within any one care setting, so the frequency must be based on the needs of the individual patient and not on any blanket policy.
- 6.26 In acutely ill people, review and, when appropriate, revision of decisions about CPR should be as responsive to changes in a patient's clinical condition and physiological observations as review and revision of any other aspect of their treatment.
- 6.27 Transfer of the patient to a different location (including transfer within a healthcare establishment) should also trigger a review of the DNAR CPR decision
- 6.28 Once a DNACPR order has been made, this decision must be communicated effectively to the relevant health professionals.
- 6.29 There may be exceptional cases where a patient has a DNACPR decision in place but cardiac or respiratory arrest occurs in circumstances that do not match those envisaged, and the cause of the arrest is easily reversible, such as choking, anaphylaxis or a blocked tracheostomy. In this situation a DNACPR decision does not override clinical judgement and active management of this acutely reversible condition should occur.

## **7.0 Restricted CPR attempts**

- 7.1 If CPR is to be attempted it should be performed competently.
- 7.2 It is inappropriate to initiate resuscitation and then not to try hard to achieve a successful outcome.
- 7.3 In some clinical settings some clinicians may advocate restriction of CPR to treatment of shockable rhythms only. This can be considered safely only in an environment where there is continuous ECG rhythm monitoring by professionals competent in the immediate, correct recognition of cardiac rhythm.
- 7.4 An advance plan to limit attempted resuscitation to defibrillation alone is not recommended. If a shockable rhythm is not terminated by the first shock from a defibrillator, delivery of effective chest compressions increases the likelihood of successful termination of the arrhythmia by a second or subsequent shock.
- 7.5 If consideration is given to making a plan to restrict the nature or extent of CPR, this must be thought through clearly on the basis of the balance of harms, burdens and

benefits to the individual patient and should be discussed with the patient (or those close to them who lack capacity).

- 7.6 If a restrictive CPR decision is made with or for an individual, the reasons justifying the limitation of CPR must be documented fully in the persons health record, and detailed instructions on how the decision is to be implemented must be recorded by the healthcare professional making the decision. The decision and associated instructions should be communicated effectively to all members of the healthcare team caring for the patient.
- 7.7 Advance decisions about the duration of CPR to be applied in the event of a future cardiorespiratory arrest are inappropriate. The duration of any resuscitation attempt should be decided by those attempting resuscitation, based on the clinical circumstances of the arrest, the progress of the resuscitation attempt and the perceived balance of burdens, risk and benefit from continuing CPR.

## **8.0 Managing the cardiac arrest situation in absence of planning**

- 8.1 Where no explicit clinical decision has been made in advance about the appropriateness or otherwise of attempting CPR, and the express wishes of the patient are unknown and cannot be ascertained, there should be a presumption that health professionals will make all reasonable efforts to attempt to revive the patient in the event of unexpected cardio-respiratory arrest.
- 8.2 In this situation initiating CPR will usually be appropriate, whilst all possible efforts are made to obtain more information to guide further decision-making.
- 8.3 There will be some cases where CPR is started on this basis, but during the resuscitation attempt further information becomes available that makes CPR inappropriate. That information may include a fully documented DNACPR decision, a valid and applicable advance decision to refuse treatment or clinical information that CPR will not be successful. In such circumstances, continuing CPR would be inappropriate.
- 8.4 There will be some people for whom attempting CPR is clearly inappropriate; for example, a person in the advanced stages of a terminal illness where death is imminent and unavoidable and CPR would not be successful, but for whom no formal CPR decision has been made and recorded.
- 8.5 There will be other circumstances where healthcare professionals discover patients with irreversible death – for example, rigor mortis. In such circumstances any healthcare professional who makes a carefully considered decision not to start CPR should be supported by their senior colleagues, employers and professional bodies.
- 8.6 If there is genuine doubt or disagreement about the most appropriate decision, a further senior clinical opinion should be sought.
- ## **9.0 Communication and documentation of DNACPR decisions – when the patient has capacity**
- 9.1 Communication and the provision of information are essential parts of good quality care.

