Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy

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The Trust strives to ensure equality of opportunity for all, both as a major employer and as a provider of health care. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it, regardless of their individual differences, and the results are available on request.

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Executive Summary
This policy is an adapted version of the NHS South of England (Central) Unified DNACPR Adult Policy for use University Hospital Southampton NHS Foundation Trust (UHS).

The policy must be followed in full when making and implementing Do Not Attempt Cardiopulmonary Resuscitation decisions.

For quick reference the guide below is a summary of actions required. This does not negate the need for all clinical staff involved in the Do Not Attempt Cardiopulmonary Resuscitation decision making process to be aware of and follow the detail of the policy.

Quick Reference Guide
- Patients should be involved in decisions concerning DNACPR. There would need to be convincing reasons for not involving the patient in this process. The Court of Appeal has recognized that a patient who is contemplating the end of his/her life is likely to be distressed by discussions concerning a DNACPR decision. But that their distress on its own is not a convincing reason to allow the clinician to avoid having this discussion with them. However, if the clinician believes that the discussion will lead to physical or psychological harm for the patient, then that would be a convincing reason to refrain from discussing the DNACPR decision. The reason for not discussing the DNACPR decision with the patient should be clearly documented in the patient’s medical notes.
- Decisions concerning Cardiopulmonary Resuscitation (CPR) will be made on the basis of an individual patient assessment by a doctor ST3 grade or above.
- Advanced care planning must occur for patients as risk of cardio respiratory arrest, which includes making decisions about CPR, as this is an important part of good clinical care.
- Patients with capacity should be involved in the decision making process if expected benefit of attempted CPR may be outweighed by the burdens.
- For patients that lack capacity, there should be evidence of a Capacity assessment within the patient’s medical records. Relevant others should be involved with the decision making process if the expected benefit of attempted CPR may be outweighed by the burdens. Those close to the patient can help clinicians explore the patient’s wishes, feelings, beliefs and values. In these circumstances, it should be made clear to those close to the patient that their role is not to take/make decisions on behalf of the patient, but to help the healthcare team make an appropriate decision that is in the patient’s best interests.
- Clinical staff must be familiar with the Mental Capacity Act (2005) and understand concepts such as Lasting Power of Attorney and Advanced Decision making by the patient. The clinical staff must then be able to apply these concepts into the DNACPR decision making process as required
- All DNACPR decisions in UHS must be recorded on the unified DNACPR documentation form (Appendix A)
- Effective communications between all involved, such as healthcare staff in the acute trust and community settings, the patient, carers and those close to the patient, is crucial.
- Prior to discharge all DNACPR decisions should be reviewed. If a DNACPR decision continues to apply when a patient is discharged from UHS sections 4 and 5 must be completed. Once completed the lilac copy should be given to the patient or

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ambulance crew as appropriate following discussion with the patient and/or carers. The DNACPR discharge checklist can be used for guidance

- A DNACPR decision applies only to CPR and not to any other aspect of care or treatment
- DNACPR decisions are reviewed on an individual patient basis as required. The frequency of review should be determined by the health professional in charge of the patient’s care at the time of the initial decision. However the need to review a DNACPR decision can change as the patient’s condition changes
- If the DNACPR decision is cancelled, the doctor should place two diagonal lines in black ballpoint ink on all pages of the form and the word ‘CANCELLED’ written clearly between them. The doctor must print their name, sign and date this change. The rationale for cancelling the DNACPR decision must be recorded in the patient’s medical notes. The cancelled form must be filed at the back of the patient’s medical notes.
- If a patient has a valid Advanced Decision to Refuse Treatment (ADRT) that includes CPR or a pre-existing unified DNACPR decision form with them on admission to UHS, then an immediate patient assessment should be undertaken. Following this review if the patient is to continue to be DNACPR during this acute admission then the UHS doctor (ST3 or above) must record the decision on the DNACPR form
- The documentation given to the clinical staff by the patient e.g. a valid ADRT should be returned to the patient.

1

1.1 Introduction
This policy is an adapted version of the NHS South of England (Central) Unified DNACPR Adult Policy for use in University Hospitals Southampton NHS Foundation Trust (UHS).

All patients are presumed to be ‘for CPR’:
- A valid DNACPR decision has been made and documented on the standardised Unified Do Not Attempt Cardiopulmonary Resuscitation (u DNACPR) form for adult DNACPR decisions (Appendix A) or
- An Advanced Decision to Refuse Treatment (ADRT) prohibits CPR

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

All DNACPR decisions are based on current legislation and guidance to ensure that when CPR would not restart the heart and breathing of the individual, it will not be attempted.

For situations when CPR might restart the heart and breathing of the individual, discussion will take place with that individual if this is possible (or with other appropriate individuals for people without capacity), although people have a right to refuse to have these discussions.

The following sections of the Human Rights Act (1998) are relevant to this policy
- 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)
1.2 **Scope**
This policy applies to all staff (including voluntary workers, students, locum and agency workers) on all sites, within UHS; whilst acknowledging that for staff other than those of the Trust, the appropriate line management will be followed in all cases.

This policy applies to DNACPR decisions for patients who are 18 years and over.

