Do not attempt Cardiopulmonary Resuscitation Policy (DNACPR) 2014

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Version History:

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<td>V1.0</td>
<td>07/2014</td>
<td>Dr Jim Crawfurd</td>
<td>To update existing DNACPR guidance included in the Resuscitation Policy and to set it out as a stand-alone DNACPR Policy</td>
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EXECUTIVE SUMMARY

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions can be difficult for patients, their relatives/ carers, and for clinical staff. This Policy brings together guidance from a number of national organisations and legal rulings, to provide robust, patient-centred direction for the Trust and its staff with regard to DNACPR decision making.

The Policy is intended primarily for JPUH staff, but in keeping with the Trust values of openness and transparency, it will be made available to patients and the general public through the Trust's website.

Good communication with patients and those close to them is essential when DNACPR decisions are being made and discussed, and the Policy aims to make this very clear. This Policy refers only to DNACPR decisions. There is a separate Trust Resuscitation Policy which covers issues pertaining to the provision and delivery of active CPR within the Trust.


The JPUH guidelines are also consistent with the East of England unified regional guidelines (www.eoe.nhs.uk/dnacpr):

- it is essential to identify (a) patients for whom cardiopulmonary arrest is an anticipated terminal event and in whom cardiopulmonary resuscitation (CPR) is inappropriate; and (b) patients who do not want to be treated with CPR;
- all institutions should ensure that there is a clear and explicit resuscitation plan for all patients. For some patients this will involve a DNACPR decision;
- where there is no resuscitation plan and the wishes of the patient are unknown, resuscitation should be initiated if cardiopulmonary arrest occurs. However, a decision not to attempt resuscitation may be appropriate when the patient’s condition indicates that CPR is unlikely to be successful, or CPR is not in accord with an applicable Advanced Decision or successful CPR is likely to be followed by a length and quality of life that is not in the best interests of the patient.

This Policy is also in keeping with the Court of Appeal Ruling in the case of Tracey vs Cambridge University Hospitals NHS Foundation Trust and others (http://www.judiciary.gov.uk/wp-content/uploads/2014/06/tracey-approved.pdf) and the subsequent Resus Council (UK) statement on the case (https://www.resus.org.uk/pages/Statements/Statement_Tracey_judgement.pdf)

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1 It is recommended that if there is any doubt about the clarity of an Advanced Decision for a particular patient that it should be discussed with the organisation’s ethics committee / Senior Resuscitation Officer / Chair of Resuscitation Committee / Legal advisor as they can be both ethically and legally complex
Title: Do Not Attempt Cardiopulmonary Resuscitation Policy
Author: Jim Crawfurd, Resuscitation Committee Chair
Issue: September 2014
Next Review: September 2017
Ref: POL/TWD/RES/JC2207/01
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1.0 Introduction

1.1 Background
Many patients admitted to hospital, especially emergency admissions, are at risk of suffering a cardiac arrest. In some circumstances, clinical staff may try to re-start the patient’s heart and breathing following cardiac arrest, a process known as cardiopulmonary resuscitation (CPR). However only around 20% of patients undergoing CPR will survive to discharge from hospital, and many of those that do will be left in a very dependent state. The chances of survival following cardiac arrest are much lower than 20% in patients who are frail, very elderly or have multiple medical problems. CPR may result in rib fractures and witnessing CPR can be distressing for relatives and other patients. Inappropriate attempts at CPR deny patients and their relatives the opportunity for a peaceful, natural end of life.

The Trust has a duty to ensure that high quality CPR is available to those patients who would potentially benefit from it, which is covered in the Trust Resuscitation Policy.

However the Trust also has a duty to ensure that CPR is not forced on those who would not benefit from it or who would not wish to have it.

This Policy lays out the process by which the Trust will ensure that this duty is carried out in an appropriate, patient-centred and sensitive manner, and how the Trust will monitor compliance with this Policy.

1.2 Scope
This Policy applies to all registered Doctors, Nursing staff, Theatre Practitioners, Allied Health Care Professionals and staff deployed within clinical areas of the James Paget University Hospitals NHS Foundation Trust. The aim of the Policy is to describe the correct process for making, documenting and implementing DNACPR decisions.

In the interests of honesty and transparency, it will be made available to patients and members of the public through the Trust website, and has been written with this in mind.

1.3 Responsibilities
The Trust Resuscitation Committee, in conjunction with the Trust Resuscitation Officers, will be responsible for implementing this Policy, training and updating staff, and monitoring compliance.

1.4 Monitoring and Review
All DNACPR forms are subject to continuous audit by the Resuscitation Department, as well as monitoring on the wards. The success of the Policy will be judged by the proportion of DNACPR forms which are correctly completed and provide evidence of good practice as laid out in this Policy.