- 9.2 Patients over 16 years of age are presumed to have capacity to make decisions for themselves unless the contrary is proven. For those who lack capacity it is equally important to ensure that decisions are made that comply with the law, in that they are in the best interests of the patient.
- 9.3 Patients have both ethical and legal rights to be involved in decisions that may affect them. When a patient with capacity is at foreseeable risk of cardiac or respiratory arrest, they should be offered information about CPR, about the local resuscitation policy services, and about their role in decision-making in relation to CPR.
- 9.4 In order to determine whether the benefits of CPR would be likely to outweigh the harms and burdens, or whether the level of recovery expected would be acceptable to the patient, there should be sensitive exploration of the patient's wishes, feelings, beliefs and values.
- 9.5 Policies and individual decisions about CPR must comply with the Human Rights Act 1998. In order to meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention.
- 9.6 Provisions particularly relevant to decisions about attempting CPR include articles:
  - a) The right to life (Article 2)
  - b) The right to be free from inhuman or degrading treatment (Article 3)
  - c) The right to respect for privacy and family life (Article 8)
  - d) The right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and
  - e) The right to be free from discriminatory practise in respect of these rights (Article 14)
- 9.7 In considering decisions about treatment in relation to the Act the courts have indicated that the degree of patient involvement required by Article 8 depends on the particular circumstances of the case and notably the nature of the decisions to be taken.
- 9.8 In relation to decisions about CPR the courts have stated that there should be a presumption in favour of patient involvement and that there need to be convincing reasons not to involve the patient.
- 9.9 The patients ability to participate in decision-making may change with changes in their clinical condition. It may not always be necessary to discuss CPR with a patient each time the decision is reviewed.
- 9.10 Where the patient has previously been informed of a decision and it subsequently changes, they should be informed of the change of decision and the reason for it.
- 9.11 Where the decision was a shared decision with the patient (or their welfare attorney), based on a balance of benefits against harms and burdens of CPR, any revision should be a shared decision with the patient (or those close to the patient if the patient has subsequently lost capacity), or where this is not practicable or not appropriate the reasons should be documented clearly.

- 9.12 CPR carries a risk of significant adverse effects, such as sternal fracture, hepatic or splenic rupture, rib fracture or becoming long-term ventilator-dependent, and most patients require treatment in an intensive care unit or a coronary care unit or both in the post-CPR period. In addition, there is a risk that the patient will be left with brain damage and resulting disability. Patients need to be sensitively informed of these risks as part of CPR discussions in order to avoid setting unrealistic expectations.
- 9.13 When it is clear that someone is dying from an advanced, irreversible condition, clinicians must be sensitive to the patients emotional and physical condition and to fluctuations therein. Conversations about DNACPR decisions are often difficult for clinicians and for patients (and those close to or representing patients), but must not be avoided just because they are difficult or because they may cause some unavoidable distress.
- 9.14 Whilst there should be presumption in favour of informing patients of DNACPR decision (made because DNACPR will not be successful) some people make it clear that they do not wish to talk about dying or discuss their end-of-life care, including decisions relating to CPR. When such wishes are expressed they should be respected.
- 9.15 It is poor practise to force CPR discussion of patients who stated clearly that they do not want them.
- 9.16 If a DNACPR decision is made and there has been no discussion with the patient because he or she has indicated a clear desire to avoid such discussion, this must be documented in the health record and the reasons must be recorded. As with any other aspect of care, health professionals must be able to justify their actions.
- 9.17 Any such refusal by a patient to discuss CPR should be documented clearly, together with a plan to ensure that optimal care of the patient is not compromised by that refusal.
- 9.18 In a minority of cases, trying to explain a DNACPR decision for whom CPR will not work will impose an unnecessary burden by causing such distress that the dying person suffers harm, which may be physical or psychological. The reasons for not explaining a decision in such circumstances must be documented fully.
- 9.19 Where a patient or those close to the patient disagree with a DNACPR decision, a second opinion should be offered and all members of the multi disciplinary team should respect this process.
- 9.20 A DNACPR applies only to cardiopulmonary resuscitation. It must be made clear to patients, people close to patients and members of the healthcare team, that it does not apply to any other aspect of treatment, and that all other treatments and care appropriate for the patient, will continue.
- 9.21 Clear and full documentation of decisions relating to CPR, the decision and the discussions that informed these decisions, are an important part of high quality care. Notes should be made in the healthcare record beyond simply completing the DNACPR form.
- 9.22 Health care professionals discussing and communicating CPR decisions to patients, and those close to them, should:

- Offer as much information as is wanted (with due regard for the patients wishes concerning confidentiality)
- Be open and honest
- Use clear, unambiguous language
- Use a combination of verbal discussion and information in printed or other formats
- Provide information in formats which people can understand, this may include the need for an interpreter or easy-to-read formats
- Provide information that is accurate and consistent
- Check understanding
- Where possible, have conversations about decisions in an appropriate environment and allow adequate time for discussion and reflection.