1.3 **Purpose**
This policy will provide clear guidance for clinical staff and a framework to ensure that DNACPR decisions:
- Refer only to CPR and not to any other aspect of the individual’s care or treatment options
- Respect the wishes of the individual, where possible
- Reflect the best interests of the individual
- Provide benefits that are not outweighed by burden

1.4 **Definitions**

**Advanced Decision to Refuse Treatment (ADRT):** a decision by an individual to refuse a particular treatment in certain circumstances. A valid ADRT is legally binding for healthcare staff.

**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. 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.

**Decision 1a:** This is a clinical judgment decision; where CPR is unlikely to be successful due to the patient’s clinical condition

**Decision 1b:** This is a quality of life decision where in the event of a cardiac arrest the patient’s heart may regain spontaneous circulation; however the patient’s quality of life post cardiac arrest may not be of overall benefit to the patient.

**Decision 1c:** DNACPR is in accord with the recorded, sustained wishes of the patient who is mentally competent.

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

**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.

**Independent Mental Capacity Advocate (IMCA):** An IMCA supports and represents a person who lacks capacity to make a specific decision as a specific time and who has no family or friends who are appropriate to represent them.

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

**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

**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. Under the Mental Capacity Act (2005), clinicians are expected to understand how the Act works in practice and the implications for each patient for whom a DNACPR decision has been made. Useful information on applying the MCA into clinical practice can be found in Appendix D.

**NHS South of England (Central):** South Central Strategic Health Authority (SHA) and the South West and South East SHA's merged in 2012 to form NHS South of England. This unified DNACPR policy was developed by South Central SHA so only applies in NHS South of England central region.

## 2 Related Trust Policies
Cardiopulmonary Resuscitation Policy 2014

### Related External Policies
Advance Decisions to Refuse Treatment, a guide for health and social care professionals. London: Department of Health ADRT guide


Court of Appeal 2014 Neutral Citation Number: [2014] EWCA Civ 822 Court of Appeal: David Tracey v Cambridge UHNHSFT and Ors - 17 June 2014 Case No: C1/2013/0045

General Medical Council 2010. Treatment and care towards the end of life: good practice in decision-making. Guidance for doctors. GMC Treatment and care towards the end of life: good practice in decision-making


NHS End of Life Care Programme and the National Council of Palliative Care 2008

3 Roles and Responsibilities

Chief Executive
The Chief Executive has ultimate accountability for ensuring robust systems are in place to support effective CPR management is in place across the organisation but delegates this responsibility to the Medical Director.

Medical Director
The Medical Director is the Executive with responsibility for ensuring robust systems are in place to support effective CPR management is in place across the organisation.

The Acuity Matron
The Acuity Matron is responsible for ensuring that:
- DNACPR awareness and principles are included in all classroom resuscitation training delivered to UHS
- The Resuscitation services link system is utilised to cascade information to the clinical departments
- The DNACPR forms returned to the Resuscitation service are stored in line with information governance principles and data protection
- Quarterly reports are produced to the Resuscitation Committee using the data from the returned DNACPR audit forms to monitor compliance against this policy
- Audits requested by the NHS South of England are completed as required

The Resuscitation Officers
The Resuscitation officers have responsibility in ensuring that
- Up to date information related to DNACPR are cascaded to their clinical link areas through dissemination of information and training.

Consultants/ ST3 grades making DNACPR decisions must:
- Be competent to make the decision
- Verify any decision made by a delegated professional at the earliest opportunity.
- Acute trusts must ensure that a DNACPR decision is verified by a professional with overall responsibility at the earliest opportunity
- Ensure the decision is documented
- Involve the individual, following best practice guidelines when making a decision, and if
- Appropriate, involve relevant others in the discussion
- Communicate the decision to other health and social care providers
- Review the decision if necessary.

Line Managers
Line Managers are responsible for:
- Releasing their staff to attend Resuscitation Training, in accordance with requirements identified in the training needs analysis
• Taking any queries raised, that they cannot answer in line with this policy to the Resuscitation service or the Acuity Matron who will provide resolution.

All Clinical Staff
All clinical staff are responsible for ensuring that they:
• Co-operate with the implementation of this policy
• Read, comply and maintain up to date awareness of the DNACPR policy
• Attend training as required, to familiarise themselves and enable compliance with the DNACPR policy relevant to their role and responsibilities; and
• Raise any queries about implementation of this policy with their line manager, Resuscitation Officers or the Acuity Matron.

Resuscitation Committee
The Resuscitation Committee is responsible for ensuring that:
• This procedural document remains up to date, is technically accurate, is in line with evidence based best practice and has been produced following consultation with stakeholders
• Processes to enable audits of compliance with the practices as detailed in this policy are in place and that the actions identified as a result of those audits are implemented.
• Through the Chair, assurance on the effectiveness of this policy and the Trust’s procedures for managing decisions relating to DNACPR, is provided through quarterly reports to the committee, including any necessary recommendations to address identified deficits
• The quarterly reports from the Acuity Matron are reviewed and standards are monitored

Care Group Governance Meetings
These groups have responsibility for
• Receiving information of the compliance with resuscitation training; and for
• Addressing any lack of compliance with the required standard, to ensure all relevant staff are appropriately trained.

