Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy
(16 years and above)

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<th>Approved By:</th>
<th>UHL Policies &amp; Guidelines Committee</th>
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                          Head of Outcomes & Effectiveness  
                          Resuscitation Lead               |
| Name of Responsible Committee/Individual: | Deputy Medical Director/Chair of Resuscitation Committee  
UHL End of Life Clinical Lead |
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DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) (16 YEARS AND ABOVE) POLICY SUMMARY

1. This policy applies to all patients aged 16 years and over.

2. All patients are presumed to be “For CPR” unless a valid DNACPR decision has been made and documented or an ADRT prohibits CPR.

3. DNACPR decisions refer only to CPR and not to any other aspect of the individual’s care or treatment options.

4. All DNACPR decisions will:
   • respect the wishes of the individual, where possible
   • reflect the best interests of the individual
   • provide benefits that are not outweighed by burden

5. When considering making a DNACPR decision for an individual it is important to consider:
   • Is Cardiac Arrest a clear possibility for this individual? If not, it may not be necessary to go any further.
   • Is Cardiac Arrest a clear possibility for the individual and CPR may be successful but will not be followed by a length and quality of life in the patient’s judgment that would not be acceptable to the person? If yes, the person’s views and wishes are essential and must be respected
   • If the individual has an irreversible condition, where death is the likely outcome, the individual should be sensitively advised that CPR will not take place, and as such they will be allowed to die a natural death.

6. All discussion around DNACPR decisions must be documented in the patient’s clinical records.

7. The Trust has a legal duty to consult with and inform patients if a DNACPR order is placed in their notes.

8. If a DNACPR decision is made, and there has been no discussion with the individual because the doctor considers that consultation would be distressful and such distress could cause physical or psychological harm, this must be documented in the patient’s clinical record.

9. The current version of the DNACPR form has limited space for documenting discussions with the patient or the rationale for no discussion. Both must therefore be documented in the patient’s clinical notes.

10. CPR decisions made by a professional without overall responsibility for the person’s care need to be reviewed within 24 hours.

11. The date for review, or ‘no review required’ must be documented on the DNACPR form and also in the patient’s clinical record. If a planned DNACPR decision is not reviewed and the form not updated, the DNACPR form becomes invalid.

12. The person in charge of the patient’s daily care is responsible for communicating the decision to colleagues on discharge or transfer.
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KEY WORDS

DNACPR, CPR, DNAR, Resuscitation, Do Not Attempt, Cardiopulmonary Resuscitation
1 Introduction

1.1 Survival following Cardiopulmonary Resuscitation (CPR) in adults is between 5-20% depending on the circumstances. Although CPR can be attempted on any person prior to death, there comes a time for some people when it is not in their best interests as it is against their wishes or would not be successful. It may then be appropriate to consider making a Do Not Attempt CPR (DNACPR) decision to enable the person to die with dignity.

1.2 The “Tracey vs Cambridge” case heard in the Court of Appeal (June 2014) confirmed that NHS Trusts have a legal duty to consult with and inform patients if a DNACPR order is placed on their records. Non discussion has been deemed as an infringement of a patient’s human rights and in particular denies them the ability to seek a second opinion if they disagree with a DNACPR decision.

1.3 The Judgement from the above case stated that causing distress was not a reason for not discussing DNACPR with patients. Only the potential to cause physical or psychological damage would be a reason for non-discussion.

1.4 In October 2014, the British Medical Association, Royal College of Nursing and Resuscitation Council (UK) published their revised guidance “Decisions relating to cardiopulmonary resuscitation”. (previously known as the “Joint Statement) This document advised that all organisations that face decisions about attempting cardiopulmonary resuscitation (CPR) should have a policy about CPR decisions.

1.5 The guidance also said “CPR decisions should be made only after careful consideration of all factors relevant to the patient’s current situation, and after discussion with the patient, (unless they refuse such discussion) or with those close to patients who lack capacity”

2 Policy Aims

2.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for DNACPR

2.2 The aims of this policy are to ensure that:

a) All patients are presumed to be “For CPR” unless a valid DNACPR decision has been made and documented or an ADRT prohibits CPR.

b) All DNACPR decisions are based on current legislation and guidance

c) Sensitive communication concerning the individual’s resuscitation status will occur between the professional making the decision and the individual themselves and communicated to all members of the multidisciplinary healthcare team involved in their care and across the range of care settings; and the individuals family and/or careers where appropriate.

d) The DNACPR decision-making process is measured, monitored and evaluated to ensure a robust governance framework.
3 POLICY SCOPE

3.1 This policy applies to all patients aged 16 years and over. A paediatric policy is in development (see Section 6.15 relating to young people aged between 16 and 18).