## **10.0 Communication and documentation of DNACPR decisions – when the patient lacks capacity**

- 10.1 Communication and the provision of information are essential parts of good quality care.
- 10.2 Policies and individual decisions about CPR must comply with the Human Rights Act 1998. In order to meet their obligations under the Act, healthcare professionals must be able to show that their decisions are compatible with the human rights set out in the Articles of the Convention.
- 10.3 Provisions particularly relevant to decisions about attempting CPR include articles:
- a) The right to life (Article 2)
  - b) The right to be free from inhuman or degrading treatment (Article 3)
  - c) The right to respect for privacy and family life (Article 8),
  - d) The right to freedom of expression, which includes the right to hold opinions and to receive information (Article 10) and
  - e) The right to be free from discriminatory practise in respect of these rights (Article 14)
- 10.4 Decision-making capacity refers to the everyday ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast, to far-reaching decisions about serious medical treatment, for example CPR. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person themselves or for other people.
- 10.5 Patients over 16 years of age are presumed to have capacity to make decisions themselves unless the contrary is proven. Individuals are, however, considered legally unable to make decisions for themselves where they are unable to:
- Understand the information relevant to the decision;
  - Retain that information;
  - Use or weigh that information as part of the process of making the decisions; or
  - Communicate the decisions whether by talking, using sign language or by other means.
- 10.6 This section explains *who* should be consulted when adults lack capacity and explains the main provisions of the Mental Capacity Act 2005 (England and Wales) and the Adults with Incapacity (Scotland) Act 2000 concerning proxy decision-

makers. Further details are available in the Trust's Mental Capacity Act Policy and the Safeguarding Vulnerable Adults Policy.

- 10.7 **Adults who lack capacity where** there is no welfare attorney or other legal surrogate and They have not made a valid and applicable advance decision refusing CPR – but do have family and/or friends.
- 10.8 Where a patient has not appointed a welfare attorney, had a welfare guardian or deputy appointed or made an advance decision the treatment decision rests with the most senior clinician responsible for the patients care.
- 10.9 The decision as to whether CPR is appropriate must be made on the basis of the patients best interest. A Mental Capacity Act (MCA) 2 form must be filled in on behalf of those patients for significant decisions relating to their on-going care.
- 10.10 Those close to the patient must be consulted about CPR decisions that are made on a balance of benefits and risks, in particular to determine any previously expressed wishes and what level or chance of recovery or risk that patient would have been likely to consider acceptable. However if CPR would not be successful, those close to the patient should be offered explanation of why decisions about CPR are needed, and should be informed of the resulting DNACPR decision and of the reasons for making it in the patients specific circumstances.
- 10.11 These conversations should take place in the context of established and agreed goals of care for the patient.
- 10.12 In England and Wales the Mental Capacity Act requires that best-interests decisions must include seeking the views of anyone named by the patient as someone to be consulted, and anyone engaged in caring for the person or interest in the patients welfare. Under the Act, all healthcare professionals must act in the best interests of a patient who lacks capacity.
- 10.13 Completion of a MCA2 form by the clinician is vital and a priority when a patient does not have capacity to make any decisions regarding their immediate and future treatment and care
- 10.14 It should be made clear to those close to the patient that their role is not to take decisions on behalf of the patient, but to help the healthcare team to make an appropriate decision in the patients best interests. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account in decision-making but that they cannot insist on a treatment or on withholding or withdrawal of treatment.
- 10.15 It is important that a decision about CPR is not delayed inappropriately (and the quality of care for the patient compromised thereby) if it is not practical and appropriate to contact the patients family members, or other carers, immediately to discuss a best interest decision or to have a DNACPR decision explained to them where CPR would not be successful. In this situation the senior healthcare professional responsible for the patients care should:
  - Record fully their reasons for not explaining the decision to those close to the patient at that time
  - Ensure that there is on-going active review of the decision and

- Ensure that those close to the patient are informed at the earliest practicable and appropriate opportunity
- 10.16 The fact that it may be inconvenient or undesirable to inform those close to the patient of a decision at a particular time does not, in itself, meet the threshold for it being not practical or appropriate to inform them.
- 10.17 Great care must be taken when people other than the patient make decisions that involve an element of quality-of-life assessment, because there is a risk that health professionals or those close to the patient may see things from their own perspective and allow their own views and wishes to influence their decision, rather than those of the patient. These considerations should always be undertaken from the patient's perspective.
- 10.18 An important factor is whether the patient (if they had capacity) would regard the level of possible recovery acceptable, taking into account the invasiveness of CPR and its likelihood of success in the individual circumstances under consideration not whether it would be acceptable to the healthcare team or to those close to the patient, nor what they would want if they were in the patients position.
- 10.19 Clinicians should ensure that those close to the patient, who have not been given specific legal authority to make decisions for the patient, understand that their role is to help inform the decision-making process, rather than being the final decision-makers.