4 Process
4.1 For the majority of people receiving care in a hospital, the likelihood of cardiopulmonary arrest is small; therefore no discussion of such an event routinely occurs unless raised by the individual

4.2 In the event of an unexpected cardiac arrest CPR will take place in accordance with the current Cardiopulmonary Resuscitation policy

4.3 Making a DNACPR Decision
4.3.1 The British Medical Association, Royal College of Nursing and the Resuscitation Council (UK) guidelines consider it appropriate for a DNACPR decision to be made in the following circumstances:
• Where the individual’s condition indicates that effective CPR is unlikely to be successful
• When CPR is likely to be followed by a length and quality of life not acceptable to the individual
• Where CPR is not in accord with the recorded, sustained wishes of an individual who is deemed mentally competent or who has a valid applicable ADRT.

4.3.2 For situations when CPR might restart the heart and breathing of the individual, discussion will take place with that individual if this is possible (or with
other appropriate individuals for people without capacity), although people have a right to refuse to have these discussions.

4.3.3 If no explicit decision has been made in advance about CPR and the express wishes of the patient are unknown and cannot be ascertained, health professionals will commence CPR in the event of a cardiac or respiratory arrest as per UHS CPR Policy. In such emergencies, there will rarely be time to make a proper assessment of the patient’s condition and the likely outcome of CPR and so attempting CPR will usually be appropriate in the acute trust setting. Medical and nursing staff will be following this policy by attempting CPR in such circumstances.

4.3.4 There may be some situations in which CPR is commenced on this basis, but during the resuscitation attempt further information comes to light that makes continued CPR inappropriate. That information may consist of a DNACPR decision, or a valid and applicable advance decision refusing CPR in the current circumstances, or may consist of clinical information indicating that CPR will not be successful. In such circumstances, continued attempted resuscitation would be inappropriate.

4.3.5 The decision making framework is illustrated in appendix E. When considering making a DNACPR decision for an individual it is important to consider the following:

- Is Cardiac Arrest (CA) a clear possibility for this individual? If not, it may not be necessary to go any further
- If CA is a clear possibility for the individual, and CPR may be successful, will it be followed by a quality of life that would not be of overall benefit to the person? The person’s views and wishes in this situation are essential and must be respected. If the person lacks capacity, a LPA will make the decision. If a LPA has not been appointed a best interests decision will be made.
- If the person has an irreversible condition where death is the likely outcome, they should be allowed to die a natural death and it may not be appropriate in these circumstances to discuss a DNACPR decision with the individual

4.3.6 If a DNACPR discussion and decision is deemed appropriate, the following need to be considered:

- The DNACPR decision is made following discussion with patient/others, this must be documented in the patient’s medical notes
- The DNACPR decision has been made and there has been no discussion with the individual because they have indicated a clear desire to avoid this, then a discussion with relatives/carers should only take place with the patient’s permission
- If a discussion with a mentally competent person, regarding DNACPR is deemed inappropriate by medical staff, the reason for this must be clearly documented in the patient’s medical notes.

4.4 Documenting a DNACPR Decision

4.4.1 Once the decision has been made, it must be recorded on the approved Adult DNACPR form (Appendix A) and this is placed at the front of the patient’s medical notes.

4.4.2 The lilac layer is used when a patient is discharged from UHS with a DNACPR decision in situ, see section 4.5 for more information. The lilac sheet should be given to be patient or ambulance crew as appropriate. This copy of the DNACPR decision must be available to travel with the patient for communication purposes and will ensure that the ambulance staff are aware of the patient’s CPR status during transfer, and it provides them with the necessary documentation to
comply with their protocols. The lilac sheet should then be provided to the patient and or carers on arrival at the destination. It is therefore essential that the DNACPR decision has been discussed prior to discharge with the patient and/or carers where applicable.

4.4.3 A white copy should be returned to the Resuscitation Services department, E level centre Block, Southampton General Hospital site for audit purposes when either the patient has been discharged, died or the form has been cancelled.

The other white copy should be placed within the patient’s medical notes as a record that the patient has had a DNACPR form.

4.4.4 If on admission, a patient has the lilac part of an uDNACPR form from the community setting or a valid Advance Decision that specifies CPR should not be attempted a medical review must take place as part of the admission process. If the patient is to remain DNACPR then the review decision should be recorded in the patient’s medical notes. If the DNACPR is to continue then the lilac sheet should be placed at the front of the patient’s medical notes. If the review finds to revoke the DNACPR then the form should be cancelled.

4.4.5 As well as completing the approved DNACPR form, information regarding the background to 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 medical records.

4.4.6 Whilst the patient is an in-patient at UHS the valid DNACPR form will be stored as the front page in the patient’s medical notes.

4.4.7 In UHS a doctor grade ST3 and above can make a DNACPR decision. The decision should be verified by a consultant within 48 hours. If more than 48 hours have elapsed the decision is still valid and the consultant’s verification must be sought as a matter of urgency. If the person making the decision is the consultant then the verification is not required.

