



Decisions to Attempt or Withhold Cardiopulmonary Resuscitation (CPR)

Regional Policy for North and North East Lincolnshire

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1. Preface

This policy is for use across the North and North East Lincolnshire region. It aims to give clear guidance to hospital and community healthcare professionals in relation to a single treatment choice: *When should cardiopulmonary resuscitation be used and when should it be withheld*. Technical language is kept to a minimum and the policy should be accessible to non-clinical staff and members of the public. References at the end of the document include internet links for ease of further reading.

It aims to achieve a coordinated approach to CPR decisions across all healthcare settings in the region – hospitals, general practice, care homes, the patient’s own home, hospices and the ambulance service – ensuring the patient’s best interests are met should their cardiac and/or respiratory function cease. It is not intended to be prescriptive, but recognises the very sensitive and unique nature of CPR decisions and the need to treat each case on an individual basis. This is concerned only with CPR decisions and has no implication for any other clinical decisions relating to the patient’s care, such as drug and invasive therapies, hydration and nutrition. Even if a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision is made, all other care and treatment should continue as appropriate. The guidelines make no distinction between basic and advanced life support as the underlying principles are the same for both.

While the complexity of the subject makes it difficult to offer simple prescriptive guidance, standards have been listed at the beginning of the policy and serve both as key-points for practice and standards for audit, with references to relevant sections in the policy. The policy is based on *Decisions relating to cardiopulmonary resuscitation* (3rd edition first revision – 2016)¹, the most comprehensive UK guidance on the subject. It is highly recommended that all clinical staff with a responsibility for any aspect of CPR decision making should read the policy from beginning to end to gain a better sense of this complex subject. Thereafter the key points below can be used to sign post specific subjects.

These guidelines apply to all areas of the North and North East Lincolnshire region where patients receive care across all settings including hospitals, GP practices, care homes and patients’ own homes. The guidelines apply to all NHS healthcare professionals working in the North and North East Lincolnshire region. Independent primary care contractors are expected to comply with the principles set out in these guidelines, in compliance with negotiated contracts. Staff working in independent healthcare facilities, such as nursing and residential homes, are encouraged to comply with the principles set out in these guidelines. It is hoped that other health professionals and nursing staff based in independent healthcare settings, for example residential and nursing homes, and hospices will seek the support of GPs and NHS nursing staff and use the standardised Yorkshire and Humber DNACPR form.

1.1 Key definitions.

- **Cardiopulmonary arrest or cardiac arrest** – A person’s heart and breathing stop⁵.
- **Cardiopulmonary resuscitation (CPR)** – A treatment which includes:

- Repeatedly pressing down on the chest (chest compressions)
 - Inflation of the lungs through a mask or tube inserted into the throat
 - Insertion of needles into the veins or bone for delivering drugs and fluids
- CPR might also include:
- One or more electric shocks across the heart
- **CPR decisions** – the process of deciding to deliver or withhold CPR.
 - **Do not attempt cardiopulmonary resuscitation (DNACPR)** – an advanced decision to withhold the treatment of CPR
 - **Relevant other:**
 - Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
 - Anyone engaged in caring for the person
 - Close relatives, friends or others who take an interest in the person’s welfare ¹².
 - **Capacity** An individual must be assumed to have capacity unless it can be shown that, on the balance of probability, that individual has an impairment or disturbance of mind or brain⁷. Where an individual is regarded as lacking capacity if, at the time of the CPR decision needs to be made, he or she is unable, even with support, to:
 - understand the information relevant to the decision
 - retain the information relevant to the decision
 - use or weigh the information as part of the process of making the decision, or
 - communicate the decision (by any means).

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed ⁶. It is beyond the scope of this policy to describe the mental capacity assessment in detail (See section 7 CPR decisions and loss of mental capacity (below)). See also the NLAG Trust policy: Mental Capacity Act (MCA) 2005 & MCA deprivation of liberty safeguards (DOLs) policy ⁹ and/or Royal College of General Practitioners Mental Capacity Toolkit ¹¹ and/or the BMA Mental Capacity Tool Kit ⁶ and/or other MCA policy specific to other provider organisations.

- **Best Interests** - All decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests ⁶, taking into account the patient’s:
 - Past and present wishes and feelings, including any relevant written statement made when they had capacity – this would include general statements of wishes, beliefs or values that would impact on the decision
 - Other factors the person would have considered if able to do so
 - judgment will involve a discussion with those close to the patient, including family, friends or carers, where it is practical or appropriate to do so, bearing in mind the duty of confidentiality

1.2 Standards for practice and audit/key points of the policy

While the standards below can be used as a measure of the quality of CPR decision making, they also summarise the main messages of the policy. Each standard makes reference to further reading in the policy. The standards are a summary of the policy and should not be used as a substitute for reading the policy through.

Standard/key point 1.

Always consider and, where possible, make a CPR decision for patients at risk of cardiorespiratory arrest and/or nearing end of life. **See Paragraph 2.1 – 2.3 inclusive.**

Standard/key point 2.

It is not necessary to initiate discussions about CPR if cardiorespiratory arrest is unlikely in the foreseeable future. **See Paragraph 2.2**

Standard/key point 3.

Where possible make CPR decisions as part of advanced care planning, to avoid crisis decisions in an emergency setting. **See Paragraph 2.3**

Standard/key point 4.

The individual patient must be central to the CPR decision making process. Never use 'blanket' policies, for example based on age, disability, illness, for who will and will not receive CPR. **See Paragraph 2.3.**

Standard/key point 5.

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 there is no realistic prospect of a successful outcome, CPR should not be offered or attempted. **See Section 3.**

Standard/key point 6.

Even when the healthcare team believe **CPR will not be successful** there must be a presumption in favour of explaining to the patient or their relevant others if the patient lacks capacity, the reasons for the clinical decision to withhold CPR. This decision should be made and explained to the patient and those close to the patient at the earliest practicable and appropriate opportunity. Patients and their relevant others do not have a right to demand clinically inappropriate treatment and healthcare professionals are not obliged to offer such treatment. There is no need to request consent to withhold DNACPR if it will not work. **See Section 3.**

Standard/key point 7.

If **CPR may be successful** there must be a presumption in favour of involving the patient in the decision making process. This is no longer solely a clinical decision. If the patient lacks capacity their relevant others must be involved to explore the patient's wishes, values and beliefs in order to reach a CPR decision in the patient's *best interests*. Relevant others must understand that while they have a valuable role in helping clinicians to reach a CPR decision in the patient's best interests, in the absence of an applicable power of attorney or court appointed deputy they cannot make decisions for the patient. **See Section 4. and Section 7.**

Standard/key point 8.

If a patient with capacity refuses CPR or a patient without capacity but a valid and applicable advanced decision to refuse (specifically life sustaining) treatment (ADRT), this must be respected. **See Paragraph 6.7 and section 7.**

Standard/key point 9.

If CPR will not be successful and the patient or relevant others of a patient who lacks capacity disagree with a DNACPR decision, a second opinion should be offered. **See Paragraph 3.3**

Standard/key point 10.

Effective communication is essential to ensure everyone involved – patient, relevant others and healthcare staff – understand what will happen should the patient suffer cardiorespiratory arrest. Discussions with patient's or their relevant others if the patient lacks capacity must be honest accurate and sensitive, allowing time for questions and checking understanding. CPR decisions should ideally form part of advanced end of life care planning, rather than during the 'crisis' of

Standard/key point 11.

Do not delay initiating CPR discussions with patients/relevant others because it is difficult or may cause distress, as this can lead to misunderstanding and dissatisfaction, as can delivering these communications in an inappropriate or insensitive way.

- A decision to delay or avoid communication of a decision to a patient must be based on that communication being likely to cause the patient physical or psychological harm.
- A decision to delay communication of a decision to those close to a patient without capacity must be based on that communication being either not practicable or not appropriate in the circumstances. *See Paragraph 2.4 and section 3*

Standard/key point 12.

It is important to stress to patients and relevant others, and for healthcare professionals to understand, that a DNACPR decision applies to one treatment only – CPR. A DNACPR must not be allowed to compromise high quality care or deny the patient other treatments and investigations that remain in their best interests. *See Section 3.*

Standard/key point 13.

The healthcare professional can override a DNACPR decision in the unlikely event that the circumstances of the cardiorespiratory arrest do not match those envisaged when the CPR decision was made. Examples of such reversible causes include but are not restricted to – choking, a displaced tracheal tube or a blocked tracheostomy tube. *See section 6.*

Standard/key point 14.

Clear and full documentation of CPR decisions should include the reasons and discussions that informed the decision, changes to the decision and any departure from the guidelines set out in this policy. This will include information beyond the content of the regional DNACPR form. *See Section 10 and table 1 of section 10*

Standard/key point 15.

A CPR decision form is not legally binding. The regional DNACPR form guides the immediate action in the event of the patient's cardiorespiratory arrest or death. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. *See section 6.*

Standard/key point 16.

Recorded decisions about CPR should accompany a patient when they move from one setting to another. The decision must be communicated to members of healthcare teams receiving patients and paper and electronic records updated appropriately. *See section 11.*