### **People with a welfare attorney or court-appointed deputy or guardian**

- 10.20 If a patient lacks capacity and has a personal welfare attorney (also described as an attorney for health and welfare) or a deputy (in England and Wales), it will be necessary to discuss matters relating to CPR with them.
- 10.21 If a patient has a property and affairs attorney (or a person with enduring power of attorney), it may well be that they should be consulted as a person close to the patient, but they do not have the same powers as a personal welfare attorney in relation to decisions about medical treatment. The court of protection may appoint a welfare deputy with similar powers to a welfare attorney, although a deputy does not have the power to refuse life-sustaining treatment.
- 10.22 The aim should be, whenever practical and appropriate, to explain, discuss and agree the intended plan of treatment for the patient, including whether or not to attempt CPR, with the personal welfare attorney or deputy. All reasonable steps should be taken to contact them in order to do that.
- 10.23 If the attorney or deputy is not contactable or not available for consultation and an immediate decision is need to ensure best possible treatment and avoid harm, clinicians have a duty of care to make and record the decision that they believe to be in the patients best interests, based on all available information, and then to consult the attorney or deputy at the earliest practicable time.
- 10.24 Neither welfare attorneys nor deputies can demand treatment that is clinically inappropriate. Where CPR may be able to restart the heart and/or breathing for a sustained period and a decision on whether or not to attempt CPR is based on a balance of benefits and risks, the attorney or deputy must be consulted, unless an

immediate decision is needed and they are not contactable or available for consultation.

- 10.25 A personal welfare attorney is not empowered to make decisions on behalf of a patient regarding whether or not CPR will be attempted, unless their power of attorney document states specifically that the personal welfare attorney has the power to consent to or refuse life-sustaining treatment (which would include CPR). It is likely that in such a case the attorney can make an advance decision the CPR should not be attempted. Such a decision should be recorded on the CPR decision form or equivalent.
- 10.26 If the welfare attorney makes that decision, it is a binding decision that clinicians must respect, unless;
- The circumstances of a cardiorespiratory arrest are not those envisaged when the advance decision about CPR was discussed with and made by the welfare attorney, or
  - The clinician has good reason to believe that the decision made by the welfare attorney was not made on the basis of the patients best interests.
- 10.27 A deputy does not have such a power, nor does any other person close to the patient.
- 10.28 Where there is disagreement between the healthcare team and an appointed welfare attorney or court-appointed guardian about whether CPR should be attempted in the event of cardio-respiratory arrest, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration. More information about welfare attorneys and the Mental Capacity Act can be found in the Mental Capacity Act code of practice.

## **11.0 Revoking DNACPR decisions**

- 11.1 In some circumstances it is necessary to revoke any previously made DNACPR decisions such that the patient is now for cardiopulmonary resuscitation in the event of a cardiac arrest. In this situation the form should be scored through with X 2 lines using black ink and the words CANCELLED written within these lines. This must be signed by the clinician who is changing the DNACPR decision. The form must remain within the medical notes.
- 11.2 The reason for the change in status should be documented clearly in the medical notes and the relevant health care professionals informed.
- 11.3 Patients with capacity should also be informed of this decision as should the relevant parties in individuals who lack capacity.

## **12.0 Non-discrimination**

- 12.1 Any CPR decision must be tailored to the individual circumstances of the patient. It must not be assumed that the same decision will be appropriate for all patients with a particular condition. Decisions must not be made on the basis of assumptions based solely on factors such as the patient's age or disability. Blanket policies which deny CPR to groups of patients, for example to all patients in a hospice or nursing home or to patients above a certain age, are considered unethical and unlawful.

12.2 When assessing whether attempting CPR may benefit the patient, decision-makers must not be unduly influenced by any of their own pre-existing negative views about living with a particular condition or disability. The key issue to consider is not the decision-maker's view of the patient's disability or level of recovery that can reasonably be expected following CPR but an objective assessment of what is in the best interests of the patient.

### **13.0 Requests for CPR in situations where it will not be successful**

13.1 Patients have no legal right to treatment that is clinically inappropriate. Sometimes patient or those close to them will try to demand CPR in a situation where it is clinically inappropriate.

13.2 If the healthcare team has good reason to believe that CPR will not re-start the heart and breathing, this should be explained in a sensitive but unambiguous way.

13.3 This should be undertaken by clinicians with the relevant training and expertise, both in assessing the likely outcome and appropriateness of CPR, and with the relevant communications skills.

13.4 If the patient does not accept the decision a second opinion should be offered, whenever possible.

13.5 If those close to the patient do not accept a DNACPR decision in these circumstances, despite careful explanation, a second opinion should be offered.

13.6 The courts have confirmed that there is no legal obligation to offer to arrange a second opinion in cases where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate.