4.5 Discharges from UHS with a DNACPR Decision in situ

4.5.1 Prior to discharge all DNACPR decisions must be reviewed as part of the discharge planning process. If a DNACPR decision is to remain in situ/valid on discharge from UHS then the doctor, grade ST3 or above, must discuss this decision and the implications, with the patient or if they lack capacity the carer. If the patient has capacity then this decision should be discussed with them in a sensitive manner. If the discussion is likely to cause physical or psychological harm then this should not proceed. This decision should be documented within the patient’s medical notes. In this circumstance the DNACPR cannot be taken out into the community with the patient.

4.5.2 Following this discussion the lilac sheet should be given to the patient/carer to take into the community setting. The DNACPR will also need to be communicated in the discharge letter and summary so that the GP is aware. The situation where this is most likely to occur is when a patient is discharged for End of Life (EoL) care at home or to a nursing home. This communication and subsequent action should be documented in full in the patient’s medical notes.

4.5.3 When transferring the patient between settings all staff involved in the transfer of care of the patient need to ensure that:
   - The receiving institution is informed of the DNACPR decision.
• Where appropriate, the patient or those close to the patient, where they lack capacity) has been informed of the DNACPR decision
• The decision is communicated to all members of the health and social care teams involved in the patient’s ongoing care

4.5.4 If there is no explicit documentation by the doctor that the DNACPR decision is in situ/valid on discharge from UHS and the patient does not have the lilac sheet nor had any discussions then as per policy the DNACPR becomes invalid on discharge. In this situation, even if there was a DNACPR decision in place during the whole inpatient episode, the patient would not have the lilac sheet

Appendix F, the UHS DNACPR Discharge flowchart and Checklist (Appendix B) should be used for guidance to ensure that all correct procedures have been followed.

4.6 Reviewing the Decisions
4.6.1 The DNACPR decision will be regarded as 'indefinite' unless:
• A definite review date is specified
• There are improvements in the patient’s condition
• The patient’s express wishes change where a 1b or 1c decision is concerned

The frequency of review should be determined by the health care professional in charge of the individual’s care.

4.6.2 It is important to note that the patient’s ability to participate in decision-making may fluctuate with changes in their clinical condition. Therefore, when a DNACPR is reviewed, the clinician 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 are 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.

4.6.3 Prior to discharge all DNACPR decisions should be reviewed and if the decision is to remain valid on discharge from UHS then section 4.5 of the DNACPR policy should be followed

4.7 Cancellation of a DNACPR Decision
4.7.1 In rare circumstances, a decision may be made to cancel or revoke the DNACPR decision by a doctor ST3 grade or above. If the decision is cancelled, the form should be crossed through with two diagonal lines in black ball-point pen and the word ‘CANCELLED’ written clearly between them, dated and signed by the healthcare professional cancelling the order. It is the responsibility of the healthcare professional cancelling the DNACPR decision to communicate this to all parties informed of the original decision. The DNACPR form is then folded in half and filed at the back of the patient’s medical notes.

4.8 Suspension of a DNACPR Decision
4.8.1 Uncommonly, some patients for whom a DNACPR decision has been established may develop CA from a readily reversible cause. In such situations CPR would be appropriate, whilst the reversible cause is treated, unless the patient has specifically refused intervention in these circumstances

4.8.2 Acute: Where the person suffers an acute, unforeseen, but immediately life threatening situation, such as anaphylaxis or choking; CPR would be appropriate while the reversible cause is treated

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4.8.3 Pre-planned: Some procedures could precipitate a CA, for example, induction of anaesthesia, cardiac catheterisation, pacemaker insertion or surgical operations etc. Under these circumstances, the DNACPR decision should be reviewed prior to the procedure and a decision made as to whether the DNACPR decision should be suspended. Discussion with key people, including the patient where applicable, will need to take place.

4.9 Situations where there is lack of agreement

4.9.1 A patient with Capacity may refuse CPR, even if they have no clinical reason to do so. This should be clearly documented in the medical and nursing notes after a thorough, informed discussion with the individual, and possibly their relatives. In these circumstances they should be encouraged to write an ADRT. An ADRT is a legally binding document which has to be adhered to, it is good practice to have a DNACPR form with the ADRT, but it is not essential.

If the patient had capacity prior to a cardiac arrest event, a previous clear verbal wish to decline CPR should be carefully considered when making a best interests decision. The verbal refusal should 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. The patient should be encouraged to make an ADRT to ensure the verbal refusal is adhered to.

4.9.2 Individuals may try to insist on CPR being undertaken even if the clinical evidence suggests that it will not provide any overall benefit. Furthermore, an individual can refuse to hold a DNACPR form in their possession. An appropriate sensitive discussion with the patient should aim to secure their understanding and acceptance of the DNACPR decision in some circumstances a second opinion may be sought to aid these discussions.

4.9.3 Individuals do not have a right to demand that doctors carry out treatment against their clinical judgment. Where the clinical decision is seriously challenged and agreement cannot be reached, legal advice may be indicated. This should very rarely be necessary.

4.10 Communication

4.10.1 Confidentiality: If the individual has 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 and friends must be respected. Where individual's lack capacity and their views on involving family and friends are unknown health and social care staff may disclose confidential information to people close to them where this is necessary to discuss the individuals care and is not contrary to their interests.