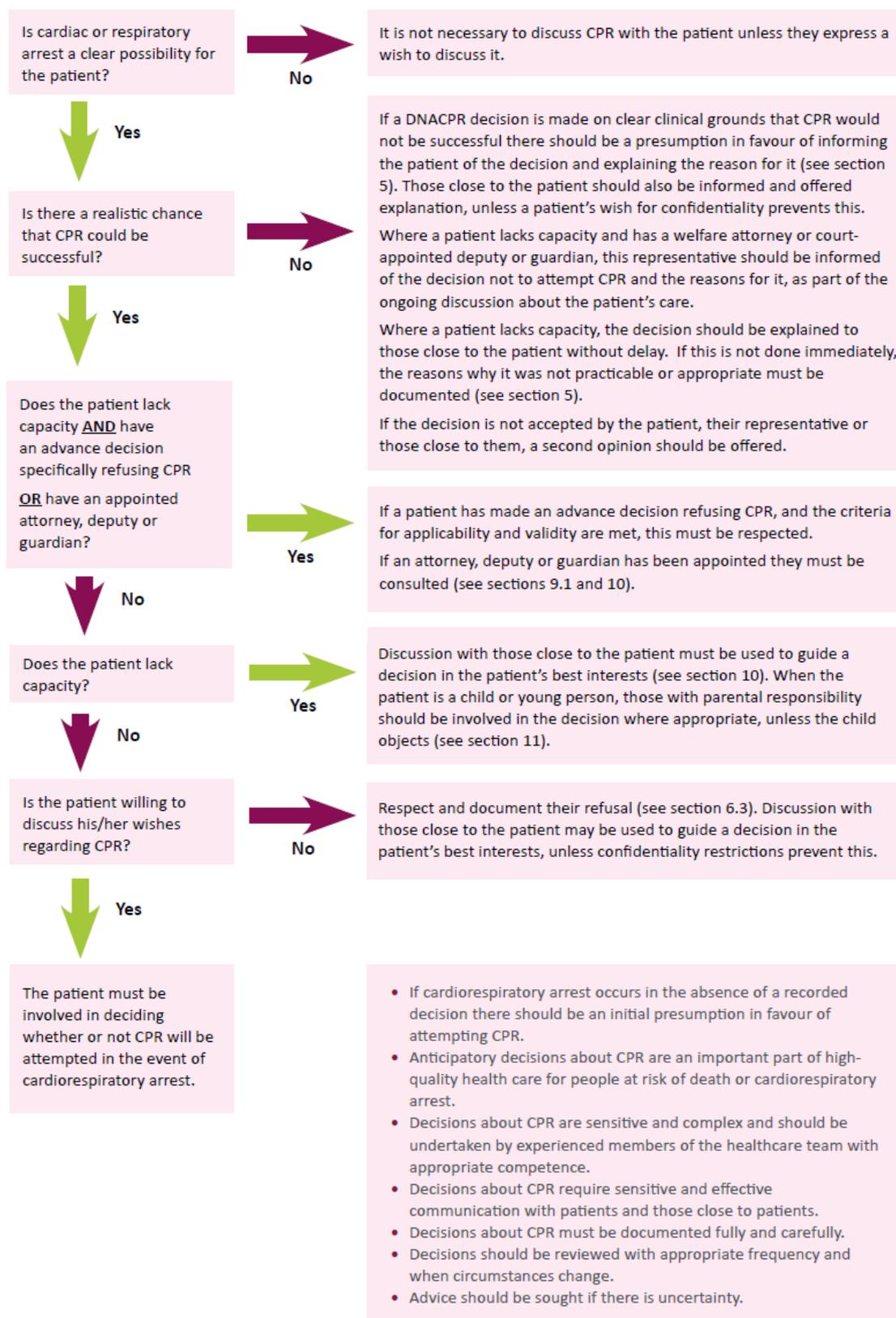
Standard/key point 17.

Where no explicit CPR decision has been recorded, there should be a presumption in favour of starting CPR in the event of cardiorespiratory arrest. In some circumstances where there is no explicit CPR decision recorded – for example the patient is in the advanced stages of a terminal illness and CPR will not be successful or the patient has signs of irreversible death, such as rigor mortis, a carefully considered decision by the health care professionals present not to start CPR should be supported. *See section 6.*

Standard/key point 18.

Each decision about CPR should be subject to review based on the person's individual circumstances. In the setting of an acute illness, review should be sufficiently frequent to allow a change of decision (in either direction) in response to the person's clinical progress or lack thereof. Triggers for review should include any request from the patient or those close to them, any substantial change in the patient's clinical condition or prognosis and transfer of the patient

1.3 CPR decision making Framework ¹



2. Introduction - To attempt or to withhold CPR

Cardiopulmonary resuscitation (CPR) is a treatment option. The decision to use or withhold CPR should be based on a careful consideration of the balance of risks and benefits to each individual patient. The chances of surviving CPR to hospital discharge and the subsequent burden on the social, emotional and physical health of each survivor vary greatly, depending on the causes and circumstances of the cardiac arrest. The patient must be placed at the centre of the decision-making process. There are a number of general considerations to bear in mind when weighing the risks and benefits of CPR.

- Successful resuscitation gives 'extended, useful and precious life to many individuals'².
- The single aim of CPR is to restore a spontaneous heart beat and breathing in a person whose heart and/or breathing has stopped. CPR cannot treat a person's underlying condition and it may prolong suffering.
- CPR is a physical, invasive and traumatic treatment. It carries a risk of adverse effects such as rib or sternal fractures and rupture of the liver and spleen. There is also some risk that CPR survivors will be left with brain damage and resulting disability.
- CPR has a low success rate with most hospitals achieving a patient survival to hospital discharge average of 15 – 20%¹. One report suggests that survival from out-of-hospital cardiac arrest in England is as low as 8.6%⁸, but even with improvements in bystander training and the availability of first responder defibrillators the best performance (Norway) is only 25%⁹.
- CPR attempts are unavoidably physical and potentially traumatic, as a result of which, death may occur in a manner that neither the person affected nor people close to them would have wished.

2.2 When and when not to initiate a CPR discussions with a patient/relevant other

When not to initiate a CPR discussion: It is a recommendation of the NCEPOD that a CPR decision is considered for all acute admissions to hospital²¹. If the risk of cardiorespiratory arrest or death of a patient in community or hospital care is low, there is no requirement to initiate a CPR discussion with the healthcare team, the patient and relevant others. However, if a patient not at risk of cardiac arrest wishes to discuss CPR, the conversation must be facilitated.

When to initiate a CPR discussion: In cases where there is a risk of cardiac arrest or death, due either to an advanced chronic condition or a life threatening acute condition, action to be taken in the event of cardiac arrest must, where possible, be considered as part of advanced care planning. CPR decisions usually take place in the context of one the following five situations

- CPR is inappropriate because the patient is at an advanced stage of dying from an irreversible illness
- CPR will not work due to the patient's advanced illness and deteriorating health

- CPR may work but will have a poor or uncertain outcome
- CPR is likely to work by restoring the patient to a quality of life they would value
- CPR is not wanted by a patient with capacity or a valid Advance Decision to Refuse Treatment (ADRT)

2.3 Advanced care planning for end of life

Where possible CPR decisions should be considered as part of advanced care planning²³, which allows more time for the patient and their relevant others to discuss the treatment and clarify their wishes with senior members of their healthcare team who know them well (GP, hospital doctors and senior hospital and community nurses). This avoids the need for decisions during the crisis of acute admission, when the patient may lack mental capacity, the healthcare professionals may have little insight into the patient's clinical history, views, beliefs and wishes for end of life, and relevant others are under great emotional stress.

It is inevitable that acute hospital teams will encounter patients at risk of cardiac arrest and with no advance CPR decision in place. Despite the complexity of these cases it is essential that DNACPR status is considered and a plan of care in the event of cardiac arrest put in place.

2.4 Human rights act

The key issue is not the decision-maker's view of the quality of life following CPR, but an objective assessment of what is in the best interests of the patient. Decisions must not be made on the basis of assumptions based solely on factors such as the person's age, disability, or on a professional's subjective view of a person's quality of life. It is unethical and illegal to operate blanket policies denying CPR to particular groups of individuals. Decisions about CPR must take account all relevant factors, particularly the patient's own views about what would be an acceptable level of recovery were CPR successful, when these can be ascertained. Decisions or policies that discriminate in favour of, or against, people with defined disabilities would be unlawful under the Equality Act 2010¹³ (in England, Wales and Scotland).

The courts, in relation to Article 8 of the Human Rights Act 1998, have made the following rulings:

- There should be a presumption in favour of involving patients in discussions about whether or not to attempt CPR and there need to be convincing reasons not to involve the patient, unless the clinician considers that to do so is likely to cause the person to suffer physical or psychological harm³.
- When a patient lacks capacity there should be a presumption in favour of involving those close to the patient in discussions about CPR whenever practicable and appropriate⁴.

In other words healthcare staff need a very compelling reason for not involving the patient, or the patient's relevant other, in discussions about whether or not to attempt CPR.

3. When CPR will not work

- **CPR is inappropriate** because the patient is at an advanced stage of dying from an irreversible illness.
OR
- **CPR will not work** due to the patient's advanced illness and deteriorating health

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 there is no realistic prospect of a successful outcome, **CPR should not be offered or attempted.**

To withhold the single treatment option of CPR, because it will not work, is a clinical decision. Patients and their relevant others cannot insist that healthcare professionals provide a treatment that will not work.

It is essential that all involved – the patient, their relevant others and the staff caring for the patient – understand that that all other appropriate treatment will continue. The term **‘do not attempt cardiopulmonary resuscitation** should be used in documentation rather than ‘do not resuscitate/attempt resuscitation’, to emphasise that only CPR is being withheld.

The final responsibility for this decision rests with the senior clinician responsible for the patient’s care, which is usually a hospital consultant or GP. The decision must be based on the patient’s individual circumstances and the most up to date evidence and professional guidance. The decision making process should include:

- A 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 and reasons for the decision to the patient or the relevant others of a patient who lacks capacity

Where people are known to have an advanced chronic illness, discussion and explanation about the realities of attempting CPR should be considered and, where appropriate, offered in advance of the last few weeks or days of life. Appropriately trained clinical nurse specialists and community nurses are well placed to initiate these discussions, following agreement of the senior clinician responsible for the patient’s care.

The clinician must be sensitive to the physical and emotional stress on patients and their relevant others, but must not avoid the conversation just because it is difficult or because it may cause distress. In a minority of cases the clinician may feel that a conversation about DNACPR will cause the dying patient a level of distress that will result in physical or psychological harm. In this case the decision not to discuss DNACPR with the patient and the reason why must be clearly documented in the patient’s medical notes. The appropriate DNACPR decision must still be made and regular reviews undertaken of the patient’s ability to enter discussions about DNACPR, with a view to initiating the conversation should this become appropriate.

In a judgment in the Court of Appeal the Master of the Rolls stated:...”doctors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them... I recognise that these are difficult issues which require clinicians to make sensitive decisions sometimes in very stressful circumstances. I would add that the court should be very slow to find that such decisions, if conscientiously taken, violate a patient’s rights under article 7 of the [European Convention on Human Rights]”.

3.1 The patient that does not wish to discuss dying and CPR

Healthcare teams must respect the decision of a patient to refuse to discuss dying, end of life care or CPR decisions and not force the conversation on them. The DNACPR decision

must still be made if CPR is not going to work, and the patient's refusal to discuss CPR clearly documented in the medical notes. Healthcare teams can ask the permission of the patient with capacity to discuss CPR with their relevant others, but should the patient decline this option their decision must be respected. A patient *with capacity* must give their permission before their condition or a CPR decision can be discussed with relevant others.

3.2 CPR will not work and the patient lacks capacity

If the patient lacks capacity check to see if they have a welfare attorney, court appointed deputy or guardian with the authority to consider health matters of this gravity on the patient's behalf. If so this person must be informed of a DNACPR decision and the reason for it. A second opinion should be offered to a welfare attorney, court appointed deputy or guardian that does not accept a DNACPR decision on behalf of the patient.