13.7 Some patients may ask for CPR to be attempted, even if the clinical evidence suggests that in their case there is only a very small chance that it will have a successful outcome. Although the healthcare team may doubt whether the risks and burdens associated with CPR are justified by the very small chance of success, the individual whose life is at stake may be willing to accept that chance. Realistic information must be provided sensitively to patients about the nature of CPR and the likely risks, including the risk of long-term neurological damage, but if patients still ask that no DNACPR decision be made, this should usually be respected. If patients subsequently suffer cardiac or respiratory arrest, further clinical decisions must be made in accordance with the advice in these guidelines.

13.8 These difficult situations are a potential source of confusion. Doctors cannot be required to give treatment contrary to their clinical judgement, but should be willing to consider and discuss patients' wishes to receive treatment, even if it offers only a very small chance of success or benefit. Where attempted CPR has a reasonable chance of successfully restarting the heart and breathing for a sustained period, and patients have decided that the quality of life that can reasonably be expected, is acceptable to them, their wish for CPR to be attempted should be respected.

13.9 In the unusual circumstance in which the doctor responsible for a patient's care feels unable to agree to the patient's expressed wishes for attempted CPR, or where there is lack of agreement within the healthcare team, seeking a second opinion is recommended, so that patients may be given an opportunity to review their decision in the light of further advice.

13.10 Transfer of the patient's care to another doctor or team can be considered if there is still a lack of agreement.

#### **14.0 Refusal of CPR by adults with capacity**

14.1 Patients will not have capacity at the time of suffering cardiac or respiratory arrest but where the possible occurrence of this event can be anticipated, patients may decide in advance that they do not want CPR to be attempted.

14.2 Adults with capacity have the right to refuse any medical treatment, even if that refusal results in their death. Where healthcare teams believe that CPR may be successful in restarting patients' heart and breathing, discussion should take place with the patients to determine their views and wishes regarding CPR.

14.3 If patients decide that they do not wish to have CPR attempted, this should be documented carefully in the hospital records and steps should be taken to ensure that this is communicated appropriately to those who need to know.

14.4 Patients are not obliged to justify their decisions, but health professionals usually wish to discuss the implications of a refusal of treatment with patients in order to ensure that the decision is based on accurate information and not on a misunderstanding; however, they must take care not to pressure patients into accepting treatment that they do not want.

14.5 Some people may be happy for their refusal of CPR simply to be documented in the health record by the healthcare team. In England and Wales, unless these records are signed by patients and the signature is witnessed, they are unlikely to meet the legal criteria for a valid advance decision and so some patients may prefer to make a formal, written advance decision.

14.6 Similarly, if patients are not currently being treated in a healthcare establishment and they wish to ensure that their wishes are respected, they may decide to make a formal, written Advance Decision To Refuse Treatment (ADRT) following the criteria stipulated in the Mental Capacity Act 2005 (England and Wales).

14.7 CPR must not be attempted if it is contrary to a valid and applicable ADRT (in England and Wales) made when the person had capacity.

14.8 in England and Wales advance decisions are covered by the Mental Capacity Act 2005. The Act confirms that an ADRT refusing CPR will be valid, and therefore legally binding on the healthcare team, if:

- The person was 18 years old or over and had capacity when the decision was made
- The decision is in writing, signed and witnessed
- It includes a statement that the advance decision is to apply even if the patients life is at risk
- The advance decision has not been withdrawn
- The person has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- The person has not done anything clearly inconsistent with its terms
- The circumstances that have arisen match those envisaged in the advance decision.

- 14.9 If an ADRT does not meet these criteria but appears to set out a clear indication of the patients wishes, it will not be legally binding but should be taken into consideration in determining the persons best interests.
- 14.10 A tattoo with the words 'Do not resuscitate' or similar does not legally constitute a binding ADRT but should be taken into consideration when assessing a persons previously expressed views and wishes, in order to make a decision in their best interests.
- 14.11 The onus is on patients to ensure that healthcare teams are aware of the existence and content of any advance decision.
- 14.12 The Health Records Service will only accept Living Wills or Advance Directives for patients who have current sets of case notes.
- 14.13 The Health Records Service will not open a set of case notes for no other reason than to file a Living Will.
- 14.14 These documents will be returned to patients if their records are:
- microfilmed;
  - archived at off-site storage;
  - archived in any other archiving system.
- 14.15 The Trust does not guarantee that any Living Will or Advance Directive that is accepted for filing in the patient record will always be available although every effort will be made to ensure its availability.