1.5 Related Policies
The Policy is also consistent with the East of England unified regional guidelines (www.eoe.nhs.uk/dnacpr):

- it is essential to identify (a) patients for whom cardiopulmonary arrest is an anticipated terminal event and in whom cardiopulmonary resuscitation (CPR) is inappropriate; and (b) patients who do not want to be treated with CPR;
- all institutions should ensure that there is a clear and explicit resuscitation plan for all patients. For some patients this will involve a DNACPR decision;
- where there is no resuscitation plan and the wishes of the patient are unknown, resuscitation should be initiated if cardiopulmonary arrest occurs. However, a decision not to attempt resuscitation may be appropriate when the patient’s condition indicates that CPR is unlikely to be successful, or CPR is not in accord with an applicable Advanced Decision\(^2\) or successful CPR is likely to be followed by a length and quality of life that is not in the best interests of the patient.

This Policy is also in keeping with the Court of Appeal Ruling in the case of Tracey vs Cambridge University Hospitals NHS Foundation Trust and others (http://www.judiciary.gov.uk/wp-content/uploads/2014/06/tracey-approved.pdf) and the subsequent Resus Council (UK) statement on the case (https://www.resus.org.uk/pages/Statements/Statement_Tracey_judgement.pdf)

This Policy should be read in conjunction with the Trust Resuscitation Policy and the Mental Capacity Act 2010

1.6 Reader Panel
The following formed the Reader Panel that reviewed this document:

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<tr>
<td>Dr A De Silva Director of Quality, Safety and Care</td>
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<td>Dr J Crawfurd Consultant A&amp;E Chair of Resuscitation Committee.</td>
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<td>Dr B Auger, Consultant in Palliative Care</td>
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<td>Dr D Millican Consultant Anaesthetist</td>
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<td>Pam Cushing Senior Resuscitation Officer</td>
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<td>Director of Nursing Liz Libiszewski</td>
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<td>Deputy Director of Nursing Julia Hunt</td>
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<td>Lead Nurse Jacky Copping</td>
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<td>Medical Director Mr Nick Oligbo</td>
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1.7 Trust Values
This Policy conforms to the Trust’s values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

\(^2\) It is recommended that if there is any doubt about the clarity of an Advanced Decision for a particular patient that it should be discussed with the organisation’s ethics committee / Senior Resuscitation Officer / Chair of Resuscitation Committee / Legal advisor as they can be both ethically and legally complex
1.8 Glossary
The following terms and abbreviations have been used within this Policy:

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<thead>
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<th>Term</th>
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<td>AD</td>
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<td>Basic Life Support</td>
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<td>CEAG</td>
<td>Clinical Ethics Advisory Group</td>
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<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
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<td>DNACPR</td>
<td>Do Not Attempt Cardiopulmonary Resuscitation</td>
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<td>FY2</td>
<td>Foundation Year 2 Doctor</td>
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<td>HCP</td>
<td>Health Care Professional</td>
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<td>NCAA</td>
<td>National Cardiac Arrest Audit</td>
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<td>TNA</td>
<td>Training Needs Analysis</td>
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1.9 Distribution Control
Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet and will also be made available to patients and public through the Trust’s public website.

2.0 Statement of Policy
CPR should be attempted for any person suffering a cardiac and/or respiratory arrest unless there is a clear, written directive to the contrary.
This Policy describes the process that should be followed when considering whether such a directive (a DNACPR decision) should be made, the discussions that should take place with patients and those close to them, and the documentation and communication that should accompany those discussions and the subsequent decision. It also describes the measures the Trust will take to monitor compliance with this process.

2.1 Policy Objectives
The overall objective of this Policy is to ensure all staff are aware of the Trust position with regard to DNACPR decisions and processes, and to guide them through the process.
3.0 Policy Details

The overall responsibility for decision about DNACPR orders rests with the Consultant in charge of the patient’s care.

Adherence to the Mental Capacity Act (2005) which came into force on 1st April 2007 is a legal requirement and should always be referred to when considering DNACPR orders and Advanced Decisions.

CPR should be attempted for any person suffering a cardiac and/or respiratory arrest unless there is a clear, written directive to the contrary.

If staff are absolutely certain that CPR would not be appropriate (e.g. rigor mortis or a terminally ill patient whose death is expected but the DNACPR directive cannot be found) then they may make a considered decision not to start CPR even in the absence of such a directive, but they must be prepared to justify this decision. Such “instant decisions” should be rare and would usually be made only by senior clinicians.

A “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) directive applies solely to cardio-pulmonary resuscitation and should not influence the continued management or care of the patient. It is clearly stated on the DNACPR directive that “all other appropriate treatment and care will be provided”.