If the patient lacks capacity their relevant others must be informed of a DNACPR decision, unless the patient has previously refused, at a time they did have capacity, any sharing of confidential health information with others. It is essential to explain that a DNACPR decision does not mean the healthcare team are giving up on the patient. The decision aims to spare the patient traumatic, undignified and futile treatment, but all other appropriate care will be provided. The aim of the conversation with relevant others is to share an understanding of the patient's condition and the aims of treatment, not just to focus on the DNACPR decision in isolation.

When the CPR decision arises in the context of acute admission to hospital of a patient lacking capacity and cardiac arrest is imminent it is vital not to delay. All reasonable effort must be made to contact the patient's relevant others to explain the decision regardless of the time of day, as soon as practicable and appropriate.. If this proves impossible the DNACPR decision should be made and the patient's relevant other contacted at the earliest opportunity. The DNACPR decision and all attempts to contact relevant others must be documented in the medical notes. Face to face conversation is far preferable to a telephone conversation, but the latter may be the only practical way of making contact with relevant others.

Ensuring that decisions are agreed whenever possible by a multi-disciplinary team may be helpful to all concerned. In some circumstances this may avoid the need for a second opinion.

In the unusual case that the healthcare team feel it would cause psychological or physical harm to the patient's relevant others to discuss CPR, the circumstances of this decision must be clearly documented in the medical notes. Failure to document reasons in this way may leave clinicians at risk of legal challenge.

3.3 The patient or patient's relevant others are requesting CPR, but the healthcare team have good reason to believe it will not work.

Sometimes patients or relevant others of patients who lack capacity will try to demand CPR in a situation where it is clinically inappropriate. Healthcare providers have the right to deny treatment to a patient if they believe it will not work. Conversations with patients and relevant others should be sensitive and non-confrontational, but honest and unambiguous, with a view to explaining why CPR will not work, why it may prolong suffering and lead to a traumatic and undignified death and reassuring that all other appropriate care and treatment will still be given.

Although the hospital consultant or GP has overall responsibility for CPR decisions, they can delegate the task of initiating conversations to an appropriate nurse or doctor.

Conversations around CPR decisions should be undertaken by doctors and nurses with the appropriate training, experience and expertise. For NLG NHS Trust staff this training will be delivered by resuscitation officers and updated as part of mandatory resuscitation training. For other provider organisations, there will be specific mandatory training requirements.

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 multidisciplinary team, all of whom take the view that a DNACPR decision is appropriate.

4. When CPR may work – decisions based on a partnership between patient and clinician

If CPR may successfully restart a patient's heart and breathing for a sustained period the potential benefits of prolonging life must be balanced with the possible social, emotional and physical burdens of survival. For a patient with capacity there should be shared decision making between patient and clinician, with the aim of empowering the patient to make an informed decision based on a sound understanding of the benefits and burdens of CPR in their unique case.

If it is believed CPR will not work it is a clinical decision to withhold the treatment (see above)
If CPR may work it is no longer the sole decision of the clinical team to withhold it.

Only the patient can judge their own quality of life and the value they place on a life after CPR. It is the healthcare team's task to sensitively but honestly discuss with the patient the likelihood of CPR working and offer insights into what the burdens of survival might be, allowing patients the time to ask the questions they wish.

4.1 CPR may work but the clinician feels the harms and burdens outweigh the benefits

If after careful and sensitive discussion of the balance of risks, burdens and benefits the patient requests CPR in the event of cardiac arrest, this decision should usually be respected. Even if the evidence suggests there is only a slim chance that CPR will be successful, the patient whose life is at stake may be willing to take that chance. Healthcare professionals cannot be required to give treatment that goes against their clinical judgement, but should be willing to consider and discuss people's wishes to receive CPR, even if it offers only a very small chance of success or benefit.

In the unusual situation that a doctor responsible for the patient's care feels unable to agree with the patient's expressed wish for CPR, or where there is a lack of agreement within the healthcare team, a second opinion can be requested. If agreement still cannot be reached the patient's care may be transferred to another doctor or healthcare team, if this is possible.

4.2 CPR may work but the patient lacks capacity

For a patient who lacks capacity, but for whom CPR may work the decision of whether or not to attempt CPR is subject to a **best interests** assessment. Best interests decisions must involve those close to the patient, unless the patient has requested that the healthcare team do not speak to relevant others. Relevant others are often best placed to give the healthcare team insights into what the patient might have wanted if they were capable of making a decision. The decision must be based on an objective assessment of what is in the best interests of the patient who is lacking capacity. The following factors must be

considered when making a best interests decision (adapted from Mental Capacity Act Code of Practice ¹²):

- Assess the level of awareness the patient has of their existence and surroundings. Do whatever is possible to permit and encourage the patient to take part, or to improve their ability to take part, in making the decision
- Try to identify all the things that the patient who lacks capacity would take into account if they were making the decision or acting for themselves
- Attempt to gain insight into patient's wishes and feelings, beliefs and values (e.g. religious, cultural, moral or political) about dying and CPR that would be likely to influence their decision – these may have been expressed verbally, in writing or through behaviour or habits.

4.3 Avoiding discrimination:

- Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then? In an acutely ill patient who lacks capacity and is at risk of cardiac arrest the decision to consider CPR cannot await clinical improvement.
- Do not make assumptions about the person's quality of life.

5. Communicating with the patient at risk of cardiac arrest (or relevant others if the patient lacks capacity)

Patients, their relevant others and even some healthcare professionals have unrealistic expectations of what CPR involves and its potential benefits. Healthcare professionals will wish to avoid alarming patients and their relevant others or deterring them from CPR and the possibility of prolonged life, but it is important that everyone contributing to the decision is aware of the nature of the treatment and the burdens that may, in that patient's case, result from survival.

The patient may have reasons to accept a short period of life following CPR. If CPR may work it is important to offer a realistic prediction of the length and quality of survival that might be expected.

It is important to explain to patients that might survive CPR (or their relevant others) that while it may be in the patient's best interests to offer CPR, this does not mean that other intensive care and procedures, such as prolonged support for multi-organ failure, will be appropriate. Conversely it may be in the best interests of the patient to withhold CPR, but still appropriate to admit them to ICU for other treatment.

If the patient may survive CPR but the balance of risks and benefits require careful consideration (best interests), it is essential to discuss with the patient, or their relevant others if they lack capacity, the following factors:

- The likelihood of re-starting the heart and/or breathing for a sustained period

- Whether cardiac arrest is likely to recur
- The level of recovery that can be expected realistically after successful CPR. The patient's human rights lay central to this discussion, including the right to life, and the right to be free from degrading treatment (which may include the right to a dignified death). Discussion should include the likelihood of surviving CPR in a state of total dependency or permanent lack of awareness or the likelihood of experiencing continuing pain or suffering that the patient would find intolerable or unacceptable.
- The likelihood of CPR resulting in an undignified or traumatic death.

5.1 Discussing and communicating CPR decisions with patients with capacity

Patients with capacity must be given the opportunity to discuss CPR decisions and information leaflets and policies should be made available to them, unless it is believed it will cause them physical or psychological harm to do so. Where CPR may be successful the clinician must open a sensitive and honest dialogue with the patient, allowing them to ask questions and explore the risks, burdens and benefits of CPR.

If a patient with capacity is unwilling to discuss CPR do not force information on them and document the patient's wishes. Where CPR may work but the patient declines to discuss the decision, or asks the healthcare team to make a decision for them, the balance of risks, burdens and benefits must be considered with a view to reaching a best interests decision. Consider asking the patient if they would like the CPR decision discussed with relevant others and respect the patient's wishes if this offer is declined.

5.2 Discussing and communicating CPR decisions with relevant others of patients that lack capacity

If the patient lacks capacity discussions around CPR decisions should be held with relevant others, unless the patient expressed a wish, at a time when they had capacity, that this information must not be shared. Discussion with relevant others is not only good practice but is also a requirement of the Human Rights Act 1998 and the Mental Capacity Act 2005. It is important to stress to relevant others who do not have the authority to make decisions for the patient that their role is to help inform the decision making process, not to make the decision themselves. Do not ask relevant others what they would like to happen if the patient suffers cardiorespiratory arrest, but emphasise the importance of understanding what the patient would want if they could speak for themselves.

5.3 General pointers for healthcare professionals discussing and communicating CPR decisions to patients and patient's relevant others

- Offer as much information as is wanted or requested (respecting any instructions from the patient for confidentiality)
- Be open and honest
- Use clear language and avoid technical terms
- Support verbal communication with the 'What if my heart stops...' information leaflet.
- Ensure information is accurate and consistent across the healthcare team
- Check understanding
- Where possible have discussions in an environment that is quiet, comfortable and interruptions are minimised.

- Allow time for questions, discussions and reflection and where feasible arrange follow-up visits to allow the patient time to absorb the information before reaching a decision.
- Avoid a rigid, prescriptive or routine approach to CPR discussions⁷, as this can create distress and inhibit patient-centred dialogue.

5.4 Printed patient information leaflets

The regional leaflet ‘What happens if my heart stops?’ contains information on CPR decisions in easy-read format, to make it as accessible to as many people as possible. It is designed as a source of information for patients and their relevant others and should be offered as a supplement to face to face discussions with healthcare professionals and not a substitute.

Patients and their relevant others should be offered access to this policy should they require more detailed information.

6. Other factors that may influence CPR decisions and how they are implemented

6.1 Circumstances when a CPR decision might not be followed

A DNACPR form is not legally binding, unless accompanied by a valid and applicable advanced decision to refuse treatment (ADRT), specifically CPR. The DNACPR form is a communication device to guide healthcare professionals on the recommended action to be taken in the event of cardiorespiratory arrest. The decision of whether or not to start CPR in an emergency rests with the health professional(s) responsible for managing the patient’s immediate situation. If they can justify the decision to resuscitate they should start CPR, even if a DNACPR form is present⁷. However great caution would be needed before deciding to override a DNACPR form that states a patient has expressed a clear wish not to receive CPR.