## **15.0 Assessing validity and applicability**

- 15.1 Although an ADRT is not relevant until a person has lost capacity and may not come to light until a person has lost capacity, there should be a presumption that the individual had capacity when an advance decision was made unless there are grounds to suspect otherwise.
- 15.2 The onus is on patients to ensure that healthcare teams will be made aware of the existence and content of any ADRT. Ensuring that their family and others close to them are fully aware of the existence and location of the ADRT document will help to maximise the likelihood that their instructions are followed.
- 15.3 Health professionals must decide whether the ADRT is applicable to the circumstances that have arisen. Particular care will be needed where advance decisions have not been reviewed or updated for a long time and attention should be given to any relevant clinical developments or changes in the persons personal circumstances since decisions were made.
- 15.4 Where there is genuine doubt about the validity of an ADRT and when time permits, further enquiries should be made and, if necessary an application made to the Court of Protection (in England and Wales), the Sheriff Court (in Scotland) or the High Court (in Northern Ireland) for a judgment. In an emergency situation, where there is no time to investigate further, the presumption should be in favour of attempting CPR where this has a realistic chance of prolonging life.

15.5 If it is agreed that an ADRT is invalid or not applicable, the reasons should be documented.

## **16.0 Children and young people**

Please refer to the Do not resuscitate: Children and Young Adult Policy.

## **17.0 Confidentiality**

17.1 Staff are required to comply with the MEHT Confidentiality Policy and Sharing Patient Information Policy. Further information is available in the NHS Information Sharing: Guidance for Practitioners and Managers.

17.2 If patients have capacity their agreement must always be sought before sharing information including family members. It may also be helpful to ask patients with capacity who they want, or do not want, to be generally involved in decision-making if they become incapacitated (although it should be made clear that unless this person is formally appointed as a welfare attorney their role will be limited to providing information for the health professional who decides about treatment). Refusal by a patient with capacity to allow information to be disclosed to family or friends must be respected and documented clearly within the medical notes.

17.3 There should be clear, accurate and honest communication with the patient and (unless the patient has requested confidentiality) those close to the patient. Their understanding of what has been explained to them should be assessed. Where there is an attorney, deputy, guardian or IMCA involved in the discussions, relevant information should be provided to them to enable them to fulfil their role.

17.4 Where people lack capacity and their views on involving family and friends are not known, doctors may disclose confidential information to those close to the patient where this is necessary to discuss the patients care and make a decision that is in their best interests.

## **18.0 Responsibility for decision-making**

18.1 The overall responsibility for decisions about CPR, including DNACPR decisions, rests with the most senior clinician in charge of the patient's care; this could be a consultant, GP or suitably qualified nurse practitioner. Effective communication is essential to ensure that decisions about CPR are made well and understood by all those involved. All decisions about CPR should be communicated to all those involved in the patient's care.

18.2 Where care is shared, for example between hospital and general practice, or between general practice and a residential facility, the health professionals involved should discuss the issue with each other, and with other members of the healthcare team. There should be shared responsibility for deciding about the likelihood of a successful outcome from CPR, and discussing the subject with the patient or with those close to patients who lack capacity where appropriate. Nevertheless one individual must take charge of ensuring that decisions are made properly, recorded properly and communicated to all those who need to know them, including locum staff.

- 18.3 Wherever possible and appropriate, a decision about CPR should be agreed with the whole healthcare team. Teamwork and good communication are of crucial importance in the delivery of high-quality care.
- 18.4 If there is doubt or disagreement about the most appropriate decision, a second opinion should be sought.
- 18.5 The GMC advises “ a second opinion should be from a senior clinician with experience of the patient’s condition but who is not directly involved in the patients care. It should be based on an examination of the patient by the clinician”.
- 18.6 Where a DNACPR decision is made because there is no realistic chance that CPR will be successful, there is no legal obligation to offer a second opinion, especially in cases where the patient is being advised and treated by a multi-disciplinary team all of whom take the view that a DNACPR decision is appropriate. Nevertheless, if the patient or those close to the patient do not accept a DNACPR decision, a second opinion should be offered, wherever possible, in the course of good practise.
- 18.7 Unless a CPR decision form documents the presence of a valid ADRT, refusing CPR and applicable to the circumstances encountered by the attending team, the decision on a CPR decision form is not legally binding. It should be regarded as a clinical assessment, recorded to try to guide immediate clinical decision-making in the event of a patients death or cardio-respiratory arrest. The final decision regarding the application of the CPR decision in an emergency rests with the healthcare professionals dealing with the patient in the emergency situation.