The rights of the patient are central to any decision-making regarding resuscitation.

Individual circumstances and up-to-date guidance must be considered carefully before such a decision is made. If a patient with capacity refuses CPR or a patient lacking capacity has a valid and applicable advance decision refusing CPR, this should be respected.

Advice and support can be sought through the Resuscitation Service or the Clinical Ethics Advisory Group (CEAG) or the Trust’s Solicitors via the Risk and Governance Department. In an emergency, advice should be sought from the patient’s consultant in the first instance, and escalated to the on-call Executive if necessary.

A flowchart (taken from the Resus Council and East of England guidance) outlining the CPR decision making process is included in Appendix B and provides clinicians with a useful “quick reference” summary.

3.1 “For CPR” decisions

The default position is that all patients should be “for CPR” unless there is a clear, written directive to the contrary. Where clinical staff feel that CPR would be appropriate and in a patient’s best interests, then the patient will be “for CPR”, unless the patient requests otherwise. As this is a standard part of active medical treatment it is not usually appropriate or necessary to initiate discussion of CPR status with the patient in these circumstances. However, if a patient with capacity (or the legally appointed healthcare power of attorney (proxy) of a patient without capacity) wishes to discuss CPR status then the clinical team should provide whatever information the patient seeks and have a sensitive discussion with the patient (or proxy), exploring their wishes and beliefs. If a fully informed patient with capacity (or the legal proxy of a patient without capacity), after such a discussion, declares a clear wish to refuse CPR even if clinical staff believe it would be appropriate, then the patient’s wishes should be respected and a DNACPR form completed and placed in the Temporary Health Care File (in-patient Hospital Notes folder).
3.2 In circumstances where CPR would be unsuccessful
Where there is no prospect of restoring heartbeat and breathing for any sustainable period, then the national and regional guidance is consistently clear that CPR should not be attempted or offered. In such circumstances a DNACPR form should be completed, stating clearly that CPR would be unsuccessful. In these circumstances it may not be appropriate to seek the patient’s views or wishes regarding CPR, given that it would not be successful and therefore should not be attempted. The clinical team should however sensitively explain the decision to the patient as part of the wider discussion of the patient’s condition and prognosis, and document this on the DNACPR form. If the patient does not accept the explanation that CPR would be unsuccessful then a second opinion should be offered and arranged in a timely manner. (see Section 3.6)

For some patients, particularly those at the end of life, discussions regarding non-treatment may be distressing. However the Court of Appeal ruling in the Tracey vs Cambridge University Hospitals and others case makes it clear that the clinical team have a duty to inform the patient of a DNACPR decision unless doing so would cause “physical or psychological harm” to the patient, and that avoiding “distress” is not a valid reason for not informing the patient. This should be done sensitively, and if the patient makes it clear that they do not want to talk about it any further then this should be respected and documented. In the very rare circumstance that the clinical team feel it would cause actual harm to inform the patient of a DNACPR decision then the clinical team should give careful consideration to informing the patient’s family of the DNACPR decision, provided that the patient has given consent for the clinical team to discuss their clinical information and treatment with them. If the patient has withheld consent for medical staff to discuss their clinical information with the family or those close to them then this must be documented on the DNACPR directive.

Where a patient lacks capacity, the clinical team MUST inform the patient’s healthcare power of attorney (if one has been appointed) or their next of kin or those close to the patient when a DNACPR decision is made on the grounds that CPR would not be successful. Again, this should occur as part of a sensitive discussion of the patient’s overall prognosis and treatment, and the conversation must be documented on the DNACPR form. If the healthcare power of attorney or next of kin/those close to the patient disagree with the decision then a second opinion should be offered and arranged in a timely manner.(see Section 3.6)

3.3 In circumstances where CPR might be successful but may not be in the patient’s best interests
Whilst CPR may restore heartbeat and breathing for a sustainable period in around 40% of those who receive it, the underlying cause of the cardiac arrest will remain, and many patients will suffer neurological damage as a result of the cardiac arrest. Only around 20% of patients receiving CPR following a cardiac arrest will survive to hospital discharge, and the majority of these will not regain their previous level of independence or neurological function. Some patients may survive as a result of CPR, but be left in a comatose or completely dependent state.

In some circumstances, the clinical team treating a patient may believe that CPR might be successful in restoring a patient’s heartbeat and breathing but may feel that the resultant quality of life would not be acceptable to the patient. In such circumstances, the views of the patient are absolutely essential, as only the patient themselves can decide what they would consider to be an “acceptable quality of life”.

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Author: Jim Crawfurd, Resuscitation Committee Chair
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Where such a “best interests” decision is being considered, the clinical team must sensitively explore the issues with the patient and ascertain what their views are. The patient should be given as much information as they would like, including an accurate assessment of the likely outcome of a CPR attempt and any doubts whether the burdens and risks of CPR interventions would outweigh the benefits.