6.2 Examples of when a DNACPR decision may not be followed

A patient with a DNACPR form may suffer a sudden, readily reversible cause of cardiorespiratory arrest not envisaged during the CPR decision making process. Examples include a blocked or displaced tracheostomy tube/endotracheal tube and choking. It may be appropriate in this situation to commence CPR while the cause of the arrest is reversed, unless the decision not to resuscitate specifically states that no treatment should be given in these circumstances. It may help to explain to patients/relevant others that the DNACPR decision applies to cardiac arrests with likely and anticipated causes, and not to an unforeseen and readily reversible cause like choking. *Healthcare professionals and acute and primary healthcare organisations in the North and North East Lincolnshire region should support a healthcare provider’s decision to start CPR in these circumstances.*

6.3 Initial assumption in favour of starting CPR if a CPR decision has not been made or is unknown.

When cardiac arrest occurs and healthcare professionals do not know the express wishes of the patient and these cannot be ascertained, CPR should be started and all efforts made to resuscitate the patient. During CPR efforts should continue to obtain as much information as possible to guide decision making. If information arises such as a valid and applicable DNACPR order, an advanced decision refusing treatment (ADRT) or clear clinical evidence that CPR will not work, CPR should be stopped.

In some cases it will be clearly apparent to the healthcare professionals caring for the patient that CPR is not appropriate, but the patient does not have a DNACPR or advanced decision refusing treatment (ADRT - with respect to CPR) in place. For example, a person in the terminal stages of a chronic disease where death is imminent or a patient discovered with signs of irreversible death, such as rigor mortis. In this case the healthcare professionals involved can make the choice not to start CPR. This decision must be documented and the senior clinician in charge of the patient's care informed as soon as possible. *Healthcare professionals and acute and primary healthcare organisations in the North and North East Lincolnshire region should fully support a healthcare provider's decision not to start CPR in these circumstances.*

6.4 Restricted or conditional CPR attempts

A clinician may believe that it would be in the best interests of a patient to deliver CPR in one set of circumstances but not another. For example a ventilated patient in an intensive care unit might be considered for CPR in the event of a shockable cardiac arrhythmia, where a quick and relatively simple treatment will restore the patient to their condition prior to the cardiac arrest, allowing for a precipitating cause to be identified and treated. In this example the decision to withhold CPR might still apply in the event of non-shockable cardiac arrest, where the prospect of restoring the pre-arrest level of health is much less likely.

The decision to restrict some aspects of CPR and allow others must be reached following careful consideration of the risks and benefits to the patient. The clinician must discuss this with the patient where appropriate, or make a best interests decision following discussion with the patient's relevant others. Restricted CPR decisions must be clearly documented in the medical and nursing notes, with clear instructions on the action to be taken in the event of cardiac arrest.

6.5 Caution with restricted CPR events.

- Do not restrict advance decisions for CPR to one shock only. Chest compressions and ventilations may increase the chances of success with a second or subsequent shock
- Do not apply restrictions to the duration of CPR in the event of cardiac arrests. The decision to end CPR once started must lie with the cardiac arrest team, and based on an assessment of reversible causes, the progress of resuscitation and a balance of the burdens and benefits to the patient of continuing CPR.

6.6 Patients with a valid DNACPR undergoing a procedure with a risk of readily reversible cardiac arrest.

Procedures such as cardiac pacing and coronary artery catheterisation carry a risk of readily reversible cardiac arrest. Routine procedures during anaesthesia, such as intubation, mechanical ventilation and use of vasoactive drugs can be viewed as resuscitative measures. In these circumstances suspension of DNACPR order for the duration of the procedure should be discussed with the patient, or their relevant other if they lack capacity, at the time of seeking informed consent for the operation. The DNACPR suspension order and the time and date of reinstatement of DNACPR should be clearly documented in the patient's medical notes and communicated to all appropriate members of the healthcare team.

If the patient requests that their DNACPR order remain in place for the duration of the procedure the clinician must assess if the treatment is safe to proceed. If the clinician believes keeping the DNACPR in place during a procedure or treatment would lead to a poor

outcome or would be unacceptably hazardous it would be reasonable not to proceed. If the patient disagrees with this decision a second opinion can be sought.

6.7 Refusal of CPR by a patient with capacity

If there is a risk of cardiac arrest and CPR may be successful the healthcare team must invite the patient to discuss the balance of risks, burdens and benefits with a view to reaching a decision in their best interests. The healthcare professional must respect the decision of a patient with capacity to refuse CPR without implied judgement of beliefs and values, even if they think this decision is wrong or irrational¹⁵. The healthcare professional must ensure the patient has accurate and clear information on which to base their decision, but not attempt to persuade a patient's final decision.

The decision should be clearly documented in the patient's medical and nursing notes.

Patients should be advised that to make their decision to refuse CPR binding, they will need to make a formal *advanced decision to refuse treatment* (ADRT), following the criteria stipulated in the Mental Capacity Act

7. CPR decisions and loss of mental capacity

7.1 Advanced decision to refuse treatment (ADRT) with respect to CPR

An ADRT is a type of advanced directive that becomes relevant if the patient loses capacity, and is a record of the patient's wishes for future care and treatment. There should be a presumption that the patient made the ADRT at a time they had capacity, unless there are grounds to suspect otherwise. The Mental Capacity Act 2005 confirms that an ADRT refusing CPR is legally binding on the healthcare team if the following conditions are met:

- Made by an adult over 18yrs with capacity at the time
- The decision is in writing, signed and witnessed
- Includes a statement that the advance decision is to apply even if the person's life is at risk
- The advance decision has not been withdrawn
- Since the original advance decision was made it has not been followed by a subsequent ADRT, appointment of a welfare attorney (health & welfare) or court order
- The person has not said or done anything clearly inconsistent with the terms of the advance decision
- The circumstances that have arisen match those envisaged by the patient when making the advance decision.

The onus is on the patient to inform relevant others of the existence and location of an ADRT, to ensure it will be applied by healthcare teams when and if they lose capacity. Healthcare professionals must decide if an ADRT applies to the presenting circumstances. . Particular care will be needed where an ADRT has not been reviewed or updated for a long time and attention should be given to any relevant clinical developments or changes in the

person's personal circumstances since the decision was made. For example, some people may have taken actions or made other important decisions that indicate that they had changed their mind.

If there is genuine doubt about the validity of an ADRT further enquiries should be made, but where local resolution is not possible an application to the Court of Protection may be necessary. In an emergency, where further investigation is not practicable, there should be a presumption in favour of CPR where it has a realistic chance of prolonging life. The reasons for viewing an ADRT as invalid or inapplicable must be documented.

7.2 Adult patients who lack capacity but have relevant others

In the case of patients who lack capacity and do not have a **welfare attorney or other legal surrogate** or have not made a valid and applicable **advanced decision refusing treatment** (ADRT for CPR), treatment decisions rest with most senior clinician responsible for the patient. This person must balance the risk of burdens to the patient of surviving cardiac arrest with potential benefits and make a CPR decision in the patient's best interests. If the patient lacks capacity and CPR *would not be successful* an explanation of the decision should still be offered to relevant others. In cases where *CPR may be successful* the patient's relevant others should be consulted, where appropriate, to determine any previously expressed wishes and the level or chance of recovery or burden the patient would find acceptable.

It should be made clear to relevant others that it is not their role to make decisions for the patient, but help the healthcare team gain insight into the patient's views, wishes and values with a view to making a decision in his or her best interests. Relevant others should be assured that their insights will be taken into account when reaching a CPR decision, but they cannot demand treatment for the patient.

It is important not to inappropriately delay CPR decision in a patient who lacks capacity (and compromise the quality of patient care) because it is not practical or appropriate to contact the relevant others immediately, to discuss a best interests decision when CPR might work or give reasons why a DNACPR decision has been made when CPR is not expected to work. For example where relevant others are not contactable despite efforts to contact them. In this situation the senior healthcare professional responsible for the patient's care should:

- Record fully their reasons for not explaining their decision to the relevant others at the time
- Ensure that there is on-going active review of the decision
- Ensure that those close to the patient are informed at the earliest practicable and appropriate opportunity.

Failing to contact relevant others to discuss a CPR decision because the healthcare professional feels it might be inconvenient to those close to the patient, or undesirable, is inappropriate. For example, it would usually be appropriate to contact relevant others in the early hours of the morning to discuss a CPR decision in a patient at imminent risk of cardiac arrest.

7.3 Adult patients who lack capacity but *do* have a welfare attorney or court appointed deputy (see Fig. 1 below)

Under the Mental Capacity Act 2005 a person over 18 years of age with capacity can give Lasting Power of Attorney for health to a relevant other, authorising this person to make health decisions when, and if, they lose capacity. Although it may be appropriate to involve a ***property and affairs attorney (or a person with enduring power of attorney)*** in CPR decisions for a patient who lacks capacity because they are close to the patient, this person *does not* have the same powers as a relevant other with Lasting Power of Attorney for health. Before accepting the person with Lasting Power of Attorney for health as having the authority to make treatment decisions for the patient, the clinical team must be satisfied that:

- The patient lacks capacity to make decisions for themselves
- There is a statement in the LPA document authorising the welfare attorney to make decisions about life-sustaining treatment
- The LPA has been registered with the Office of the Public Guardian (their LPA document will have been marked with an official stamp)

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.