4.10.2 Effective communication concerning the individual's resuscitation status will occur between all members of the multidisciplinary healthcare team involved and across the range of healthcare settings.

4.10.3 The DNACPR information leaflet (Appendix G) should be made available, where appropriate, to individuals and their relatives or carers.

4.11 Children

4.11.1 DNACPR decisions involving children are complex and must be undertaken by a Consultant only. Within UHS, these decisions are normally made as part of advance care and following in-depth discussion with the family.
4.11.2 All discussions are recorded in the health records and the principles of review, cancellation, communication, ongoing patient care, temporary suspension and confidentiality (where appropriate) apply.

4.11.3 A specific document may be used, referred to as a Paediatric Advanced Care Plan and these are available through the Paediatric Department. Use of this document should involved the relevant Paediatric Consultant(s).

4.11.4 Under particular circumstances it may be necessary to involve the Courts. If this should prove to be the case, the Trust’s Head of Litigation and Insurance must be contacted.

5 Implementation and Training

5.1 Training on DNACPR forms part of the Trust’s essential skills and training requirements for clinical staff; as identified in the Training Needs Analysis. The training for awareness of DNACPR processes is incorporated into Adult Basic Life Support training sessions which is a two yearly update (Refer to Cardiopulmonary Resuscitation policy).

5.2 All training is recorded onto Wired through which wards, care groups and Divisions can monitor their compliance with requirements.

5.3 Compliance is further monitored through Divisional performance reviews with the Executive team.

6 Process for Monitoring Compliance/Effectiveness

6.1 The purpose of monitoring is to provide assurance that the agreed approach as set out in this policy in relation to DNACPR is being followed – this ensures we get things right for patients, use resources well and protect our reputation. Our monitoring will therefore be proportionate, achievable and deal with specifics that can be assessed or measured.

Key aspects of the procedural document that will be monitored:

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(1) State post not person.

Where monitoring identifies deficiencies actions plans will be developed to address them.

7 Arrangements for Review of the Policy

This policy will be reviewed every three years by the Resuscitation Committee. National policy or guideline changes may require additional review and this will be conducted as necessary, and ratified accordingly. Should no amendments be required then the policy will be updated at least every three years. Archiving of this policy will be conducted in accordance with the Trust’s archiving procedure.
8 References
British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing 2014. Decisions Relating to Cardiopulmonary Resuscitation. A Joint Statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing.  http://www.resus.org.uk/pages/dnar.htm


9 Appendices
Appendix A Unified DNACPR form
Appendix B DNACPR Guidance checklist
Appendix C DNACPR Explanation notes
Appendix D MCA into Clinical Practice
Appendix E Decision making Framework
Appendix F UHS DNACPR Discharge flowchart and Checklist
Appendix G DNACPR Information leaflet
Appendix A Unified DNACPR Form (This form is in triplicate - top sheet is lilac)

Lilac Form stays with person wherever they are being cared for.
White forms for audit and notes.

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)
In the event of cardiac or respiratory arrest no attempts at CPR will be made. All other appropriate treatment and care will be provided.

Name __________________________
Address _________________________
Date of birth ___ / ___ / _________
NHS or hospital number ________ __________

Date of DNACPR Decision __ / __ / ______

Institution Name ________________________________
Form completed electronically? Yes ☐ No ☐
Before completing this form, please see explanation notes.

1. Reason for DNACPR decision
   A) CPR is unlikely to be successful due to
   ☐ The person has been informed of the decision Yes ☐ No ☐ If no state reason __________
   ☐ The relevant other has been informed of the decision Yes ☐ No ☐ If no state reason __________
   ☐ Name of relevant other __________
   B) CPR maybe successful, but followed by a length and quality of life which would not be of overall benefit to the person.
   ☐ Person involved in discussions? Yes ☐ No ☐ If no state reason __________
   ☐ Person lacks mental capacity and has a legally appointed Welfare Attorney: Name __________
   ☐ Person lacks mental capacity and does not have a legally appointed Welfare Attorney: Decision is made on the balance of overall benefit to the person in discussion with: Name(s) __________
   ☐ There is a valid advance decision to refuse CPR in the following circumstances: All circumstances Yes ☐ No ☐
   ☐ Specific Circumstances (please state) __________

Attach a copy of the Advance Decision to Refuse Treatment (ADRT) to the back of the DNACPR form.

2. Person making this DNACPR decision:
   Name __________________________ Position __________________________
   Signature __________________________ Date __ / __ / ______ Time __:____
   if decision has been made by a delegated professional, the decision needs to be verified at the earliest opportunity:
   Name __________________________ Position __________________________
   Signature __________________________ Date __ / __ / ______ Time __:____

3. Review: This is an indefinite decision / Needs reviewing (delete as appropriate)
   Review date if appropriate __ / __ / ______
   Outcome of review: DNACPR to continue? Yes ☐ No ☐
   Name __________________________
   Signature __________________________
   Date __ / __ / ______ Time __:____

4. Who has been informed of this DNACPR decision?
   ☐ GP ☐ Ambulance Warning Flag ☐ Out of Hours
   ☐ Care Provider (Please state) __________
   ☐ Other (Please state) __________

5. Other Important Information:
For example, Ambulance crew instructions on transfer, Ceilings of treatment, Prolonged place of care/ death.