In the vast majority of cases, patients tend to reach the same conclusion regarding CPR as their clinical care team.

In a small percentage of cases, even after being given full information and realistic advice on likely outcomes, a patient may express a wish to receive CPR even where the clinical team feel it would lead to a very poor outcome. Such a wish should usually be respected, but the clinical team may seek a second opinion if they disagree with the patient’s decision.

If the patient lacks capacity and a “best interests” DNACPR decision is being considered then the clinical team MUST seek to establish the patient’s views from those close to the patient.

Where the patient has a legally appointed Healthcare Power of Attorney, then the clinical team must involve them in any decision regarding CPR, as they have the authority to make decisions for the patient. The existence of a Healthcare Power of Attorney may be apparent in the patient’s medical records, or may be related to staff by the patient themselves or those close to the patient. If it is not clear whether such a Power of Attorney exists, staff should actively contact the patient’s next of kin to find out.

In the absence of such a legally appointed proxy, the clinical team should sensitively seek to establish what the patient’s views would be by speaking to the patient’s next of kin or others close to the patient. It should be made absolutely clear that these people are not being asked to make a decision for the patient, but to represent the patient’s views so that the clinical team can make an informed decision. The responsibility for making a decision remains with the clinical team.

The discussion with the patient, or those close to them, should be documented on the DNACPR form (or in the clinical notes if the outcome of discussion is a “for CPR” decision) and the rationale for the decision clearly documented.

In a small percentage of cases, even after being given full information and realistic advice on likely outcomes, the Healthcare Power of Attorney or those close to the patient may feel strongly that the patient would wish to receive CPR even where the clinical team feel it would lead to a very poor outcome. Such a wish should usually be respected, but the clinical team may seek a second opinion if they feel this is genuinely not in the patient’s best interests. This should be documented.

3.4 Communicating DNACPR decisions to those close to the patient
For patients who lack capacity, any DNACPR decision must be communicated to their Healthcare Power of Attorney or next of kin or those close to the patient. This paragraph describes the process for communicating DNACPR decisions to relatives of patients who DO have capacity.

It is normal for relatives and close friends of patients to want to be aware of important decisions that are made about their care, and CPR decisions are no exception to this. However standard principles of confidentiality apply, and the patient’s consent should be
sought before informing family members or others close to the patient of any DNACPR discussions. If a patient asks that their family or anyone close to them be involved in the discussions, then this should be accommodated. Where the family or others close to the patient have not been involved in the discussions between the patient and the clinical team, you should seek the patient's agreement to share the DNACPR information with family members, close friends or carers at the earliest opportunity following a DNACPR decision. It may be appropriate for the patient to tell family members or others themselves, if they are happy to do so, with support of the clinical team if desired. Alternatively, if the patient would prefer the clinical team to talk to the family or others close to them on their behalf, then this should be arranged. The decision as to who will inform those close to the patient, and the record of that discussion, should be recorded on the DNACPR directive.

A minority of patients may express a wish for their family or others close to them not to be informed of a DNACPR decision. In such circumstances, the patient's views should be explored and clinical staff should offer to help the patient broach the subject with the family or others close to them. If, despite this, a competent patient is clear that they do not wish their family or others close to them to be told of the DNACPR decision, then the clinical staff must respect the patient’s right to confidentiality and the patient’s decision should be clearly documented on the DNACPR form and communicated to all members of the clinical team.

3.5 Temporary Suspension of DNACPR decisions

In certain circumstances patients with a “DNACPR” directive may have specific interventions appropriate to their care that carry a risk of cardiac arrest i.e. induction of anaesthesia, anaphylaxis or other procedure which may precipitate a cardiac arrest. In such circumstances, cardiac arrest may be more easily and rapidly reversed than a “natural” cardiac arrest. In these situations it may be appropriate to revoke the decision unless the patient has specifically refused intervention in these circumstances. This should be discussed with the patient (and/or legal proxy or family/carers as appropriate). The time at which the decision is reinstated should be discussed, agreed and documented. The Royal College of Anaesthetists provides guidance on this matter for patients undergoing anaesthesia. Where a decision is temporarily revoked, this should be documented on the DNACPR form and communicated to all staff involved during that episode of care. When the decision is re-instated, this should again be clearly documented on the DNACPR form and communicated to the staff taking over patient care.

3.6 Second Opinions

In the rare event of there being an irreconcilable disagreement over CPR status between the clinical team and the patient (or the Healthcare Power of Attorney or next of kin or others close to a patient who lacks capacity), then a second opinion should be sought.