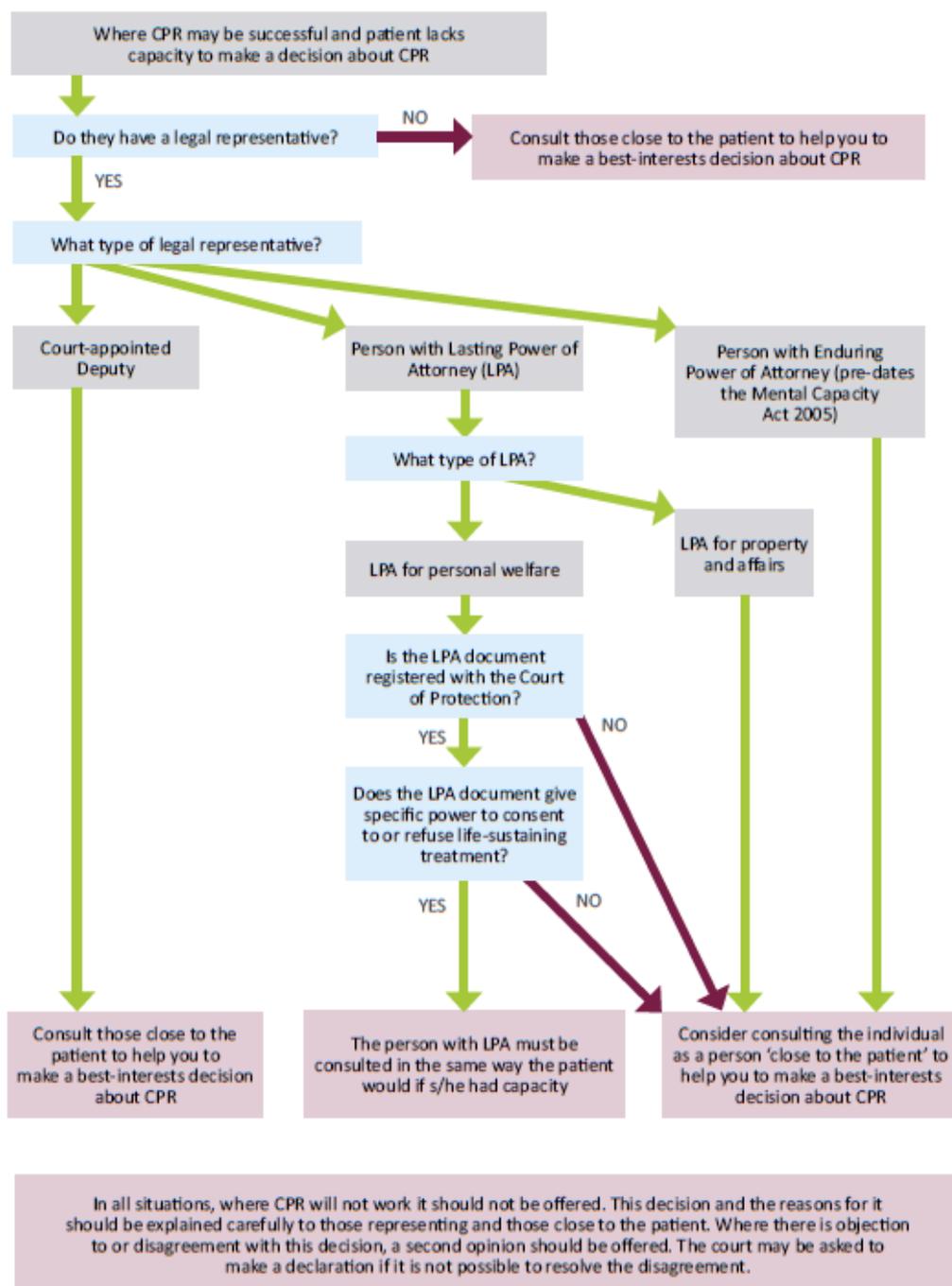
If CPR may work for the patient a discussion must be held with the welfare attorney or deputy to explain, discuss and agree whether or not CPR is in the patient's best interests. The welfare attorney can only make decisions on behalf of the patient regarding CPR if the power of attorney document states specifically that the welfare attorney has the power to consent to or refuse life-sustaining treatment. If the welfare attorney makes that decision on behalf of a patient, it is a binding decision that must be respected by the healthcare team 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 welfare attorney's decision was not made in the patient's best interests.

All reasonable steps must be made to contact the welfare attorney or deputy, but if this relevant other is not contactable and an imminent decision is required the healthcare team will need to make a best interests decision, based on the information available. The welfare attorney/deputy must be contacted at the earliest opportunity.

The welfare attorney cannot demand treatment on behalf of the patient that the healthcare team consider clinically inappropriate. If there is a disagreement between the welfare attorney or court-appointed deputy about whether CPR should be started or withheld, and this cannot be resolved through discussion and a second clinical opinion, the Court of Protection may be asked to make a declaration.

Fig 1 Making CPR decisions when the patient has appointed a lasting power of attorney for personal welfare or court appointed deputy¹



7.4 Adults that lack capacity and have no relevant others to consult

If a CPR decision is required and the patient without capacity has no relevant others to speak on their behalf, an independent mental capacity advocate (IMCA) must be consulted. An IMCA should be consulted if CPR will not work and if it might work, but the risk of burdens and benefits to the patient require consideration. If the IMCA is not available and an imminent decision is required the healthcare team must make the decision in the patient’s best interests and the IMCA consulted at the earliest possible opportunity. An IMCA does not have the power to make a CPR decision but must be consulted when there is no person

to talk on the patient's behalf as part of the process of reaching a decision in the patient's best interests.

8. Confidentiality

A patient with capacity must give their permission before any aspect of their care and treatment, including CPR decisions, is shared with their relevant others. It can be helpful to ask patients with capacity to name the relevant others they would like information shared with should they lose capacity. It is important to explain that this relevant other cannot make decisions for the patient unless they are formally appointed welfare attorney. If a patient with capacity refuses for their information to be shared this should be respected, even if they subsequently lose capacity.

If a patient at risk of cardiorespiratory arrest lacks capacity and their views on disclosing their health information with relevant others are not known, the healthcare team can share the appropriate clinical information required to reach a CPR decision in the patient's best interests.

- Welfare attorneys and court appointed deputy should be provided with the information required to reach a decision in the patient's best interests.
- An IMCA representing a patient without capacity has a legal right to information, including access to relevant sections of the patient's medical notes.

9. Who is responsible for making CPR decisions?

The consultant or GP caring for the patient takes overall responsibility for making CPR decisions in most cases. Where the care of the patient involves more than one team (for example two consultants or a consultant and GP) there should be, where appropriate, shared responsibility for deciding on the likelihood of the success of CPR. However the clinician whose team has initiated the CPR decision should take overall responsibility for this aspect of care, including ensuring that decisions are properly recorded and communicated to all those that need to know them, including locum staff. This may be the GP, hospital consultant or hospice medical director.

It is good practice to share this decision making process with other members of the healthcare team, to ensure decisions are fully informed and the final decision is communicated appropriately. If agreement cannot be reached within the team or across multiple teams (for example in hospital and primary care) a second clinical opinion should be sought. A second opinion should be provided by a senior clinician with experience in the condition but not directly involved in the patient's care. It should be based on an examination of the patient by the clinician.

The clinician responsible for the patient's care may devolve to appropriate members of his or her team the decision to initiate conversations about CPR with patients and their relevant others and make CPR decisions

- Doctors:
 - A CT 1 and 2 doctor or a GP trainee can make a CPR decision but this must be reviewed by the senior doctor on call within 24 hours
 - A CT3 and above can make a CPR decision or review the decision of a CT 1 or 2 doctor, but this decision must be reviewed by the Consultant/GP responsible for the patient at the earliest opportunity and the DNACPR form countersigned.
- Registered nurses (RN):
 - An appropriately trained RN can initiate CPR discussions with patients and make CPR decisions. This must have been discussed with the doctor in charge of the patient's care in advance to ensure agreement that the patient is at risk of cardiorespiratory arrest or is in the advanced stages of incurable disease. The DNACPR form must be countersigned by the doctor with overall responsibility for the patient's care at the earliest opportunity and preferably within 72 hours.
 - In exceptional circumstances an RN or registered paramedic working as an unscheduled care practitioner with appropriate training can initiate appropriate emergency discussions with the patient, or relevant others if the patient lacks capacity, with a view to making a CPR decision. For example a dying patient in the community being attended by an unscheduled care practitioner or a dying patient on an oncology ward with no senior doctor availability. The following criteria must be met:
 - ✓ The patient must be in the final stages of a previously diagnosed chronic disease.
 - ✓ Death must be thought to be imminent
 - ✓ CPR will not, in the judgement of the RN or paramedic making the decision, be successful for longer and will cause the patient a traumatic and undignified death.
 - ✓ Every reasonable effort to contact a senior doctor to assess the need for a CPR decision has failed
 - ✓ There is no advanced decision to refuse CPR in place for a patient without capacity.

This must be reviewed at the earliest opportunity by a senior doctor responsible for the patient's care and not later than 24 hours.

Healthcare professionals and acute and primary healthcare organisations in the North and North East Lincolnshire region should support a healthcare provider's decision to place a valid DNACPR status

10. Documenting DNACPR decisions

Good documentation and communication of CPR decisions reduces the risk of unnecessary suffering

When witnessing a patient in cardiorespiratory arrest it is usually very difficult for most healthcare professionals *not* to start CPR. A red bordered, readily available, legible and correctly completed DNACPR form will give the (often quite junior) clinician the confidence to resist the urge to save life in favour of allowing the patient a peaceful and dignified death. Poor communication/documentation will confuse, give rise to anxiety and can result in a patient undergoing a traumatic and undignified treatment that is not in their best interests. Such CPR attempts may traumatise the patient's relevant others and health care professionals.

DNACPR decisions made in the North and North East Lincolnshire region should be documented in the following way:

- A red bordered *Do Not Attempt Cardiopulmonary Resuscitation* regional form (form code WQN290) should be used. This form is recognized by ambulance services, acute hospital Trusts and many primary care organisations across the North and North East Lincolnshire region and Yorkshire. (nb RDASH order code is WZT 652)
- The use of a black and white photocopy of this form completed in handwritten ink is acceptable but discouraged, due to the risk that the form will not be recognized by ambulance and hospital admissions staff. This has in the past led to patients undergoing inappropriate CPR. *If a black and white photocopy is used it must be completed in ink.*

While a photocopy of a completed form is not acceptable, it should prompt admitting hospitals to review the patient's CPR status on admission, as should DNACPR forms from outside the region, hand written notes and tattoos declining CPR.

- Acute hospital staff will complete the form in triplicate. DNACPR forms completed in the community need to be read-coded on SystemOne, where available, and scanned into the patient electronic records. The form must be completed correctly, review dates (if appropriate) clearly dated, or the 'valid until end of life box' ticked, and countersigned by the senior doctor where appropriate
 - **Copy 1** (original - hand written): The original form should accompany the patient. The form may be given to the patient or their relevant other if the patient lacks capacity or kept in the medical notes for as long as the patient is in a hospital setting. See Section 11 for management of the DNACPR form on discharge or transfer of the patient.
 - **Copy 2** (carbon copy – hospital only): Retained in the front of the hospital medical notes
 - **Copy 3** (carbon copy – hospital only): Send to the '*Audit Department*' in a sealed envelope.