3.2 The policy applies to all staff involved in the DNACPR process within UHL.

4 DEFINITIONS

4.1 Cardiopulmonary resuscitation (CPR): Interventions delivered with the intention of restarting the heart and breathing. These will include chest compressions and ventilations and may include attempted defibrillation and the administration of drugs.

4.2 Cardiac Arrest (CA) is the sudden cessation of mechanical cardiac activity, confirmed by the absence of a detectable pulse, unresponsiveness, and apnoea or agonal gasping respiration. In simple terms, cardiac arrest is the point of death.

4.3 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) refers to not making efforts to re-start breathing and/or the heart in cases of respiratory/cardiac arrest. It does not refer to any other interventions/treatment/care such as analgesia, fluid replacement, feeding, antibiotics and basic care etc.

4.4 Advanced Decision to Refuse Treatment (ADRT)
An ADRT (or a living will) is a decision made by a person who has mental capacity to refuse medical treatment at some time in the future.

5 ROLES AND RESPONSIBILITIES

5.1 Chief Executive
The Chief Executive has overall responsibility for Trust compliance with this Policy and Procedures.

5.2 Medical Director
The Medical Director is responsible for making arrangements to support the safe and effective implementation, monitoring and review of this policy.

5.3 The Resuscitation Committee
The Resuscitation Committee, meeting monthly, acts as an decision making body for development and implementation of operational policies relating to resuscitation.

The Committee, supported by the Resuscitation Lead, is responsible for:

a) continuing to develop this policy
b) consideration of educational needs
c) monitoring compliance with this policy and completion of the DNACPR form
d) review of this policy
5.4 Resuscitation Lead

In addition to supporting the Resuscitation Committee with 5.3, the Resuscitation Lead has a responsibility for co-ordinating educational programmes relating to DNACPR.

5.5 Clinical Management Group (CMG) Directors and Heads of Nursing are responsible for:

a) Making sure that all staff in their CMG are made aware of the policy and procedure for completion of a DNACPR form.

b) Making sure that staff groups and individuals are given appropriate training to complete and assess the validity of the DNACPR form (see Section 7).

c) Managing the effectiveness of this policy through a robust system of reporting, investigating and recording incidents and report any concerns / issues to the CMG Quality and Safety Boards.

d) Ensuring process are in place to undertake audits of compliance, results reviewed and actions taken to address any areas of non compliance.

5.6 Ward Managers, Heads of Service/Department are responsible for ensuring:

a) Staff and trainees are aware of the UHL DNACPR policy and the East Midlands DNACPR form.

b) Staff and trainees have had the opportunity to attend the appropriate level of training as part of their contract of employment. (See Section 7).

c) Review of audit results and actions taken where applicable.

5.7 Consultants/Associate Specialists are responsible for ensuring:

a) DNACPR decisions are considered, dependent upon a patient’s individual circumstances and preferences.

b) DNACPR discussions with patients and relatives/carers are undertaken in line with this policy and documented accordingly in the patients’ records.

c) The DNACPR form is correctly completed and reviewed, as appropriate.

d) Any DNACPR decisions not made by either a Consultant or Associate Specialist are verified within 24 hours.

e) Review DNACPR orders as appropriate.

5.8 Healthcare professionals making a DNACPR decision or completing a DNACPR Form should be either a Consultant/Associate Specialist or Middle Grade Doctor and must:

a) Have undertaken appropriate training and education in communication and resuscitation decision making, in line with this policy. See Section 7.

b) Explain the decision to the patient making every effort to involve the patient in the decision and, where appropriate, involve their relatives/carers.
c) Document discussions with the patient and relative/carer or provide rationale if no discussion has taken place

d) Document the discussion and decision on the DNACPR form and in patient’s notes

e) Effectively communicate the decision to the rest of the team

f) Review the decision if necessary

5.9 All UHL Employees are responsible for:

a) Adhering to this policy and supporting procedures

b) Notifying their line manager of any training needs and for undertaking relevant training

c) Ensuring they are aware of the existence of a DNACPR decision

d) Checking the validity of a DNACPR

e) Communicating the existence of a DNACPR decision at handover

f) Notifying other services of the DNACPR decision on the transfer of the patient – both internally and externally

g) Participating in the audit process and acting on the results accordingly.

h) Under the Mental Capacity Act (2005), staff are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made. (see Appendix 3 for more details)

6 POLICY STATEMENTS

6.1 General

a) DNACPR decisions refer only to CPR and not to any other aspect of the individual’s care or treatment options.

b) The likelihood of cardiopulmonary arrest (cessation of breathing and heartbeat) depends on a person’s condition. Discussions relating to CPR will depend on the individual person’s circumstances and their preferences.

c) For some individuals, early discussions could be an important part of their own care planning.

d) All DNACPR decisions will:

• respect the wishes of the individual, where possible
• reflect the best interests of the individual
• provide benefits that are not outweighed by burden

6.2 DNACPR decision making considerations

a) The decision-making framework is illustrated at Appendix 2. When considering making a DNACPR decision for an individual it is important to consider the following
• Is Cardiac Arrest a clear possibility for this individual? If not, it may not be necessary to go any further.