If a DNACPR decision is challenged by a patient or those close to the patient, the DNACPR decision should be temporarily suspended until a second opinion has been obtained, and this must be very clearly marked on the DNACPR form by writing “Suspended pending second opinion” in large letters diagonally across the form.

The second opinion should be provided in a timely manner by an experienced clinician (usually a Consultant) with a full understanding of the clinical and ethical considerations of providing CPR. Suitable individuals might include ICU Consultants, senior physicians and members of the Resuscitation Committee. The Resuscitation Officers and/or resuscitation committee chair should be approached when a second opinion is required and will assist in the process.
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION POLICY

The outcome of the second opinion will determine whether the DNACPR decision is annulled (by marking “VOID” in large clear letters across the form) or reinstated (in which case a new form will need to be completed).

In the event that disagreement is not resolved by the second opinion, then the matter should be escalated to the Medical Director to provide a third opinion. Again, the decision should be temporarily suspended until the third opinion has been provided.

3.7 DNACPR documentation
It is the responsibility of the Consultant in charge of the patient to ensure that when any decision either for CPR or DNACPR is made, it is clearly documented in the patient’s notes and communicated to the healthcare team.

Once the DNACPR decision has been made the DNACPR form MUST be completed (see Appendix C) Each section on the form must be completed giving brief explanation of the reason for the decision and whether the decision has been discussed and communicated with the patient and/or family or others close to the patient. The instruction must be signed, with the name of the person responsible for the decision printed clearly and legibly as well as the date and time. A review date (if applicable) must be documented. If there is to be no review date this must be clearly documented.

If a DNACPR decision has been made and no discussion with the patient and/ or family or others close to the patient has taken place this MUST be clearly documented, as must the reason for non-communication. It is the responsibility of the senior nursing staff to communicate to all healthcare professionals involved that a DNACPR decision has been made and the DNACPR process check must be followed. The top copy of the DNACRP form must be placed in the front section of the patient’s current clinical file and the third carbonated copy must be returned to the Resuscitation Service for audit. Where it has not been possible to contact family members or others close to the patient when a DNACPR decision has been made, repeated efforts should be made to contact them and these efforts and the outcome of the contact should be documented and dated on the DNACPR form.

A DNACPR directive with regular review is the responsibility of the Consultant in charge. A staff physician or specialist registrar may deputise but must inform the Consultant or a named deputy at the earliest opportunity. The planned review date must be clearly documented at the institution of the order, but can be reviewed earlier if there is a significant change in the patient’s condition. This decision should include all members of the multidisciplinary team responsible for the continued care of the patient, as well as the patient (or legal proxy). In an emergency and there is no senior doctor available a FY2 may implement a DNACPR decision based on clinical outcome but must have the decision ratified as soon as possible.

In the event of an inter hospital transfer the DNACPR order is still valid. A valid DNACPR form must accompany the patient on transfer (usually this will be the top copy along with the rest of the patient’s notes), and the DNACPR status must be conveyed to the receiving clinical team and the ambulance crew carrying out the transfer. For patients who are being discharged home, or to a community care setting, it may be appropriate for the DNACPR decision to remain in place, or be revoked, depending on the views of the clinical team and the patient (or legal proxy). If it is agreed that the DNACPR decision should remain in place, clinical staff should ensure that the patient/legal proxy (and family if the patient wishes/ lacks capacity) is in agreement with this, and a copy of the East of England community DNACPR form should be completed and accompany the patient on discharge.
3.8 Advance Decisions

Where a patient has a clear and valid Advance Decision, this should be taken into account and respected when DNACPR decisions are being considered.

An Advance Decision (AD) is a record of what treatment a person specifically refuses should they lose the mental capacity to make such decisions in the future.

At law, an adult patient with mental capacity has the right to refuse medical treatment, even if that refusal may lead to their death. This right includes the right to decide in advance what treatment to refuse should he/she become incompetent or unable to communicate his/her wishes.

Under the Mental Capacity Act 2005 an Advance Decision to refuse treatment, including life sustaining treatment will be valid and legally enforceable should certain criteria be met.

There are overriding principles when managing an AD

- The person may have a written AD. If the patient has capacity and can communicate, then normal consent principles apply. An oral or written AD can be withdrawn orally at any time.
- A written AD concerning life sustaining treatment cannot be amended orally. Any amendments must reflect the strict provisions of the Act concerning such a decision.
- A suicide note is not considered to be an AD. Assisted suicide or euthanasia remains a criminal offence in the United Kingdom.
- If the lead clinician is unwilling to deliver care within the boundaries articulated by an AD, then they are personally responsible for transferring care of the patient to an appropriate colleague. The lead clinician remains accountable for the patient’s care until this is achieved.
- An AD cannot be used as a means of insisting upon a particular form of treatment.
- An AD cannot authorise treatment or any action which is unlawful, including assisted suicide.
- An AD must acknowledge that the refusal of treatment may lead to death.