__________________________

__________________________

__________________________

The DNACPR form is located __________________________

Cut off top and place in message in a bottle.

Name __________________________
Address _________________________
Date of birth ___ / ___ / _________
NHS or hospital number ________ __________
Appendix B DNACPR Guidance Checklist
DNACPR (Lilac) Form Transfer and Discharge Checklist

Guidance to ward staff in the event of transfer of care or discharge of a patient who has an active (lilac) DNA CPR form.

If you are the nurse leading the transfer or discharge, please ensure that you check the following prior to transferring the form either to the patient, their relative or a transferring crew.

<table>
<thead>
<tr>
<th>Item to be checked</th>
<th>Y/N/N/A</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it appropriate for the DNA CPR form to be discharged / transferred with the patient? Check whether the patient/their relatives/representatives are aware that a DNACPR decision has been made and ensure the lilac form includes a tick in the section for “patient informed/discussed with or relevant other.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REMEMBER</strong>. any vulnerable adult who may lack mental capacity should have had a full mental capacity assessment. If they lack capacity, the appropriate representatives should have been involved in DNACPR decision-making. Is there evidence of this?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you are unsure at this point please contact the patient’s medical team as a matter of urgency to discuss.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all patient details included correctly on the lilac form? Ensure they are included on the white carbonated copy as well.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within part 1, have the applicable sections been completed and “name of relevant other” documented where appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has section 2 been signed by the Consultant leading the patient’s care? The patient should not be discharged or transferred if the form has not been verified by the patient’s consultant. Is the decision documented in the patient’s notes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has Section 4 been completed and has the medical team notified as to who is to be informed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the medical team completes Section 5 prior to transfer / discharge if the patient is going home via ambulance. (If this is not completed then an ambulance / transferring crew should not accept the care of the patient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you torn off the slip at the bottom of the form and placed it in the “message in a bottle”? You need to ensure that the place where the lilac form is to be kept once the patient is discharged is written on the tear off slip.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The lilac form needs to be placed at the front of the patient’s medical notes if being transferred within the hospital. Ensure the DNACPR decision is communicated on handover.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If it is not appropriate for the lilac form to accompany the patient it should be crossed through cancelled, signed and dated by the medical team.(It should be followed and placed at the back of the patient’s medical notes – it should not be discarded))</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have any concerns please escalate to your Consultant, Ward Manager or Matron.

For further information please refer to the Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) Policy available on Staff Net.
**For further enquiries please contact Resuscitation Services on Ext 4342 or Karen Hill, Acuity Matron on Bleep 1359.**
Appendix C DNACPR Explanation notes

UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)

Consider using this form (as part of Advance Care Planning (ACP)), if you would not be surprised if the patient were to die in the next year. For more info on ACP please access the toolkit at http://www.southofengland.nhs.uk/wp-content/uploads/2012/04/ACP-toolkit-v5.pdf

This is not an Advance Decision to Refuse Treatment (ADRT). www.adrt.nhs.uk

Explanation Notes

This form should be completed legibly in black ball point ink

- The person’s full name, NHS or Hospital number, date of birth, date of writing the decision and institution name should be completed and written clearly. Address may change due to person’s deterioration e.g. into a nursing home. If all other information is correct the form remains valid even with incorrect address.

- If the decision is cancelled the form should be crossed through with 2 diagonal lines in black ball point ink and “CANCELLED” written clearly between them, signed and dated by the healthcare staff. It is the responsibility of the healthcare staff cancelling the DNACPR decision to communicate this to all parties informed of the original decision (see section 4.1 form).

- Electronic form must be printed and signed on A4 paper and copies kept for audit purposes and notes.

- Triplicate forms, keep together until person is discharged/ dies or decision is cancelled. Lilac with the person, 1st white copy for audit and 2nd white copy retain in the notes.

Compulsory sections of the form: Top section, Section 1 and Section 2.

1. Reason for DNACPR decision

1.A CPR is unlikely to be successful

Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the person’s best interest’s. Be as specific as possible. In this situation discussion with person / relevant other is not compulsory, although it is considered best practice to inform the person of the decision, if the person is discharged home they need to know about the decision. Record the details of discussion or the reason for not discussing in the person’s notes.

1.B CPR may be successful, but may be followed by a length and quality of life which would not be of overall benefit to the person

Summary of communication with person...

State clearly what was discussed and agreed. If this decision was not discussed with the person state the reason why this was inappropriate.

- Check that patient, relatives or friends have been consulted and may be able to help by indicating what the person would decide if able to do so. If there is no one appropriate to consult and the person has been assessed as lacking capacity then an instruction to an Independent Mental Capacity Advocate (IMCA) must be considered. If the person has made a Lasting Power of Attorney (LPA), appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted.

- A Welfare Attorney may be able to make life-sustaining treatment on behalf of the person if this power is included in the original Lasting Power of Attorney. You need to check this by reading the LPA.