• Is Cardiac Arrest a clear possibility for the individual and CPR may be successful but will not be followed by a length and quality of life in the patient’s judgment that would not be acceptable to the person? If yes, the person’s views and wishes are essential and must be respected.

• If the individual has an irreversible condition, where death is the likely outcome, the individual should be sensitively advised that CPR will not take place, and as such they will be allowed to die a natural death.

b) All discussion around DNACPR decisions must be documented in the patient’s clinical records.

6.3 Unexpected cardiac arrest and DNACPR

a) In the event of an unexpected cardiac arrest, every attempt to resuscitate the individual will take place in accordance with the advice given by the Resuscitation Council (UK) unless a valid DNACPR decision or an appropriate ADRT or Lasting Power of Attorney (LPA) is in place and made known.

b) CPR must be commenced immediately and not stopped until either:
   • a valid DNACPR form is presented or
   • irreversible death is confirmed by an appropriately qualified healthcare professional (i.e. qualified to certify death) or
   • the arrest team determine that CPR is not in the patient’s best interests.

c) Professional judgement must be exercised at all time in any decision making. Providing a rational process in decision making can be demonstrated, UHL will support staff if this decision is challenged.

d) Consideration of the following will help to inform a decision:
   • what is the likely expected outcome of undertaking CPR
   • is the undertaking of CPR contravening the Human Rights Act (1998) where the practice could be inhuman and degrading if futile?

6.4 DNACPR discussions with patients

a) The Trust has a legal duty to consult with and inform patients if a DNACPR order is placed in their notes.

b) If a DNACPR decision is made, and there has been no discussion with the individual because the doctor considers that consultation would be distressful and such distress could cause physical or psychological harm, this must be documented in the patient’s clinical record.

c) Every effort should then be made to discuss with the patient’s relatives/next of kin with the patient’s permission.

d) The DNACPR patient information leaflet should be made available, where appropriate to patients and their relatives or carers.

e) See Section 6.9 in respect of patients without mental capacity.
6.5 DNACPR decision making as part of Consultant Ward Round
   a) The decision to complete a DNACPR form should be made by the patient’s consultant and DNACPR decision making must be part of consultant ward rounds.

   b) Any discussions must be documented in the notes and the decision must be shared with the Multidisciplinary Team at the next opportunity.

6.6 DNACPR decisions by non Consultant/Associate Specialists
   CPR decisions made by a professional without overall responsibility for the person’s care need to be reviewed within 24 hours

6.7 Documentation of DNACPR and use of the East Midlands DNACPR Form
   a) Currently UHL uses a paper DNACPR form, should an electronic version of the form become available, a paper copy must be printed and signed and filed in the patient's clinical record. Only the original is a valid document as copies may have been superseded

   b) The current version of the DNACPR form has limited space for documenting discussions with the patient or the rationale for no discussion. Both must therefore be documented in the patient’s clinical notes. Specifically:
      i. Information regarding the background of the decision, the reasons for the decision, those involved in the decision and a full explanation of the process must be recorded in the individual's notes / care records / care plans
      ii. Where DNACPR discussions are not held with the patient, details of the potential physical or psychological harm that would be caused to the patient
      iii. If a DNACPR decision is made but the clinician would like to review that on a particular date, this section of the form should be filled in.
      iv. The date for review, or ‘no review required’ must be documented on both the DNACPR form and also in the patient’s clinical record. If a planned DNACPR decision is not reviewed and the form not updated, the DNACPR form becomes invalid

6.8 Lack of Capacity
   a) If a patient lacks capacity, then discussions about resuscitation status should be with the family or friends and carers as appropriate.

   b) Any Advance Decision to Refuse Treatment remains legally binding and enquiries should be made as to whether there is a Lasting Power of Attorney / Personal Welfare Attorney appointed. These are permitted to make decisions about treatment if the patient lacks capacity.