Fig 2 Regional DNACPR form

Northern Lincolnshire and Goole NHS NHS Foundation Trust				
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION				
Yorkshire & Humber Regional Form for Adults and Young People aged 16 and over				
Print Code: WQN 290 Version: 13.0				
In the event of cardiac or respiratory arrest NO attempts at cardiopulmonary resuscitation (CPR) will be made. All other treatment should be given where appropriate.				
NHS No:		Hospital No:		Next of Kin / Emergency Contact:
Name:				
Address:			Relationship:	
Postcode:		Date of Birth:		Telephone No:
Section 1 – Reason for DNACPR decision: Select as appropriate from A – D				
<i>Details of all discussions, mental capacity assessments and MDT decisions must be recorded in the patient's notes.</i>				
<i>(Guidance overleaf)</i>				
A. <input type="checkbox"/> CPR has been discussed with this patient. It is against their wishes and they have the mental capacity to make this decision.				
<i>(Guidance overleaf)</i>				
B. <input type="checkbox"/> CPR is against the wishes of the patient as recorded in a valid advance decision. The right to refuse CPR in an Advance Decision only applies from the age of 18.				
<i>(Guidance overleaf)</i>				
C. <input type="checkbox"/> The outcome of CPR would <i>not</i> be of overall benefit to the patient and:				
i) They lack the capacity to make the decision <input type="checkbox"/> or				
ii) They have declined to discuss the decision <input type="checkbox"/>				
This represents a best interests decision and must be discussed with relevant others				
This has been discussed with (name) on (date/time)				
Relationship to patient:				
<i>(Guidance overleaf)</i>				
D. <input type="checkbox"/> CPR would be of no clinical benefit because of the following medical conditions:				
.....				
In these situations when CPR is not expected to be successful, it is good practice to explain to the patient and/or relevant others why CPR will not be attempted.				
This has been discussed with the patient <input type="checkbox"/> Date:...../...../..... Time:.....				
This has not been discussed with the patient <input type="checkbox"/> <i>Specify Reason:</i>				
This has been discussed with (name) on (date/time)				
Relationship to patient:				
Section 2 – Review of DNACPR decision: Select as appropriate from i OR ii				
i) DNACPR decision is to be reviewed by:..... <i>(specify date)</i>				
Review Date	Full Name and Designation	Signature	DNACPR still applies	Next Review Date
			<input type="checkbox"/> <i>(tick)</i>	
			<input type="checkbox"/> <i>(tick)</i>	
			<input type="checkbox"/> <i>(tick)</i>	
ii) DNACPR decision is to remain valid until end of life			<input type="checkbox"/> <i>(tick)</i>	
Section 3 – Healthcare professionals completing DNACPR Form <i>(Guidance overleaf)</i>				
<i>(Countersignature if required)</i>				
Date: Time:		Date: Time:		
Signature:		Signature:		
Print name:		Print name:		
Designation & Organisation:		Designation & Organisation:		
GMC / NMC No:		GMC / NMC No:		
Top Copy: To accompany the patient (see over)				
Middle Copy: To be filed in the front of the <u>Current Admission Sheet</u> in the patient's notes				
Bottom Copy: Send to Clinical Audit				

- The DNACPR form will contain the essential information required to communicate the CPR decision to other health care professionals in an emergency, but additional information will usually require documenting in the main health record at the time of the decision and updated where appropriate. It is the responsibility of the person making the CPR decision to clearly document the DNACPR order in the patient’s paper or electronic health records (see table 1 below).
- The senior hospital/community registered nurse responsible for the patient is also responsible for ensuring the DNACPR order is clearly documented in the patient’s paper or electronic nursing record and verbally communicated to all members of the ward or community nursing team (See Appendices 2a and 2b for examples of acute and non-acute documentation).

Table 1. Standards for completion of red-bordered DNACPR forms and the main health record. The following must be documented	Where information should be documented
<ul style="list-style-type: none"> • The decision, including date and time Only use term: <i>Do Not Attempt Cardiopulmonary Resuscitation</i> 	Main medical notes and DNACPR form
<ul style="list-style-type: none"> • Detailed reasons for making the decision 	Main medical notes and short version on DNACPR form
<ul style="list-style-type: none"> • Name and position of person making the decision. If the person making the decision is not the clinician with overall responsibility for the patient, the name of this person should be noted too. 	Main medical notes and DNACPR form
<ul style="list-style-type: none"> • Time and date of required senior clinician review 	Main medical notes and DNACPR form
<ul style="list-style-type: none"> • A formal assessment of the patient’s capacity at the time of the decision, if required 	Main medical notes
<ul style="list-style-type: none"> • The existence and identity or the absence of an individual with legal authority to make decisions for a person who lacks capacity 	Main medical notes
<ul style="list-style-type: none"> • Details of discussions held with the patient or, if the patient lacks capacity, the patient’s relevant others, including welfare attorney, court appointed deputy or IMCA 	Main medical notes
<ul style="list-style-type: none"> • If no discussions have taken place reasons why must be documented 	Main medical notes
<ul style="list-style-type: none"> • Details of the information offered to the patient and/or their relevant others members of the healthcare team who contributed to the decision (for example those attending a multi-disciplinary meeting or best interests meeting) 	Main medical notes
<ul style="list-style-type: none"> • Details of a second opinion if requested 	Main medical notes
<ul style="list-style-type: none"> • Details of legal advice sought 	Main medical notes
<ul style="list-style-type: none"> • Contact details of relevant others 	Main medical notes and next of kin details on front sheet

10.1 Electronic patient record systems

- Where possible electronic health systems such as WEB V (acute hospitals), SystemOne/EMIS (primary care), Symphony (emergency care centres) and the East Midlands Ambulance Service should alert users to patients with DNACPR orders or advanced decisions to refuse treatment (ADRT). *The clinician responsible for the DNACPR order must ensure the appropriate electronic alert is activated.*
- Only DNACPR orders valid until end of life should alert on electronic systems. A DNACPR order with review dates may be cancelled on paper but not electronically, which might deny patients CPR when it is in their best interests (see Section 12 below).
- At the time of writing this policy electronic systems in the region were not robustly communicating CPR decisions to each other. This should be a priority to ensure a DNACPR without review will alert healthcare professionals, such as paramedics, across the region. *Ideally the red-bordered DNACPR form should be electronically available to all appropriate healthcare professionals across all sectors of care in the region, which will allow confirmation of the validity of the DNACPR order and the reason the decision was made. This will reassure staff that their response in the crisis of cardiorespiratory arrest, should it occur, is based on careful assessment of the patient's best interests*

11. Communicating a DNACPR order on transfer/discharge of the patient

The consultant, GP or hospice medical director with overall responsibility for a DNACPR order is also responsible for ensuring the decision is communicated effectively to other healthcare professionals. In practice this will involve delegating responsibility for sharing information with other members of the healthcare team.

- On discharge/transfer ensure the patient, or relevant other of a patient who lacks capacity, is given a valid, (preferably) red-bordered, up to date and correctly completed DNACPR form in legible hand written ink. This should be in a sealed and clearly labelled envelope.
Or
Sealed in a clearly marked envelope and passed to the senior healthcare professional receiving the patient on transfer to another health care setting.

The healthcare professional responsible for the CPR decision must decide the most reliable and appropriate person to safeguard the form. Ideally this should be the patient but might also be a relevant other of a patient without capacity, or healthcare professional. It may be appropriate to discuss with the patient and/or relevant others the continued relevance of the DNACPR form and the reasons for transferring or discharging them with it.

- Instruct the patient, relevant other or healthcare professional safeguarding the DNACPR form to ensure it is easily accessible at all times. The form should be presented to the receiving healthcare professional when the patient moves between health care settings; for example, from home to an emergency ambulance or from hospital to a nursing home. On receipt of a transferred DNACPR order staff in the receiving healthcare setting should document the decision and verbally brief their teams. The original form should be returned to the patient or relevant other where appropriate, or

retained by the healthcare team. *The retaining of photocopies of the original form is discouraged.*

- The healthcare professional responsible for arranging transport of a patient with a valid DNACPR must inform the patient transport service or ambulance crew that the patient is not for CPR. The PTS/ambulance crew will usually wish to view the DNACPR form, which is accepted as valid by East Midlands Ambulance service ²⁰.
- Hospital doctors/GPs discharging or transferring the patient between health care settings must ensure electronic or paper discharge/transfer letters clearly document the DNACPR order and that any electronic alerts are activated. Correspondence should state who holds a copy of the original DNACPR form.
- Hospital/community registered nurses responsible for the patient's nursing care must ensure the DNACPR decision is documented in the patient's nursing notes and communicated to other members of their clinical team (for example the ward nursing team or community nursing team). This should include appropriate therapy teams that are expected to care for the patient, who in turn must document the decision in their notes and verbally communicate it with their team members.
- If there is ever doubt about the validity of a DNACPR order following the transfer of a patient (for example because the DNACPR form is incomplete or illegible), the healthcare professional responsible for receiving the patient must clarify and confirm the CPR decision at the earliest opportunity. This can be done by contacting the clinician with overall responsibility for the patient's care or members of his or her team and/or the named healthcare professional responsible for transferring the patient.
- In some clinical settings discussion of the decision may have been impossible or inappropriate due to the person's health at the time, or may have been declined by the patient. In many circumstances, involving the patient in the decision-making process through discussion or explanation is required under Article 8 of the Human Right Act. The transfer of a CPR decision form with a patient greatly increases the importance of this. Prior to transfer, where appropriate, the continued relevance of a CPR decision and the reason for transfer with them of a CPR decision form should be discussed and explained to patients.

12. Review of CPR decisions

Review of DNACPR status by the clinician with overall responsibility for the patient's care (or their deputy) should always take place when there is a change in the patient's circumstances. In the case of acutely unwell patients such reviews may take place on a day to day or even hour to hour basis. For a patient with an irreversible illness, approaching the end of life, a DNACPR decision will usually remain valid until the end of life and reviews tend to be less frequent or not required at all.

A review may result in the decision to attempt or withhold CPR. Circumstances prompting the review and its outcome must be clearly recorded in the patient's medical and nursing notes (if separate), together with who was involved in the decision making process. Review of DNACPR decisions should take place in the following circumstances:

- A change in the patient's wishes
- On transfer of Medical Responsibility (e.g. hospital to community or *vice versa*)
- Whenever there are significant changes in the patient's condition or the senior clinician changes the plan of care
- At consultant ward rounds, MDT or Gold Standards Framework meeting.
- Fixed review dates for CPR decisions should be used with caution, as they increase the risk that healthcare staff will view the decision as invalid if the review date has passed without a documented review. This may result in contra-indicated or unbeneficial CPR ¹. Section 2 of the regional DNACPR form allows for the review of a decision at a specific date in the future. Fixed reviews of DNACPR forms will rarely if ever be required for community based patients, but may have a role to play for acutely unwell in-patients, where the condition may improve or deteriorate in a relatively short time span. Review should ideally be triggered in the circumstances listed above.
- It is not necessary to enter discussion with the patient/relevant others every time a decision is reviewed, unless it is likely the decision will be revised. It is essential to discuss changes to CPR status with the patient or relevant other in the case of a patient who lacks capacity. Where the decision was shared with the patient (or their welfare attorney) because CPR *may* work, any further CPR decisions should be shared with the patient (or their relevant other if they have since lost capacity), or where this is not practicable or not appropriate the reasons should be documented clearly.