Requirements of a valid AD (Appendix D for checklist).

In law there is a presumption that the adult has the capacity to consent or refuse treatment.

Under the Mental Capacity Act 2005 an AD to refuse general (not life sustaining) medical treatment will be valid and legally enforceable if:

- 18 years or over when making the decision
- Had mental capacity when making the decision
- Makes clear which treatments are to be refused. Medical terminology need not be used as long as the intention is clear
- Explains the circumstances to which the refusal refers (eg. Ventilator dependence, irretrievable loss of ability to communicate)
3.9 Children and DNACPR Decisions

DNACPR decisions in children are an uncommon occurrence and should take place as part of a lengthy and detailed communication between clinical staff, the parents and, where appropriate, the child themselves (dependent on their age/ability to understand the matters being discussed).

The person with parental responsibility may give consent for any medical intervention (including CPR) for any child or young person up to the age of 18 years although the age of consent is 16 years. However if a child is under 16 years and is judged competent to make decisions he/she can give consent for any treatment without the person with parental responsibility. Full discussion with parents should be encouraged. However the child or young person cannot withhold consent for life saving treatment.

The specific needs of the child must remain the priority within a child orientated consultation process.

The key position of the parents must be acknowledged but there should be no obligation on the caring team to give futile and/or burdensome treatment even with dissent from parents and/or other professionals.

Senior medical staff has a duty to provide parents with adequate information regarding withholding of such treatment and should guide them towards their professional recommendations based on the child’s medical and emotional needs.

The decision-making process must be implemented in an atmosphere of open honest communication between parents and senior medical/nursing staff. The clinician must judge the quality of life the child would have to endure if given the proposed treatment and decide whether in all circumstances such a life would be so afflicted as to be intolerable to the child.

The responsibility for decision-making rests solely with the Consultant in charge of the child. Where the parents or patient (if competent) disagree with the Consultant’s decision on CPR status then an urgent second opinion should be sought and there should be a very low threshold for escalating the matter to the Medical Director and Trust Legal Team.
Appendix A – Registration Bodies and their Guidance

Registration Bodies and their Guidance
Resuscitation Council (UK)
5th Floor Tavistock House North
Tavistock Square
London
WC1H 9HR
0207 388 4678
www.resus.org.uk

Nursing and Midwifery Council
23 Portland Place
London W1
0207 7637 7181
www.nmc-uk.org.uk

General Medical Council
178 Great Portland Street
London
W1N 6JE
0845 357 3456
www.gmc-uk.org

Publications
Resuscitation Council (UK) Resuscitation Guidelines October 2010

Resuscitation Council (UK). “Cardiopulmonary Resuscitation - Standards for Clinical Practice and Training”.
A Joint Statement from
The Royal College of Anaesthetists
The Royal College of Physicians of London
The Intensive Care Society
The Resuscitation Council (UK)
October 2004

The Foundation Programme Committee of the Academy of Medical Royal Colleges in co-operation with Modernising Medical Careers in the Departments of Health 2004

Resuscitation Council (UK) “The legal status of those who attempt resuscitation”. December 2005

BMA Ethics “Decisions relating to Cardio-Pulmonary Resuscitation” A statement from the BMA and RCN in association with the Resuscitation Council (UK) October 2007
NMC “Guidelines for records and record keeping” April 2002

NMC “Code of Professional Conduct” June 2002
East of England unified regional guidelines (www.eoe.nhs.uk/dnacpr)
Appendix B – CPR decision making flowchart

1. Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient?
   - NO
   - YES

2. Is there a realistic chance that CPR could be successful?
   - NO
   - YES

3. Does the patient lack capacity and have an advance decision refusing CPR or a LPA health and welfare with relevant authority?
   - NO
   - YES

4. Are the potential risks and burdens of CPR considered to be greater than the likely benefits of CPR?
   - NO
   - YES

5. CPR should be attempted unless the patient has capacity and states that they would not want CPR attempted.

6. If there is no reason to believe that the patient is likely to have a cardiac or respiratory arrest it is not necessary to initiate discussion with the patient (or those close to patients who lack capacity) about CPR. If, however, the patient wishes to discuss CPR this should be respected.

7. When a decision not to attempt CPR is made on these clear clinical grounds, it is not appropriate to ask the patient’s wishes about CPR, but careful consideration should be given as to whether to inform the patient of the DNACPR decision. Where the patient lacks capacity and has a LPA health and welfare or CAD, this person should be informed of the decision not to attempt CPR and the reasons for it as part of the ongoing discussions about the patient’s care. If a second opinion is requested, this request should be respected, whenever possible.