   c) If the patient is deemed to be unbefriended, then the ‘decision maker’ has a legal duty to instruct and consult an Independent Mental Capacity Advocate (IMCA) in the decision. The decision maker in this case will be the consultant in charge of the patient’s care.

   d) The only exception to this is where an urgent decision is needed. Please see IMCA POhWER Referral Flowchart LLR (UHL)¹ available on INSITE
e) If a DNACPR decision is needed when an IMCA is not available (for example at night or at a weekend), the decision should be made and the reasons for it should be recorded in the patient’s notes and an IMCA should be consulted at the first available opportunity.

f) An IMCA does not have the power to make a decision about CPR but must be consulted by the clinician responsible for the person’s care as part of the determination of that person’s best interests.

g) Please refer to UHL’s Mental Capacity Act Policy (ID: UHLSP-600-6933) available on Sharepoint for further guidance.

6.9 On-going Communication of DNACPR decision

a) The person making a DNACPR decision is responsible for communicating the decision to colleagues within the same care setting; once the decision has been made, it must be recorded on the regionally approved form (Appendix 1) and full documentation of the discussion with the patient and or their family recorded in the notes; this must include consideration relating to capacity etc.

b) The person in charge of the patient’s daily care is responsible for communicating the decision to colleagues on discharge or transfer

c) The DNACPR decision should always be recorded on the discharge summary and the DNACPR form must also go with the patient on discharge or transfer from UHL

d) However, if a patient is distressed about DNACPR conversations, careful consideration needs to be given to how to ensure the form is available for primary care staff, ambulance crews etc.

e) Confidentiality. If the individual has the mental capacity to make decisions about how their clinical information is shared, their agreement must always be sought before sharing this with family and friends. Refusal by an individual with capacity to allow information to be disclosed to family or friends must be respected. Where individuals lack capacity, and their views on involving family and friends are not known, staff may disclose confidential information to people close to them where this is necessary to discuss the individual’s care and is not contrary to their interests.

6.10 DNACPR Review

a) DNACPR Review Timescales

Review timescales should be based on the person’s individual circumstances and should be sufficiently frequent to allow a change of decision (in either direction) in response to the person’s clinical progress or lack thereof.

Where a patient is receiving end-of-life care for a progressive, irreversible condition there may be little or no need for review of the decision

b) Change of Care Setting

The DNACPR must be reviewed when there is a change in care setting. If a DNACPR form is not cancelled on transfer, then the previous DNACPR decision remains in effect. The frequency of review should be determined by the health
professional in charge of the individual's care at the time of the initial decision. This should be recorded.

c) Patients with an East Midlands DNACPR form

When a patient is admitted or transferred into the Trust, who is subject to a DNACPR order using the East Midlands DNACPR form, there is no need to complete a new form, unless there is a need for change to their DNACPR status.

Existence of the DNACPR form and its origin should be documented in the patients clinical notes.

It should be noted that GP practices in the LLR health economy have an electronic template for the East Midlands DNACPR form. Patients will have a signed printed copy of this form but it will look slightly different to the original East Midlands DNACPR form, especially if printed in black and white. (See Appendix 6).

d) ‘Out of area’ Patients with a non East Midlands DNACPR form

When an ‘out of area’ patient is admitted or transferred into the Trust who is subject to a DNACPR order from a different authority, this DNACPR form will be considered valid as long as it has an original signature and is dated. However, it is essential that the admitting medical team review the DNACPR order at the earliest opportunity and document their decision on to the East Midland’s recognised ‘Do Not Attempt Cardiopulmonary Resuscitation’ form.

e) Patients’ involvement in DNACPR Review

It is important to note that the person’s ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR decision is reviewed, staff must consider whether the person can contribute to the decision-making process each time. **It is not usually necessary to discuss CPR with the person each time the decision is reviewed, if they were involved in the initial decision.** Where a person has previously been informed of a decision and it subsequently changes, they should be informed of the change and the reason for it.

6.11 DNACPR where there is lack of agreement

a) A person with mental capacity may refuse any treatment from a doctor or nurse, even if that refusal results in death: any treatment carried out against their wishes is technically an assault. Individuals should be encouraged to make an ADRT. Should the person refuse resuscitation, this should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives, has taken place.

b) A verbal refusal of resuscitation should not be ignored and does need to be taken into account when making a best interest decision. The verbal refusal of CPR needs to be documented by the person to whom it is directed and any decision to take actions contrary to it must be robust, accounted for and documented.

c) Individuals may insist on CPR being undertaken even if the clinical evidence suggests that it will not succeed. Sensitive discussion with the person should aim to secure their understanding and acceptance of the DNACPR decision.
d) Although individuals do not have a right to demand that doctors carry out treatment against their clinical judgement, the person’s wishes to receive treatment should be respected if possible. Unless the DNACPR decision has been made following a multi-disciplinary consultation, it would be best practice to seek a second opinion if there are differing views.

e) Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice may be indicated. This should very rarely be necessary - advice should be sought from the Head of Legal Affairs – ext 8585

6.12 Cancellation of a DNACPR Decision

a) In some circumstances, a decision may be made to cancel or revoke the DNACPR decision. If the decision is cancelled, the DNACPR form should be crossed through with two diagonal lines in black ballpoint ink and the word ‘CANCELLED’ written clearly between them, dated and signed by the healthcare professional.

b) It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision and document in notes.

c) Electronic versions of the DNACPR decision must be cancelled as per guidance above.

6.13 Suspension of a DNACPR Decision

a) In some circumstances, there are reversible causes of a cardiorespiratory arrest. These are either pre-planned or acute care, and the individual should receive treatment, unless intervention in these circumstances has been specified.

b) **Pre-planned**: Some procedures could precipitate a cardiopulmonary arrest, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the person if appropriate, will need to take place.

c) **Acute injury or emergency situation**: Where the person suffers an acute, unforeseen, but immediately life-threatening situation, such as anaphylaxis or choking. CPR may be appropriate in this instance even if a DNACPR decision is in place.

6.14 DNACPR and Young People (16 to 18 years of age)

a) As with adults, decisions about CPR must be made on the basis of an individual assessment of a young person’s current situation.

b) DNACPR decisions relating to children and young people should be taken within a supportive partnership involving patients, parents and the healthcare team.

c) If it is not possible to reach agreement between the patient, the individuals with parental responsibility and the healthcare team, legal advice should be sought.
d) In England, refusal of treatment by competent young people up to the age of 18 is not necessarily binding upon doctors.

e) Personal care plans might be more appropriate for Young People who have life limiting conditions. Until the Paediatric DNACPR Policy is available, interim guidance should be sought from the Children’s Hospital.

7 EDUCATION AND TRAINING REQUIREMENTS

7.1 To support implementation of this policy, DNACPR teaching is included in the resuscitation training programme.

7.2 This will take the form of both e-learning and videos with opportunity for discussion at the beginning of the resuscitation teaching sessions.

8 PROCESS FOR MONITORING COMPLIANCE –

8.1 Compliance with this policy will be overseen by the UHL Resuscitation Committee using the Key Performance Indicators detailed in Appendix 4 and DNACPR Audit tool in Appendix 5.

9 EQUALITY IMPACT ASSESSMENT

9.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

9.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

10 LEGAL LIABILITY

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their CBU to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable - such decision to be fully recorded in the patient’s notes.

It is recommended that staff have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.
Suitable Professional Indemnity Insurance Cover is generally available from the various Royal Colleges and Professional Institutions and Bodies. For further advice contact: Head of Legal Services on 0116 258 8960.

11 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

UHL Resuscitation Policy A14/2001


Coroners Act 1988 London: Crown Copyright. [Coroners Act 1988 (c. 13)]
http://www.opsi.gov.uk/acts/acts1988/ukpga_19880013_en_1


http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1


Tracey v Cambridge Uni Hospital NHS Foundation Trust and others. [2014] EWCA Civ 822

Decisions relating to cardiopulmonary resuscitation (Oct 2014) 3rd Edition. Guidance from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.

12 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

This document will be uploaded onto SharePoint and available for access by Staff through INsite. It will be stored and archived through this system.

The policy will be reviewed in 12 months’ time from date of original approval and the Chair of the Resuscitation Committee is responsible for identifying the appropriate reviewer(s).
**APPENDIX 1 - EAST MIDLANDS DNACPR FORM**

### DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

**Section 1: DNACPR Category**
- A. For a person at the end of life, DNACPR applies across all care settings. No review necessary.
- OR
- B. DNACPR decision for periodic review during admission/change in place of care or on discharge. State the first review date in section 5. (Should option A then become applicable a new form must be completed)

**Originated by** (Optional):
- E.g., Doctor in training (PRINT).................Signature..................
- GMC No..........................................................Date..........

**Originated by and/or endorsed by** (Optional):
- Responsible clinician/nurse (PRINT).................Signature..................
- Designation.............................................Date.............Organisation..........................................
- If applicable GMC No..................................