12.1 Cancellation of a DNACPR

Cancellation of a DNACPR order must be clearly documented in all relevant patient records and two bold diagonal lines drawn across *all* copies of DNACPR forms with the word 'cancelled' written in bold capitals

The image shows a sample of a DNACPR form titled "DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION". The form is partially filled out and has the word "CANCELLED" written in large, bold, black capital letters across its center. Two bold diagonal lines are drawn across the form, one from the top-left to the bottom-right and another from the top-right to the bottom-left, intersecting the word "CANCELLED". The form includes sections for patient information, reasons for the decision, and a review section.

13.CPR Decisions in Children and young people under 18 years of age

CPR decisions should ideally be based on a supportive partnership involving the young person, the parents and the healthcare team. There is helpful documentation and forms from Sheffield Children's Hospitals, which includes Limitation of Treatment Agreements.

CPR decisions in the case of children and young adults have similarities with those for adults. For example:

- There is no requirement to discuss CPR decisions for a child or young person if the risk of cardiorespiratory arrest is low.
- CPR should not be attempted if it will not work

As in adults difficulties tend to arise when CPR may restore the child or young person's heart beat and breathing for a sustained period, but the potential benefits of CPR must be weighed with the risk of harm and burdens. In these cases the views of the child/young person must, where possible, be taken into account.

Where difficulties arise in reaching a CPR decision between the child/young person, the relevant others with parental responsibility and the healthcare team, legal advice should be sought in a timely manner. A doctor cannot be forced to deliver CPR if he or she believes it will not be effective, but in cases where some doubt remains over the best interests of the child/young person all efforts should be made to accommodate the wishes of children and parents. A limitation of treatment agreement (LOTA) /End of Life (EOL) care plan with the young person/ parents is helpful. Full resuscitation in children / young people with complex needs will usually go ahead where LOTA / EOL care plans are not in place, pending the arrival of parents. If legal advice is required, this should be sought in a timely manner.

If a competent child/young person up to the age of 18 refuses CPR, healthcare professionals should seek legal advice if they believe CPR may benefit the patient. Where a young person who is competent refuses CPR, the potential harm caused by violating his or her choice must be balanced against the risk from not giving CPR. This refusal by a competent child/young person is not necessarily binding upon doctors and the courts have overridden competent young people's refusal of life-saving treatment in the past, but young people who are competent are entitled to give consent to medical treatment. Where the child/young person is not competent it is usually the relevant other with parental responsibility who will make the decision on the child's behalf.

Young people 16 years of age and over are assumed to be competent to consent to medical treatment unless there is evidence to the contrary. Young people under the age of 16 can also be assessed to be competent to consent to medical treatment (competency to consent in children younger than 16 is sometimes referred to as '*Gillick competency*'¹⁸).

13.1 Children/Young adults and confidentiality

While the child/young adult is usually content to share decisions with their parents, the same rules of confidentiality apply to children and adults. If a competent child/young person is reluctant to involve their relevant other with parental responsibility in a CPR decision, every effort should be made to persuade them.

Where the child is not competent and does not want parental involvement, but the doctor believes it is in the child/young adult's best interest to disclose information, this information can be shared with relevant others with parental authority or appropriate authorities¹⁹.

13.2 Children/young people and DNACPR forms

Parental co-signing of DNACPR forms for children/young people is not a legal requirement and not recommended¹. Co-signing can cause additional distress and may lead relevant others with parental responsibility to mistakenly infer that they are signing for making the decision to withhold CPR.

14. CPR decisions – Training

CPR decisions usually involve sensitive and complex conversations with patients, their relevant others and healthcare professionals. Registered nurses and doctors initiating the CPR decision making process must be appropriately trained, competent and experienced.

Healthcare professionals initiating and acting on CPR decisions should:

- Read and understand this policy
- Maintain their mandatory resuscitation training competency, which includes a CPR decisions update commensurate with their role and seniority
- Attend non-mandatory training designed to develop skills required for patient-centred CPR decision making

Training courses should develop and consolidate the skills senior healthcare professionals require to:

- Make appropriate decisions about CPR
- Understand where further information and advice can be found
- Understand something of the law and ethics of CPR decisions
- Provide information to patients and their relevant others
- **Communicate effectively with patients and those close to them**
- Support involvement of patients and those close to them through sensitive discussions
- Undertake appropriate review of decisions about CPR.

15. CPR decisions – Standards and audits

- Acute hospital resuscitation to manage National cardiac arrest Audit (NCAA) of in hospital arrests. Based on NCAA data, attendance at cardiac arrests and DATIX incident reports resuscitation officers to conduct mortality reviews of patients thought to have undergone cardiac arrest when it was either inappropriate, futile or not in their best interests. All mortality reviews to be escalated via the acute trust mortality work-streams.
- Audit department to conduct a rolling annual audit of all returned copies (sent to the Quality and Audit Department in a sealed envelope marked 'confidential') of the regional DNACPR form, using standards selected from this policy (pages 5-6 and Table 1). Outcomes to be reported to the clinical management team of the directorate being audited, the Medical Director, the Head of Governance and the NLAG End of Life group as well as the Multi-Agency End of Life Strategy Group.

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Consultation

- Multi-agency End of Life Group – all members, including providers and commissioners

Appendix 1 Training competencies for senior doctors and nurses making DNACPR decisions

Competencies for training doctors and nurses how to make DNACPR orders	
<p>A simpler version of the key points can be offered to 'non-decision makers' such as ward RNs, foundation doctors and AHPs on mandatory resuscitation courses.</p> <ul style="list-style-type: none"> • Important to stress to ward RNs and FY doctors that while CPR is the default response if there is no documented CPR decision, they will be supported if they decide not to start CPR in a patient with advanced signs of irreversible death such as rigor mortis or a person in the terminal stages of a chronic disease where death is imminent and it has been impossible to find a senior doctor to make a DNACPR decision. • They will also be supported if they decide to start resuscitation for a patient with a DNACPR order or applicable and valid ARDT who has developed life threatening problems not anticipated by the DNACPR/ADRT. For example choking a blocked tracheostomy or displaced/blocked ET tube, to mention a few. 	
Competency	Explanation to candidates
Competency 1. Recognise when to initiate CPR discussions	Risk of cardiac arrest/death. Advanced planning for end of life.
Competency 2. Recognise when CPR <i>will not</i> be successful and when CPR <i>may be</i> successful	<ul style="list-style-type: none"> • <u><i>If CPR will not work</i></u> it must not be offered to the patient. The clinician should still discuss the decision with the patient or relevant other if the patient lacks capacity (unless the patient has expressly stated at a time they had capacity they do not want this discussed with others). • <u><i>If CPR may work</i></u> and the decision is a shared one with a patient <i>with capacity</i>. If after careful explanation, and even when the chances of success are low, the patient wants CPR, the clinician will usually respect this wish. • The healthcare team is not obliged to deliver CPR if they believe it will not work. A second opinion should be offered to patients/relevant others.
Competency 3. Recognise when a patient lacks capacity using the capacity criteria	<ul style="list-style-type: none"> • Go through capacity criteria. See 1.1 Key definitions above
Competency 4. Understand who to discuss a CPR decision with if <i>CPR may be successful</i> but the patient lacks capacity	<ul style="list-style-type: none"> • If patient has a valid and applicable advanced decision to refuse treatment with respect to life sustaining treatment this should be respected • If the patient has a court-appointed deputy or welfare attorney they must be consulted • If the patient does not have an ADRT or legal representative then discuss with relevant others (but stress that they are unable to make decisions for the patient and their role is to help the healthcare team understand what the patient would want if they could speak for themselves. • For a patient who lacks capacity and has no relevant others an independent mental capacity advocate (IMCA) should be appointed. (An IMCA should probably be appointed for a patient without capacity when <i>CPR will not work</i>.)
Competency 5. Understand what action to take if a patient with capacity is unwilling to discuss a CPR decision.	<ul style="list-style-type: none"> • Respect this decision. The patient may be willing for the clinician to discuss with relevant others, but respect the patient's decision if they refuse this option.
Competency 6. Other key points the candidate must understand	<ul style="list-style-type: none"> • No CPR decision – presumption to start CPR if arrest occurs • CPR decisions require sensitive and effective communication. <i>Role play</i> is an excellent way of developing these skills in suitably experienced nurses and doctors. Stress importance of explaining that to patients/relevant others that other beneficial treatments will not be withheld. A DNACPR does not mean 'giving up' on the patient. • Go through documentation with reference to the regional DNACPR form and the DNACPR continuation sheet. • CPR decisions may require review in patients whose circumstances, such as prognosis or wishes, change • Give information of where advice can be sought if uncertainty arises

Affix addressograph label or enter patient details

Appendix 2a Acute care example of documentation

Patient Name:

NHS No.

D.O.B.

Continuation Case Sheet

Do Not Attempt Cardiopulmonary Resuscitation

Decisions (DNACPR) Only

Table 1. Standards for completion of red-bordered DNACPR forms and the main health record. The following must be documented	Where information should be documented
• The decision, including date and time. Only use term Do Not Attempt Cardiopulmonary Resuscitation	Main medical notes and DNACPR form
• Detailed reasons for making the decision	Main medical notes and short version on DNACPR form
• Name and position of person making the decision. If the person making the decision is not the clinician with overall responsibility for the patient, the name of this person should be noted too.	Main medical notes and DNACPR form
• Time and date of required senior clinician review	Main medical notes and DNACPR form
• A formal assessment of the patient's capacity at the time of the decision, if required	Main medical notes
• The existence and identity or the absence of an individual with legal authority to make decisions for a person who lacks capacity	Main medical notes
• Details of discussions held with the patient or, if the patient lacks capacity, the patient's relevant others, including welfare attorney, court appointed deputy or IMCA	Main medical notes
• If no discussions have taken place reasons why must be documented	Main medical notes
• Details of the information offered to the patient and/or their relevant others members of the healthcare team who contributed to the decision (for example those attending a multi-disciplinary meeting or best interests meeting)	Main medical notes
• Details of a second opinion if requested	Main medical notes
• Details of legal advice sought	Main medical notes

Date & Time	Contact details of relevant others	For all entries print name, designation and sign	Main medical notes and next of kin details on front sheet
09:40 01/02/2016			ATSP by FY2 on call in view of worsening condition. Not for ITU admission. See entry in notes above. Due to recent stroke with dense hemiplegia and incomplete swallow reflex, exacerbated by aspiration pneumonia and possible sepsis patient is at risk of cardiac arrest. I do not expect CPR to be successful. I have discussed the situation with Mr Parker's partner and her son. Staff Nurse Moore present. I have explained that we will continue to give IV antibiotics, oxygen and IV fluids and ensure Mr Parker is comfortable, but if his heart stops it is extremely unlikely that we will be able to re-start it. continued overleaf

Affix addressograph label or enter patient details below:-

Patient Name:

NHS No.