## **19.0 Recording decisions**

- 19.1 Any decision about whether or not to attempt CPR must be recorded clearly in the patients current health records and should be immediately accessible to all health professionals who may need to know it.
- 19.2 The health record should contain clear documentation of the decision, and sufficient detail to allow a healthcare professional facing an emergency situation to assess quickly and easily the basis on which the decision was made, the people involved (including the patient and if not, reasons why not), and others who have been informed of the decision.
- 19.3 NHS East of England have developed a model form which is included in Appendix 2 and should be completed for each DNACPR decision. The form is in triplicate, with the top copy staying with the patient, the second copy remaining in the notes and the third copy sent to the resuscitation department for audit purposes. It should be filed in the patient’s health record behind the patient demographic sheet and should be readily accessible.
- 19.4 The DNACPR form should be countersigned within 24hrs by the lead clinician responsible for the patients care.
- 19.5 In the event of a DNACPR form being signed, the clinician is responsible for ensuring that:
- an ALERT sticker is placed on the front of the patient’s record;
  - the ALERT section is completed on the inside front cover of the record indicating the nature of the ALERT;

- the DNACPR form is filed in the front of the records behind the patient demographic sheet.

19.6 When a CPR decision form is transferred with a patient, this fact should be documented in the health record.

## **20.0 Communicating decisions to other health care providers**

20.1 The person who makes the DNACPR decision is responsible for ensuring that the decision is communicated effectively to other relevant health professionals in both primary and secondary care.

20.2 Any decisions about CPR should be communicated between health professionals whenever a patient is transferred to another establishment or discharged home from a healthcare establishment. Clinical guidelines issued by the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) advise ambulance staff that they should always initiate CPR unless:

- There is a formal DNACPR decision, or valid and applicable advance decision made by the patient, in place which has been seen by the ambulance crew, and the circumstances in which CPR may be attempted are consistent with the wording of the DNACPR decision or advance decision; or
- The patient is known to be terminally ill and is being transferred to a palliative or terminal care facility (unless specific instructions have been received that CPR should be attempted).

20.3 In order that ambulance staff can comply with these guidelines, they must be notified of the patient's CPR status and receive the necessary documentation, before the journey commences.

20.4 The GMC places a professional obligation on doctors to follow agreed systems and ensure good communication

- "You should check the handover arrangements where you work, and use the available systems and arrangements for information storage and exchange, to ensure that the agreed care plan is shared within the healthcare team, with both paid and unpaid carers outside the team and with other healthcare professionals involved in providing the patients care".

20.5 The NMC places a professional obligation on nurses and midwives:

- "You must keep your colleagues informed when you are sharing the care of others" and
- "You have a duty to communicate fully and effectively with your colleagues ensuring that they have all the information they need about the people in their care".

20.6 Where a CPR decision has been recorded on paper form that is recognised and accepted by other healthcare providers it is recommended that the form travels with the patient, to ensure continuity. However this requires particular care to make certain that the patient is aware of, understands and accepts the continuing CPR decision and the reasons for it.

## **21.0 Monitoring Compliance**

- 21.1 Documentation of DNACPR decisions will be subject to regular yearly clinical audit. This will be undertaken on an annual basis by the Resuscitation Department with the support of the Clinical Audit Team.
- 21.2 All DNACPR orders in place on each ward will be reviewed on a given day to assess compliance.
- 21.3 The findings of the audit will be reported to the DPG for review and approval. Where deficiencies are identified, the DPG will approve an action plan with identified leads and timescales and monitor progress with implementation at subsequent meetings.
- 21.4 The key findings of the report will be disseminated to the Patient Safety Group via the Integrated Learning report and to all staff via the electronic newsletter.
- 21.5 The report will be distributed to the Chief Medical Officer and Clinical Directors. Where local actions are indicated, progress will be monitored at Directorate Governance meetings.

## **22.0 Policy review**

This policy will be reviewed at three yearly intervals or sooner in response to issues identified as a result of local or national initiatives.

## **23.0 Communication and Implementation**

- 23.1 The policy will be uploaded on the Trust Intranet site and website.
- 23.2 The policy will be circulated to Clinical Directors to disseminate within their areas of responsibilities.

## **24.0 References**

Decisions relating to Cardiopulmonary Resuscitation (3<sup>rd</sup> edition, 1<sup>st</sup> revision) Guidance from the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing (previously known as the joint statement).

The BMA produces detailed guidance on patients' statutory rights of access to their health records. British Medical Association. Access to health records by patients. London: BMA, 2000.

NHS Information Sharing: Guidance for Practitioners and Managers. Available at: <http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf>

Department for Constitutional Affairs. Mental Capacity Act 2005 Code of Practice. London: TSO, 2007.

The Scottish Executive has published five codes of practice, training materials, public information leaflets and other guidance to assist with the implementation and operation of the Adults with Incapacity (Scotland) Act 2000. See [www.scotland.gov.uk/justice/incapacity](http://www.scotland.gov.uk/justice/incapacity) (accessed 6 July 2007).