**Address/Letterhead**

**Section 2: Reason for DNACPR (please tick those that apply):**
- Patient’s condition indicates that CPR is unlikely to be successful because
- CPR is not in accord with a valid Advance Decision to Refuse Treatment
- Patient does not consent to CPR

**Section 3: Communication with patient and carers/relevant others**
- (Tick all that apply):
- This has been discussed with the patient
- This has been discussed with ________ (name) on date, ________ Relationship to patient
- This has not been discussed with the patient because it would cause unnecessary distress or they lack capacity
- Fully record details of all CPR discussions in the patient’s notes

**Section 4: Complete section below only for patients who lack capacity**
- Does the patient have a legally appointed and registered welfare attorney?
- Yes No
- Have they been consulted and discussion documented? (if yes to question above)
- Yes No
- If no attorney or others to contribute to Best Interests decision, has an IMCA been contacted?
- Yes No
- Confirm that decision made following the best interest process of Mental Capacity Act
- Yes No

**Section 5: DNACPR review**
- Please complete the index and state on the date stated below

<table>
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<th>Date of review</th>
<th>Reviewer’s name (capitals)</th>
<th>Reviewer’s signature</th>
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**Section 6: IF DNACPR CANCELLED - CLEARLY CROSS THROUGH DOCUMENT WITH 2 LINES**
- NAME, DATE AND SIGN WITH A REASON FOR CANCELLATION

**Section 7: Organisational communication**
- The clinical team must ensure the DNACPR paperwork accompanies the patient on transfers and that professional colleagues receiving the patient are aware of the decision
- Patient’s GP........................................Telephone No..................................Professional contact out of hours Name........................................Telephone No..................................Address........................................Address........................................
- Has person in charge of patient’s daily care (e.g. GP, Community Nurse or Care Home) been informed
- Yes No
- A copy should be kept in the notes exclusively for audit purposes and marked as COPY

**When at home or place of care/residence**
- Ensure the original form is accessible to visiting health or social care professionals. E.g., place the form at front of community notes or message in a bottle. Ensure it is ready should an emergency/urgent call be made

**Does the patient have a preferred place of care at the end of life?**
- Yes No

**If yes, where?**
- Tick Box: Home [ ] Hospital [ ] Care Home [ ] Hospice [ ] Other (please state).................................
APPENDIX 2 – DNACPR FLOW CHART FROM EAST MIDLANDS FORM

MAKING A DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) DECISION FRAMEWORK

Healthcare Professional Completing This DNACPR Form

This will vary according to circumstances and local arrangements. In general, this should be the most senior healthcare professional immediately available. Whether in the acute hospital or the community setting, he will be a senior experienced, doctor or nurse, who has undertaken appropriate training and education in communication and resuscitation decision making, according to the requirements of their employer. This decision should be shared with the Multi-disciplinary Team at the next opportunity.

Is cardiac or respiratory arrest a clear possibility in the circumstances of the patient? NO

YES

Is there a realistic chance that CPR could be successful? NO

YES

Does the patient lack capacity? NO

YES

Are the potential risks and burdens of CPR considered greater than the likely benefits of CPR? NO

YES

(CPR should be attempted)

It may not be possible to make an advance CPR decision if you cannot anticipate what you would write on the death certificate if the patient arrested. If you cannot anticipate an arrest you cannot consent for or obtain refusal of CPR since any arrest will be unexpected.

Consequences:
- The patient should be given opportunities to receive information or an explanation about any aspect of their treatment. If the individual wishes, this may include information about CPR treatment and its likely success in different circumstances.
- Continue to communicate progress to the patient (and to the family) if the patient agrees. Continue to elicit the concerns of the patient, partner or family.
- Review regularity to check if circumstances have changed.

In the event of an unexpected arrest: carry out CPR treatment if there is a reasonable possibility of success (if in doubt, start CPR and call for help).

It is likely that the patient is going to die naturally because of an irreversible condition. Where a decision not to attempt CPR is made on these clear medical grounds, it is not appropriate to ask the patient's wishes about CPR (or those close to the patient where the patient lacks capacity), but careful consideration should be given to whether to inform the patient of the decision.

Consequences:
- Document the fact that CPR treatment will not benefit the patient, e.g. The clinical team is as clear as it can be that CPR treatment cannot benefit the patient in the event of a cardiac or respiratory arrest due to advanced cancer, so DNACPR (Do Not Attempt CPR).
- Continue to communicate progress to the patient (and to the family) if the patient agrees or if the patient lacks capacity. This explanation may include information as to why CPR treatment is not an option (as described above) and might include: Unfortunately CPR will not work in your circumstances and we need to ensure all others know about this decision to ensure your comfort at the end of your life, if that is OK?
- Continue to elicit the concerns of the patient, partner and family.
- Review regularly to check if circumstances have changed.
- To ensure a comfortable and natural death effective supportive care should be in place, with access necessary to specialist palliative care, and with support for the family and partner.
- If a second opinion is requested, this request should be respected, whenever possible.