- If the person has capacity ensure that discussion with others does not breach confidentiality.

State the names and relationships of relatives / relevant others with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

1.C DNACPR is in accord with the recorded, sustained wishes of the person who is mentally competent.

- Check for the validity and applicability of the Advance Decision to refuse Treatment (ADRT). Is the ADRT 1. Specific to CPR? 2. in writing, signed and witnessed?

- 3. Contains the statement “even if life is at risk” 4. Has the person been consistent with their ADRT? If the answer to all the above is “Yes” the ADRT is valid and applicable.

- If the ADRT contains specific circumstances when CPR would not be appropriate write these on the form. Attach a copy of the ADRT to the person’s DNACPR form.

2. Person making this DNACPR decision/ Verification

State names and positions. In general this should be the most senior healthcare professional immediately available. If the decision is made by a delegated professional it must be verified by the most senior healthcare professional responsible for the person’s care at the earliest opportunity. If the person making the decision is not the most senior person, verification is not required.

3. Review

A fixed review date is not recommended. This decision will be regarded as “INDEFINITE” unless:

- a definite review date is specified
- there are changes in the person’s condition
- their expressed wishes change

Reviewer needs to complete all details on the form and document the outcome in the notes.

4. Who has been informed of this DNACPR decision?

Please ensure that all health and social care staff who have been informed are aware of their responsibility to document the decision in their own records, as the original stays with the person. It is the responsibility of health and social care staff to ensure those who have been informed of the decision are informed if the patient dies, or the form is cancelled.

5. Other important information

This information needs to be very clear and precise. For example, if transferring include name, address and telephone number of destination and next of kin. Details of treatment include where ACP is kept. Preferred place of care should be noted.

Tear off slip

Complete details and place in “message in a bottle” if available with location clearly stated. For example “in the nursing notes in the top drawer of the bedside table in the dining room.”

• For further information regarding EoL C, ordering new DNACPR forms, for the policy or for the electronic form access: http://www.southofengland.nhs.uk/what-we-do/end-of-life-care/central-area-documents
Assessing Capacity

Patients over 16 years of age are presumed to have capacity to make decisions for themselves, unless there is evidence to the contrary. The Mental Capacity Act (2005) Code of Practice details what must be considered when assessing a person’s capacity to make a decision.

2 questions to assessing capacity:
1. Does the patient have an impairment of the mind or brain or some disturbance that affects the way the brain or mind works e.g. mental illness, dementia, loss of consciousness, alcoholism, drug addiction etc
2. Does the impairment or disturbance mean that the individual is unable to make the specific decision when required to do so

It is important to note that capacity can vary depending on the question being asked and can fluctuate, just because a patient lacks capacity today does not mean they will lack capacity tomorrow.

The points below are used to assess question 2 above:

Individuals are considered legally unable to make decisions for themselves if they are unable to:
- Understand the information relevant to the decision
- Retain that information
- Use or weigh that information as part of the process of making the decisions, or
- Communicate the decisions (whether by talking, using sign language, visual aids or by other means)

The first 3 points above need to be applied together so if a person cannot do any of the first 3 points they will be treated as unable to make a decision. The fourth only applies in circumstances where people cannot communicate their decision in any way.

Advance Decisions to Refuse Treatment

It is well established in law and ethics that adults with capacity have the right to refuse any medical treatment, even if it results in death.

If the patient is not currently being treated in a healthcare institution then the patient should be advised they can make a formal, written advance decision. Age UK has an information sheet on advance decisions which patients may find useful Age UK Factsheet 72 Advanced Decisions and the Office of the Public Guardian also has guidance on this subject.

Advanced Decisions refusing CPR are covered by the Mental Capacity Act (2005). They are valid and legally binding on the healthcare team if:
- The patient was 18 years old or over and had capacity when the decision was made
- The decision is in writing, signed and witnessed
- It includes a statement that the advance decision is to apply even if the patient's life is at risk
- The advance decision has not been withdrawn
- The patient has not, since the advance decision was made, appointed a welfare attorney to make decisions about CPR on their behalf
- The patient has not done anything clearly inconsistent with its terms
- The circumstances that have arisen match those envisaged in the advance decision.

**Patients with a Personal Welfare Attorney**
The Mental Capacity Act (2005) allows people over the age of 18 years of age who have capacity to make a Lasting Power of Attorney (LPA), by appointing a Personal Welfare Attorney who can make decisions on their behalf once capacity is lost. Before relying on the authority of this person the healthcare team must be satisfied that:

- The patient lacks capacity to make the decision
- A statement has been included in the LPA specifically authorising the welfare attorney to make decisions relating to life-prolonging treatment
- The LPA has been registered with the Office of the Public Guardian. The website is [http://www.justice.gov.uk/about/opg](http://www.justice.gov.uk/about/opg)
  
  Office of the Public Guardian  
  PO Box 16185  
  Birmingham  
  B2 2WH  
  Phone Number 0300 456 0300 – Phone lines are open Mon-Fri 9am-5pm (Except Wednesday 10am -5pm)  
  Fax number 0870 739 5780  
  Email: customerservices@publicguardian.gsi.gov.uk
- The decision being made by the attorney is in the patient’s best interests

The role of the Personal Welfare Attorney is to inform the decision making process, not to be the decision maker. They cannot demand treatment that is clinically inappropriate.