The BMA has separate guidance on parental responsibility available at [www.bma.org.uk/ap.nsf/Content/Parental](http://www.bma.org.uk/ap.nsf/Content/Parental) (accessed 6 July 2007).

Information about significant legal developments relevant to these guidelines will be made available on the BMA's website at [www.bma.org.uk/ethics](http://www.bma.org.uk/ethics).

Joint Royal Colleges Ambulance Liaison Committee. UK Ambulance Service Clinical Practice Guidelines. London: JRCALC, 2006.

British Medical Association. Withholding or withdrawing life-prolonging medical treatment (3<sup>rd</sup> ed). London: Blackwell Publishing, 2007.

General Medical Council, Treatment and Care towards the end of life; good practise in decision making

### Other published guidance

British Medical Association. Decisions relating to cardiopulmonary resuscitation. October 2014.

Medical Ethics Department

British Medical Association

BMA House, Tavistock Square, London WC1H 9JP

Telephone: 020 7383 6286, Fax: 020 7383 6233

Email – [ethics@bma.org.uk](mailto:ethics@bma.org.uk), Internet: [www.bma.org.uk/ethics](http://www.bma.org.uk/ethics) - go there

General Medical Council. Seeking patients' consent: The ethical considerations. London: GMC, 1998.

General Medical Council

Regent's Place, 350 Euston Road, London NW1 3JN.

Telephone: 0845 357 3456

Email - [gmc@gmc-uk.org](mailto:gmc@gmc-uk.org), Internet: [www.gmc-uk.org](http://www.gmc-uk.org) - go there

Joint Working Party between the National Council for Hospice and Specialist Palliative Care Services and the Ethics Committee of the Association for Palliative Medicine of Great Britain and Ireland. Ethical decision-making in palliative care: cardio-respiratory resuscitation (CPR) for people who are terminally ill. London: National Council for Hospice and Palliative Care Services, August 1997 (available at the Council's website: [www.ncpc.org.uk](http://www.ncpc.org.uk) - go there).

National Council for Hospice and Specialist Palliative Care Services

First Floor, 34-44 Britannia Street, London WC1X 9JG

Telephone: 020 7520 8299, Fax: 020 7520 8298

Resuscitation Council (UK). Resuscitation guidelines 2015. London: Resuscitation Council (UK), 2005.

Resuscitation Council (UK)

Tavistock House North, Tavistock Square, London WC1H 9HR

Telephone: 020 7388 4678, Fax: 020 7383 0773

Email - [Enquiries@resus.org.uk](mailto:Enquiries@resus.org.uk), Internet: [www.resus.org.uk/](http://www.resus.org.uk/) - go there

Royal College of Paediatrics and Child Health, Royal College of Obstetricians and Gynaecologists. Resuscitation of babies at birth. London: BMJ Publishing Group, 1997 (under revision)

Royal College of Paediatrics and Child Health

50 Hallam Street, London W1W 6DE

Telephone: 020 7307 5600, Fax: 020 7307 5601

Email - [Enquiries@rcpch.ac.uk](mailto:Enquiries@rcpch.ac.uk), Internet [www.rcpch.ac.uk/rcpch/](http://www.rcpch.ac.uk/rcpch/) - go there

DNACPR form and decision making framework

**Appendix 2**



Proof.pdf

Appendix 3 Monitoring Tool

**Document Name:** Dr Katherine Rowe  
**Document owner:** Adult Do Not Attempt CardioPulmonary Resuscitation policy  
**October 2018**  
**NHSLA: 4.8**

**Policy Number:** 05102  
**Date of Review:**

Element to be monitored	Lead	Method / Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s) may include:	Change in practice and lessons to be shared
Duties	Lead Clinician, Resuscitation	Ongoing & review following audit of DNACPR and Cardiac Arrest	Ongoing	Any identified issues reported to DPG	Chief Medical Officer Clinical Directors Resuscitation Team	Required changes in practice will be identified and actioned within a specified timeframe and lessons will be shared
Documentation of DNACPR orders	Lead Clinician, Resuscitation	DNACPR audit tool to assess compliance with key criteria.	Annually	Deteriorating Patient Group Patient Safety Group via Integrated Learning report Chief Medical Officer Clinical Directors	DPG to develop, approve and monitor progress with action plan to address any deficiencies.  Those responsible for acting on recommendations may include: <ul style="list-style-type: none"> <li>• Chief Medical Officer</li> <li>• Clinical Directors</li> <li>• Resuscitation Team</li> <li>• Others as indicated</li> </ul>	