In the event of expected death, AND (Allow Natural Dying) with effective supportive and palliative care.

In adults: is there an Advance Decision to Refuse Treatment (ADRT) refusing CPR, or signed valid Welfare Attorney (LPA) order (with accompanying 3rd party certificate) with the authority to decide on serious medical conditions - the most recent order takes precedence. Otherwise make a decision in the patient's best interests, following the processes stipulated by law, e.g. the Mental Capacity Act.

When there is only a very small chance of success and there are questions whether the burdens outweigh the benefits of attempting CPR: the involvement of the patient (or, if the patient lacks capacity, an ADRT, Lasting Power or Attorney as above or those contributing to Best Interests) in making the decision is crucial. When patients have mental capacity their own view should be the primary guide to decision-making. In cases of doubt or disagreement, a second opinion should be requested.
APPENDIX 3

The Mental Capacity Act (2005) (MCA) was fully implemented on 1 October 2007. The aim of the Act is to provide a much clearer legal framework for people who lack capacity and those caring for them by setting out key principles, procedures and safeguards.

Mental Capacity An individual over the age of 16 is presumed to have mental capacity to make decisions for themselves unless there is evidence to the contrary. Individuals that lack capacity will not be able to:
- understand information relevant to the decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate the decision, whether by talking or sign language or by any other means.

Lasting Power of Attorney (LPA) / Personal Welfare Attorney (PWA) :The Mental Capacity Act (2005) allows people over the age of 18 years and over, who have capacity, to make a Lasting Power of Attorney by appointing a Personal Welfare Attorney who can make decisions regarding health and welfare being on their behalf once capacity is lost.

Independent Mental Capacity Advocate (IMCA)
An independent advocate appointed to support and represent the views of a person who lacks mental capacity to make important decisions about medical treatment and who has no one appropriate (other than paid carers) to consult about those decisions. IMCAs can also become involved if staff are concerned that family members/carers/friends are not acting in a patient’s best interests.

Relevant Other
For the purpose of this policy, the term “relevant others” is used to describe patient’s spouses, partners, relatives, carers (who are not acting in a paid, professional capacity), representatives, advocates, people with lasting power of attorney, IMCAs and court appointed deputies.

A Court-appointed deputy is appointed by the Court of Protection (Specialist Court for issues relating to people who lack capacity to make specific decisions) to make decisions in the best interests of those who lack capacity.

Under the Mental Capacity Act (2005), staff are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made.

The following sections of the Human Rights Act (1998) are relevant to these principles:
- the individual’s right to life (article 2)
- to be free from inhuman or degrading treatment (article 3)
- respect for privacy and family life (article 8)
- freedom of expression, which includes the right to hold opinions and receive information (article 10)
- to be free from discriminatory practices in respect to those rights (article 14).

Staff have a professional duty to report some deaths to the Coroner and should be guided by local practice as to the circumstances in which to do so. However, deaths should always be reported where the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention.

For more information see: Coroners, post-mortems and inquests : Directgov - Government, citizens and rights

http://www.direct.gov.uk/en/Governmentcitizensandrights/Death/WhatToDoAfterADeath/DG_066713
### APPENDIX 4 – DNACPR POLICY MONITORING KEY PERFORMANCE INDICATORS

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Lead</th>
<th>Tool</th>
<th>Frequency</th>
<th>Reporting arrangements</th>
<th>Lead(s) for acting on recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of DNACPR Form</td>
<td>Resuscitation Lead</td>
<td>Case Notes and DNACPR Form</td>
<td>Monthly</td>
<td>Resus Cttee and CMG Q&amp;S Boards</td>
<td>CMG Clinical Directors / CMG Q&amp;SB</td>
</tr>
<tr>
<td>Resus Team called where DNACPR form not followed</td>
<td>Resuscitation Lead</td>
<td>Resus Audit Forms</td>
<td>Monthly</td>
<td>Resus Cttee and CMG Q&amp;S Boards</td>
<td>CMG Clinical Directors / CMG Q&amp;SB</td>
</tr>
<tr>
<td>DNACPR considered as part of Supportive and Palliative Care</td>
<td>Resuscitation Lead</td>
<td>Clinical Handover and Case Note audit</td>
<td>Annually</td>
<td>Resus Cttee and CMG Q&amp;S Boards</td>
<td>CMG Clinical Directors / CMG Q&amp;SB</td>
</tr>
</tbody>
</table>