8. If a patient has made an advance decision refusing CPR and the criteria for applicability and validity are met, this must be respected. If an attorney or deputy has been appointed they should be consulted.

9. When there is only a small chance of CPR being successful and/or there are questions about whether the burdens outweigh the benefits of attempting CPR, the involvement of the patient (or, if the patient lacks mental capacity, those close to the patient) in making the decision is crucial.

PLEASE NOTE: Decisions about CPR are sensitive and complex and should be undertaken by experienced members of the healthcare team and documented carefully. Advice should be sought if there is uncertainty.
Appendix C – Do Not Attempt Cardiopulmonary Resuscitation Form

### DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION

Adults aged 18 years and over

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
<th>NHS or hospital number</th>
</tr>
</thead>
</table>

**Date of DNAR order:**

| / | / |

**DO NOT PHOTOCOPY**

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. **Does the patient have capacity to make and communicate decisions about CPR?**
   - **YES**
   - **NO**
   - If "NO", are you aware of a valid advance decision refusing CPR which is relevant to the current condition? **YES**
   - If "YES", go to box 6
   - If "NO", has the patient appointed a Welfare Attorney to make decisions on their behalf? **YES**
   - If "YES" they must be consulted.
   - All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

2. **Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient’s best interests:**

3. **Summary of communication with patient (or Welfare Attorney). If this decision has not been discussed with the patient or Welfare Attorney state the reason why:**

4. **Summary of communication with patient's relatives or friends:**

5. **Names of members of multidisciplinary team contributing to this decision:**

6. **Healthcare professional completing this DNAR order:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

7. **Review and endorsement by most senior health professional:**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review date (if appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Name</td>
<td>Date</td>
</tr>
<tr>
<td>Signature</td>
<td>Name</td>
<td>Date</td>
</tr>
</tbody>
</table>
Appendix D – Advance Decision Checklist

Always assume the person has capacity to consent to or refuse treatment. You are required to maximise the person’s capacity and facilitate communication.

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>ANSWER YES/NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does the person have capacity to give consent to or refuse treatment him or herself, with appropriate support where necessary</td>
<td>YES: The person has capacity to make the decision him or herself. The advance decision is not applicable. Ask what s/he wants to do NO: Continue with check list</td>
</tr>
<tr>
<td>IS THE ADVANCE DECISION VALID?</td>
<td></td>
</tr>
<tr>
<td>2. Has the person withdrawn the advance decision? (This can be done verbally or in writing)</td>
<td>YES: This is not a valid advance decision. Make sure that you have identified and recorded the evidence that the person withdrew the advance decision. NO: Continue with check list</td>
</tr>
<tr>
<td>3. Since making the advance decision, has the person created a lasting power of attorney (LPA) giving anybody else the authority to refuse or consent to the treatment in question?</td>
<td>YES: This is not a valid advance decision. The donee(s) of the LPA must give consent to or refuse the treatment. The LPA decision must be in the person’s best interests. NO: Continue with check list</td>
</tr>
<tr>
<td>4. Are there reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of making the advance decision and which would have affected his/her decision had s/he anticipated them?</td>
<td>YES: If such reasonable grounds exist, this will not be an applicable advance decision. It is important to identify the grounds, discuss this with anybody close to the person, and identify why they would have affected his/her decision had s/he anticipated them, and record your reasoning. NO: Continue with the checklist</td>
</tr>
<tr>
<td>5. Has the person done anything that is clearly inconsistent with the advance decision remaining his/her fixed decision?</td>
<td>YES: This is not a valid advance decision. It is important to identify what the person has done, discuss this with anybody close to the person, explain why this is inconsistent with the advance decision remaining his/her fixed decision, and record your reasons. NO: The advance decision is valid. Continue with the checklist</td>
</tr>
<tr>
<td>IS THE ADVANCE DECISION APPLICABLE?</td>
<td></td>
</tr>
<tr>
<td>6. (a) Does the advance decision specify which treatment the person wishes to refuse?</td>
<td>YES: to both (a) and (b): Continue with the checklist NO: This is not an applicable advance decision</td>
</tr>
<tr>
<td>(b) Is the treatment in question that specified in the advance decision?</td>
<td></td>
</tr>
<tr>
<td>7. If the advance decision has specified circumstances in which it is to apply (see question 3 above), do all of those circumstances exist at the time that the decision whether to refuse treatment needs to be made? (N.B. It is possible for a person to decide that the advance decision should apply in all circumstances)</td>
<td>YES: Continue with the checklist NO: This is not an applicable advance decision</td>
</tr>
</tbody>
</table>
Appendix E - Equality Impact Assessment

Policy or function being assessed: DNACPR Policy and Procedure
Department/Service: Resuscitation
Assessment completed by: Jim Crawfurd
Date of assessment: 23/7/2014

1. Describe the aim, objective and purpose of this Policy or function.
   The Policy provides guidance on DNACPR decision making for those clinicians involved in discussing, making and implementing such decisions. It also provides information for other staff, patients and those close to patients about the process of making decisions about CPR.