**Patients without a Personal Welfare Attorney but who do have family or friends**
Where a patient has not appointed a personal Welfare Attorney or made an Advanced Decision, the treatment decision rests with the most senior clinician in charge of the patient’s care. Where CPR may restart the patient’s heart and breathing for a sustained period, the decision as to whether CPR is appropriate must be made on the basis of the patient’s best interests.

In order to assess best interests, the views of those close to the patient should be sought, where possible. The purpose of this discussion is to establish any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR. These considerations should always be from the patient’s perspective and only relevant information should be shared to ensure confidentiality standards are maintained.

In reaching a decision the Mental Capacity Act (2005) requires that best interests decisions include seeking the views of anyone named by the patient as someone to be consulted, anyone engaged in caring for the patient or interested in the patient’s welfare.

In these circumstances, it should be made clear to those close to the patient that their role is not to make decisions on behalf of the patient, but to help the healthcare team make an appropriate decision in the patient’s best interests. Relatives and others close to the patient should be assured that their views on what the patient would want will be taken into account but that they cannot insist on treatment or non-treatment.

**Patients without a Personal Welfare Attorney and no family or friends**
Where a patient has no family or friends, no Personal Welfare Attorney and no advance decision has been made, the doctor (SpR/ST3 or above) will make the decision in the patient’s best interests.

If the DNACPR is a clinical decision, and it is clear that CPR would not restart the patient’s heart or breathing then this is documented in Section 1 of the Unified DNACPR form with an explanatory statement in the patient’s medical notes detailing the decision making process.

The Mental Capacity Act (2005) requires that an Independent Mental Capacity Advocate (IMCA) is involved in decisions about ‘serious medical treatment’ where a patient has no family or friends, no Personal Welfare Attorney and no advance decision. For DNACPR decisions based on the balance of benefit versus burden the decision should be discussed with an IMCA. However if an IMCA is not available when required (e.g. weekends or out of hours) then the DNACPR decision should be made and documented on the Unified DNACPR form and explanation recorded within the patient’s medical notes as to why the IMCA was not involved at that point. The decision should then be discussed with the IMCA at the first available opportunity as part of the decision making process.

The contact details for the IMCA service in Southampton can be obtained from the South of England Advocacy Project website www.seap.org.uk
Appendix E Decision Making Framework

Decision-making framework

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

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

3. Does the person lack capacity?
   - NO
   - YES

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

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

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

When a DNACPR decision is made on these clear clinical grounds, it is not appropriate to ask the person’s wishes about CPR, but careful consideration should be given as to whether to inform them of the DNACPR decision. Where the individual lacks capacity and has a Lasting Power of Attorney (LPA), Court Appointed Deputy or guardian, this person must be consulted about the DNACPR decision and the reasons for it as part of the ongoing discussions about the individual’s care. If a second opinion is requested, this should be respected, whenever possible.

Do they have a valid and applicable ADRT; if so this must be respected. If an attorney, deputy or guardian has been appointed they should be consulted.

If no, a decision will be made on the basis of best interests. Decision makers have a legal duty to consult with those close to the individual who lacks capacity.

If there is no one appropriate to consult and the person has been assessed as lacking capacity, then an instruction to an Independent Mental Capacity Advocate (IMCA) must be considered.

When there is only a very small chance of success and there are questions as to whether the burdens outweigh the benefits of attempting CPR, the involvement of the individual (or if the person lacks mental capacity those close to him / her) in making the decision is crucial. When the individual has mental capacity their own view should guide the decision making.

Adapted from: Decisions relating to cardiopulmonary resuscitation. A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. October 2007.

Appendix F UHS DNACPR Discharge Flowchart

Disclaimer: It is your responsibility to check against Staffnet that this printout is the most recent issue of this document.
At the point the Consultant decides the patient is medically fit for discharge the DNACPR decision should be reviewed.

- **No Longer appropriate – DNACPR decision cancelled as per policy**
  - A sensitive discussion will be held with the patient (or carer if patient lacks Capacity) informing them that a DNACPR decision is in place by a doctor, ST3 grade or above.
  - The lilac form is then given to the patient (or carer if patient does not have capacity). It may be given to the ambulance crew if the patient is being transferred to another healthcare setting e.g. a nursing home.
  - All the above fully documented in the patient’s medical notes and on the discharge summary.

- **DNACPR decision still appropriate**
Appendix G  Information leaflet for relatives and carers (This information leaflet can be obtained from The Resuscitation Department Extension 4342 or downloaded from http://www.southampton.ac.uk/healthsciences/business_partnership/services/eolc.page

Information for you, your relatives and carers about

Do Not Attempt
Cardiopulmonary Resuscitation decisions

For a translation of this document, an interpreter or a version in large print or Braille, please contact Access to Communication by telephone 023 8024 1300

www.southofengland.nhs.uk/what-we-do/end-of-life-care


Disclaimer: It is your responsibility to check against Staffnet that this printout is the most recent issue of this document.