D.O.B.

Continuation Case Sheet

Do Not Attempt Cardiopulmonary Resuscitation
Decisions (DNACPR) Only

Date & Time	For all entries print name, designation and sign
09:40 01/02/2016	<p>It is my belief that he will not survive to hospital discharge. I have also explained what CPR involves.</p> <p>Mr Parker's son is adamant he wants his father resuscitated in the event of cardiac arrest. I have offered him a second opinion. Dr Patel, consultant elderly medicine, will discuss with family. SN Moore has left a DNACPR leaflet with the family.</p> <p>Dr P. Ramrakha</p> <p>CT5 Elderly medicine Bleep 111</p>
11:30 01/02/2016	<p><i>Consultant Review</i></p> <p><i>Myself and Sister Norbert discussed DNACPR status with Mr Parker's wife and son. Explained that Mr Parker is at risk of cardiac arrest and while we will continue to do our best to make him better we must also plan for the worst outcome. I have stressed that CPR is a very unpleasant treatment which will not, in my view, work but may cause Mr Parker more suffering. I have stressed that as doctors and nurses we should not be delivering care that is unlikely to work but may cause additional suffering. Family are distressed but understand the decision.</i></p> <p style="text-align: center;"><u>NOT FOR CARDIOPULMONARY RESUSCITATION</u></p> <p><i>Dr R. Patel</i></p> <p><i>Consultant Elderly Medicine</i></p>

Patient Name:

NHS No.

D.O.B.

Continuation Case Sheet

Do Not Attempt Cardiopulmonary Resuscitation

Decisions (DNACPR) Only

Table 1. Standards for completion of red-bordered DNACPR forms and the main health record. The following must be documented	Where information should be documented
<ul style="list-style-type: none"> The decision, including date and time Only use term Do Not Attempt Cardiopulmonary Resuscitation 	Main medical notes and DNACPR form
<ul style="list-style-type: none"> Detailed reasons for making the decision 	Main medical notes and short version on DNACPR form
<ul style="list-style-type: none"> Name and position of person making the decision. If the person making the decision is not the clinician with overall responsibility for the patient, the name of this person should be noted too. 	Main medical notes and DNACPR form
<ul style="list-style-type: none"> Time and date of required senior clinician review 	Main medical notes and DNACPR form
<ul style="list-style-type: none"> A formal assessment of the patient's capacity at the time of the decision, if required 	Main medical notes
<ul style="list-style-type: none"> The existence and identity or the absence of an individual with legal authority to make decisions for a person who lacks capacity 	Main medical notes
<ul style="list-style-type: none"> Details of discussions held with the patient or, if the patient lacks capacity, the patient's relevant others, including welfare attorney, court appointed deputy or IMCA 	Main medical notes
<ul style="list-style-type: none"> If no discussions have taken place reasons why must be documented 	Main medical notes
<ul style="list-style-type: none"> Details of the information offered to the patient and/or their relevant others members of the healthcare team who contributed to the decision (for example those attending a multi-disciplinary meeting or best interests meeting) 	Main medical notes
<ul style="list-style-type: none"> Details of a second opinion if requested 	Main medical notes

Date & Time

For all entries print name, designation and sign

12/01/2016
10:22

Specialist respiratory nurse clinic

Saw Mr Smith and his wife today.

Exercise tolerance further reduced, now at less than 10 feet. Sleeping down stairs. On maximum medication. Frequent admissions for acute exacerbation of COPD and pulmonary fibrosis. Propped on 6 pillows at night and having difficulty sleeping. 24% oxygen. Spends most of the day seated or in bed. I discussed Bob's care with Dr Williams following my meeting with Bob and his wife last week (see 07/01/2016 above) and it was agreed to initiate a discussion about end of life. Discussed end of life with Bob and his wife and what they would like to happen.

Continued over

Affix addressograph label or enter patient details below:-

Patient Name:

NHS No.

D.O.B.

Continuation Case Sheet

Do Not Attempt Cardiopulmonary Resuscitation

Decisions (DNACPR) Only

Date & Time	
12/01/2016 10:22	<p>what CPR involved and that it was unlikely it would do more than prolong his suffering Bob has full mental capacity. that CPR is not in his best interests and he does not want to be resuscitated should his heart stop.</p> <p><u>CARDIORESPIRATORY RESUSCITATION</u></p> <p>completed as per policy and a copy left with the patient. I have discussed with Bob and his wife that I will continue to support him and I have discussed with Dr Williams, the consultant, his GP and the end of life team.</p> <p>CNS Bryant Senior nurse specialist Bleep 111</p> <p>Review</p> <p><u>NOT FOR CARDIORESPIRATORY RESUSCITATION</u></p> <p>DNACPR form countersigned. CNS Bryant has contacted End of Life team and I will write to GP. CNS Bryant to continue to provide support visits.</p> <p>Dr Williams Physician Consultant Physician</p>
12/01/2016 11:10	<p>should do anything. He would not want to be resuscitated.</p> <p>s and a copy of the DNACPR form at I will continue to provide treatment</p> <p><u>NOT FOR CARDIORESPIRATORY RESUSCITATION</u></p> <p>ected End of Life team Physician</p>

Appendix 3 Deactivating Implantable Cardiac Defibrillators (ICD)

Some important points to explain to people about ICD deactivation

Deactivating your ICD will not cause death.

Once your ICD has been deactivated, if you have a heart rhythm change that could cause death, your ICD will not deliver treatment for it.

Deactivating the shock function of your ICD does not deactivate its pacemaker function.

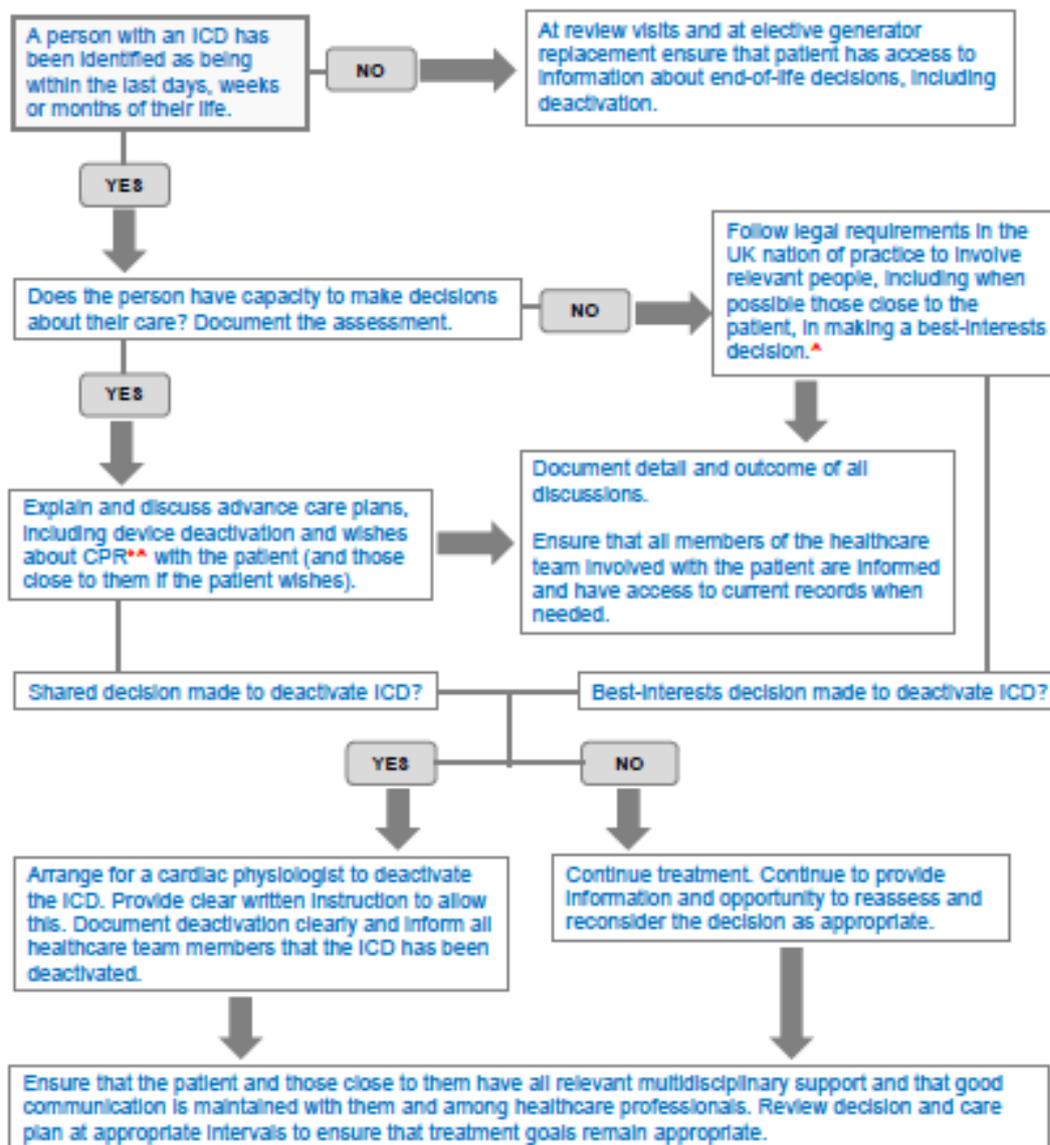
Deactivating your ICD will be painless.

Near the end of your life your ICD may deliver shocks that are painful and distressing and are of no benefit.

If your condition improves unexpectedly or you change your mind the ICD can be reactivated.

It is best to think and decide about ICD deactivation in advance, rather than in a crisis.

Decision chart for ICD deactivation towards the end of a person's life



* A DNACPR decision does not automatically warrant ICD deactivation and vice versa.
 ** See "Cardiovascular Implanted Electronic Devices in people towards the End of Life, during Cardiopulmonary Resuscitation and after Death" and "Decisions relating to Cardiopulmonary Resuscitation" www.resus.org.uk.

Decision chart for emergency ICD deactivation