2i. Who is intended to benefit from the Policy or function?
   Staff X  Patients X  Public X  Organisation X

2ii. How are they likely to benefit?
   Patients for whom CPR would not be appropriate will benefit from the guidance to help clinicians make appropriate DNACPR decisions with sensitive consultation with the patient (or those close to the patient) as appropriate.

2iii. What outcomes are wanted from this Policy or function?
   That DNACPR decisions are made appropriately within the Trust, and that appropriate discussion of these decisions takes place between the clinical team and the patient (or those close to the patient).

For Questions 3-11 below, please specify whether the Policy/function does or could have an impact in relation to each of the nine equality strand headings:

3. Are there concerns that the Policy/function does or could have a detrimental impact on people due to their race/ethnicity?
   N If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

4. Are there concerns that the Policy/function does or could have a detrimental impact on people due to their gender?
   N If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data

5. Are there concerns that the Policy/function does or could have a detrimental impact on people due to their disability?
   N If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>N</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Are there concerns that the Policy/function does or could have a detrimental impact on people due to their <strong>sexual orientation</strong>?</td>
<td>N</td>
<td>If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data</td>
</tr>
<tr>
<td>7.</td>
<td>Are there concerns that the Policy/function does or could have a detrimental impact on people due to their <strong>pregnancy or maternity</strong>?</td>
<td>N</td>
<td>If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data</td>
</tr>
<tr>
<td>8.</td>
<td>Are there concerns that the Policy/function does or could have a detrimental impact on people due to their <strong>religion/belief</strong>?</td>
<td>N</td>
<td>If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data</td>
</tr>
<tr>
<td>9.</td>
<td>Are there concerns that the Policy/function does or could have a detrimental impact on people due to their <strong>transgender</strong>?</td>
<td>N</td>
<td>If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data</td>
</tr>
<tr>
<td>10.</td>
<td>Are there concerns that the Policy/function does or could have a detrimental impact on people due to their <strong>age</strong>?</td>
<td>N</td>
<td>If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data</td>
</tr>
<tr>
<td>11.</td>
<td>Are there concerns that the Policy/function does or could have a detrimental impact on people due to their <strong>marriage or civil partnership</strong>?</td>
<td>N</td>
<td>If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data</td>
</tr>
<tr>
<td>12.</td>
<td>Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this Policy/function?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td><strong>Specific Issues Identified</strong></td>
<td>None</td>
<td>Page/paragraph/section of Policy/function that the</td>
</tr>
</tbody>
</table>
### 15. Proposals

| How could the identified detrimental impact be minimised or eradicated? | N/A |
| If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11? | N/A |

### 16. Given this Equality Impact Assessment, does the Policy/function need to be reconsidered/redrafted?

N

### 17. Policy/Function Implementation

Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the Policy/function should be adopted by the Trust.

Please print:

**Name of Director/Head of Service:** Nick Oligbo  **Title:** Medical Director  
**Date:** 18/7/2014

**Name of Policy/function Author:** Jim Crawfurd  **Title:** Resus Committee Chair/A&E Consultant  
**Date:** 18/7/2014

(A paper copy of the EIA which has been signed is available on request).

### 18. Proposed Date for Policy/Function Review

July 2017

Please detail the date for Policy/function review (3 yearly): 2017

### 19. Explain how you plan to publish the result of the assessment? *(Completed E.I.A’s must be published on the Equality pages of the Trust’s website)*

Title: Do Not Attempt Cardiopulmonary Resuscitation Policy  
Author: Jim Crawfurd, Resuscitation Committee Chair  
Issue: September 2014  
Ref: POL/TWD/RES/JC2207/01  
Next Review: September 2017  
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In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures.

They are that all staff intend to do their best by:

Putting patients first, and they will:
- Provide the best possible care in a safe clean and friendly environment,
- Treat everybody with courtesy and respect,
- Act appropriately with everyone.

Aiming to get it right, and they will:
- Commit to their own personal development,
- Understand theirs and others roles and responsibilities,
- Contribute to the development of services

Recognising that everyone counts, and they will:
- Value the contribution and skills of others,
- Treat everyone fairly,
- Support the development of colleagues.

Doing everything openly and honestly, and they will:
- Be clear about what they are trying to achieve,
- Share information appropriately and effectively,
- Admit to and learn from mistakes.

I confirm that this Policy/function does not conflict with these values. ☑