**Lead(s)**: CMG Clinical Directors / CMG Q&SB
### APPENDIX 5 – DNACPR AUDIT TOOL

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Is there a DNACPR decision?</td>
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<tr>
<td>2  Has the decision been recorded on approved documentation?</td>
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<tr>
<td>3  Has the decision been made by an appropriate clinician?</td>
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<td>4  Is the record clearly dated, timed and signed in full?</td>
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<tr>
<td>5  Are there clear patient identifiers?</td>
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<tr>
<td>6  Are all fields of the records completed?</td>
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<tr>
<td>7  Is there evidence that the mental capacity of the patient has been considered?</td>
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<tr>
<td>8  Is there evidence of discussions with the patient?</td>
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<tr>
<td>9  Is there evidence of discussions with the relatives, significant others or IMCA?</td>
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<tr>
<td>10 Is there evidence that the multidisciplinary team are aware of the decision?</td>
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<tr>
<td>11 Is there evidence that decisions are reviewed and documented?</td>
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<tr>
<td>12 Are the DNACPR principles easily accessible to relevant staff?</td>
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<tr>
<td>13 Has an electronic form been used?</td>
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</table>
DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

This document applies to CPR decisions exclusively and must be used in accordance with local resuscitation policy.
The person must be appropriately assessed to ensure they receive all other appropriate care.
Form developed by the NHS in the East Midlands.

Section 1: DNACPR Category. Delete A or B to identify which applies

A. For a person at the end of life. DNACPR applies across all care settings. No review necessary.

OR

B. DNACPR decision for periodic review during admission/change in place of care or on discharge. State the first review date in section 5 (Should option A then become applicable a new form must be completed)

Originated By (Optional):
e.g. Doctor in training Signature
GMC No Date

ORIGINATED BY AND/OR ENDORSED BY (Obligatory)
Responsible clinician/nurse Signature
Designation Date 16/01/2015 Organisation
If applicable GMC No

Section 2: reason for DNACPR
(Please tick those that apply):

- Patient’s condition indicates that CPR is unlikely to be successful because
- CPR is not in accord with a valid Advance Decision to Refuse Treatment
- Patient does not consent to CPR

Section 3: Communication with patient and carer / relevant others
(Tick all that apply):

- It is good practice to explain why CPR will not be attempted, unless doing so would cause unnecessary distress.
- This has been discussed with the patient
- This has been discussed with (name) on date
- Relationship to patient contact details
- This has not been discussed with the patient because it would cause unnecessary distress or they lack capacity (delete as applicable)
- This has not been discussed with any relevant other e.g. family/carer because
- Fully record details of all CPR discussion in the patient’s notes

Section 4: Complete section below only for patients who lack capacity

- Does the patient have a legally appointed and registered welfare attorney? Yes ☐ No ☐
- Have they been consulted and discussion documented? (If yes to question above) Yes ☐ No ☐
- If no attorney or others to contribute to Best Interests decision, has an IMCA been contacted? Yes ☐ No ☐
- Confirm that decision made following the best interest process of Mental Capacity Act Yes ☐ No ☐
- Fully record details in the patient’s notes

Section 5: DNACPR review. Please complete if indicated by B in section 1 on the date stated below

<table>
<thead>
<tr>
<th>Date of Review</th>
<th>Reviewer’s name (capitals)</th>
<th>Reviewer’s signature</th>
<th>Next review due</th>
<th>Designation &amp; contact details</th>
<th>Location of patient</th>
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</tbody>
</table>

Section 6: IF DNACPR CANCELLED – CLEARLY CROSS THROUGH DOCUMENT WITH 2 LINES

NAME, DATE AND SIGN with a reason for cancellation

Section 7: Organisational communication

The clinical team must ensure the DNACPR paperwork accompanies the patient on transfers and that professional colleagues receiving the patient are aware of the decision

Patient’s GP Dr Amine Boughellam Telephone No 0116 Professional contact out of hours Name Telephone No Address
2413801

Address Dr A J J Bentley Partners, 155 Downing Drive, Leicester LE5 6LP

Has person in charge of patient’s daily care (e.g. GP, Community Nurse or Care Home) been informed Yes ☐ No ☐

A copy should be kept in the notes exclusively for audit purposes and marked as COPY.

When at home or place of care / residence ensure the original form is accessible to visiting health or social care professionals. E.g. place the form at the front of community notes or message in a bottle. Ensure it is ready should an emergency / urgent call be made.

Does the patient have a preferred place of care at the end of life? Yes ☐ No ☐

If yes, where? (TICK) Home ☐ Hospital ☐ Care Home ☐ Hospice ☐ Other (please state)